



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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3232 Elder Street
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CERTIFIED MAIL: 7012 1010 0002 0836 2359

August 23, 2013

Lori A. Bentzler, Administrator
Twin Falls Center
674 Eastland Drive
Twin Falls, ID 83301-6846

Provider #: 135104

**RE: CORRECTION MADE TO THE SEVERITY STATEMENT IN THE FIRST
PARAGRAPH OF THE SURVEY COVER LETTER DATED AUGUST 20, 2013**

Dear Ms. Bentzler:

On **August 2, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Twin Falls Center by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct"

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(listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 3, 2013**. Failure to submit an acceptable PoC by **September 3, 2013**, may result in the imposition of civil monetary penalties by **September 23, 2013**.

The components of a Plan of Correction, as required by CMS include:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to

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implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **September 6, 2013 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **September 6, 2013**. A change in the seriousness of the deficiencies on **September 6, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 6, 2013** includes the following:

Denial of payment for new admissions effective **November 2, 2013**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 2, 2014**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid

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Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **August 2, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **September 3, 2013**. If your request for informal dispute resolution is received after **September 3, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135104	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 8/2/2013
NAME OF PROVIDER OR SUPPLIER TWIN FALLS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 204	<p>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG</p> <p>A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a record of the disposition of personal possessions was retained for 1 of 3 residents (Resident #16) reviewed, who were discharged from the facility. This resulted in the potential loss of valued possessions. The findings include:</p> <p>1. Resident #16's record included a 5/6/13 admission form which documented he was admitted to the facility on 5/2/13 with diagnoses that included stroke and hypertension. He expired on 5/10/13.</p> <p>Documentation regarding the disposition of his personal possessions could not be found in his record.</p> <p>When asked, during an interview on 8/1/13 at 12:45 p.m., the RN Consultant stated no documentation related to Resident #16's personal possessions could be found.</p> <p>The facility failed to maintain record of the disposition of Resident #16's personal possessions.</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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NAME OF PROVIDER OR SUPPLIER TWIN FALLS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual Federal recertification and complain investigation survey conducted at your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Karen Marshall, MS, RD, LD Team coordinator Arnold Rosling, BSN, RN, QMRP Debbie Bernamonti, RN Ashley Henscheid, QIDP</p> <p>Survey Definitions:</p> <p>CNA = Certified Nurse Aide ADON Assistant Director of Nursing DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MASD = Moisture-Associated Skin Damage MDS = Minimum Data Set assessment RN = Registered Nurse ROM = Range of Motion</p>	F 000	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Twin Falls Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”</p>	
F 225 SS=E	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p>	F 225	<p>RECEIVED SEP - 3 2013 FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Joie Bentler</i>	TITLE Administrator	(X6) DATE 8/29/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of investigations and staff interview, it was determined the facility failed to ensure all allegations of abuse, neglect and/or mistreatment were thoroughly investigated, and appropriate corrective action was taken. That failure directly impacted 5 residents (Residents #11, #17 - #19 and #20) involved in significant incidents. This resulted in a lack of sufficient information being available on which to base corrective action decisions. The findings included, but were not limited to, the following:</p>	F 225	<p><u>F225</u></p> <p><u>Specific Residents Identified</u></p> <p>1a. Resident #17 was re-interviewed by the administrator on 8/1/13 related to the event that occurred on 1/28/13. The summary of that interview was documented and placed in the investigative file by the administrator on 8/2/13.</p> <p>1b. Resident #17's daughter was interviewed by the administrator on 8/5/13 related to the event that occurred on 1/28/13. The summary of that interview was documented and placed in the investigative file.</p> <p>1c. Licensed Nurse #8 was interviewed by the Director of Nursing and Administrator on 8/5/13 related to the event that occurred on 1/28/13. The summary of that interview was documented and placed in the investigative file on 8/5/13 by the administrator.</p>

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F 225	<p>Continued From page 2</p> <p>1. An investigation, dated 1/28/13, documented Resident #17 was transferred from her bed to her shower chair by CNA #10 and CNA #11 and the transfer resulted in a right humerus fracture. However, the investigation was not thorough, as follows:</p> <p>a. The investigation stated, "During the transfer, [Resident #17] said she felt a pop which was painful." Resident #17's statement, including her account of what led up to the "pop," was not included with the investigation.</p> <p>Further, Resident #17 was interviewed on 7/30/13 at 11:15 a.m. by the surveyor. She stated that when CNA #10 cued her for a shower, she requested that he wait so she could have her morning visit with her daughter. Resident #17 stated CNA #10 and CNA #11 pulled her out of bed, each CNA holding an arm. She stated that despite her requests for a later shower time, the CNAs continued to transfer her to her shower chair and CNA #10 took her to the shower.</p> <p>Resident #17 reported that once in the shower, she was crying in pain because her arm was injured during the transfer. She stated CNA #10 told her she was fine and that she needed to rinse her hair. Resident #17 stated she told CNA #10 she did not want to rinse her hair, but CNA #10 told her hot water would do her good.</p> <p>b. The investigation included an Interdisciplinary Progress Notes entry, dated and timed 1/28/13 at 7:45 a.m. and signed by LN #8, which stated, "After shower res[ident] daughter had arrived to facility." No information related to an interview with Resident #17's daughter, including what she witnessed and what her mother told her about the</p>	F 225	<p>1d. The Administrator and Director of Nursing updated the investigative file to include the medical care that was provided to Resident #17 between 0735 and 0830 am on 1/28/13.</p> <p>1e and 1f. The Nursing assistants reenacted the transfer for the Director of Nursing on the day of the event. The Director of Nursing noted that the transfer was completed appropriately. The investigative file was updated by the Director of Nursing on or before 9/5/13 that the re-enactment occurred.</p> <p>2. Resident # 18 has been discharged from the facility.</p> <p>3. Resident #19 has been discharged from the facility.</p> <p>4a. Resident #20's investigative file was updated to include a summary of interviews that were completed to determine how the event was caused by the Director of Nursing on or before 9/5/13.</p> <p>5. LN # 6 was re-educated by the Director of Nursing on or before 9/5/13 related to completing an incident report for any new bruise or injury that is identified.</p>		

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F 225	<p>Continued From page 3 incident, was included with the investigation.</p> <p>Further, Resident #17's daughter was interviewed on 7/30/13 at 11:35 a.m. by the surveyor. She stated that she did not witness the incident firsthand and the CNAs described the event as though they were trying to save Resident #17 from falling.</p> <p>However, Resident #17's daughter stated Resident #17 reported to her that she begged not to shower and the CNAs made her take the shower anyway. Resident #17 told her daughter that the CNAs told her she would feel better after the shower.</p> <p>Resident #17's daughter stated Resident #17's arm dislodged during the incident and she thought if the CNAs had not forced her mother to shower her arm may not have dislodged.</p> <p>c. The investigation included a written statement from CNA #10 which stated "Our nurse was informed and assessed [sic] the situation." During an interview on 7/30/13 from 3:37 - 3:48 p.m., CNA #10 stated "our nurse" was referring to LN #8. However, no statement regarding what LN #8 witnessed or what she found during her assessment was included in the investigation.</p> <p>d. The information entered in the facility's electronic incident reporting system, dated and timed 1/28/13 at 1:51 p.m. by LN #8, documented Resident #17's injury occurred at 7:35 a.m. The entry also documented Resident #17 was transferred to the ER at 8:30 a.m. The investigation did not include any information related to the 55 minute gap in medical care.</p>	F 225	<p>The left wrist of Resident #11 was assessed by the Director of Nursing or designee on 8/29/13 with no discoloration, pain or decreased range of motion noted.</p> <p>The investigation reports for incidents involving Residents # 11, #17 and #20 were updated to include the missing components and then were reviewed by the Administrator and Director of Nursing for completeness on or before 9/5/13.</p> <p>Resident #11 was interviewed by the administrator on 8/29/13 and was unable to provide a statement regarding the events that may have led to the bruise on the hand/wrist on 3/25/13. Staff who worked during the 24 hours prior to the bruise being discovered were interviewed by the Director of Nursing or designee regarding the bruise and their statements added to the investigation. The bruise was determined to be related to resident's wrist watch. The resident is no longer wearing wrist watch.</p>	
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F 225	<p>Continued From page 4</p> <p>Additionally, during an interview on 7/30/13 at 11:35 a.m., Resident #17's daughter stated after the incident Resident #17 was in pain so Resident #17's daughter requested that the CNAs contact the physician. She was told that they could not call the doctor until 9:00 a.m. Resident #17's daughter asked the employees what they would do for their own mothers, to which she was told they would call 911. Resident #17's daughter requested that they contact the hospital immediately and get Resident #17 a pain medication. She stated she made pain medication and medical care requests multiple times before Resident #17 received care.</p> <p>Further, an Interdisciplinary Progress Notes entry, dated and timed 1/28/13 at 7:45 a.m. and signed by LN #8, stated "Daughter began to state desire for res[ident] to be sent to ER for eval[uation]."</p> <p>e. Resident #17's care plan, dated 3/23/12, stated "Use gait belt when transferring, as needed." The investigation stated, "care plan updated ... a gait belt is to be used by staff during transfers." However, no additional information related to the gait belt (i.e. whether it was used in the transfer) was included in the investigation.</p> <p>Additionally, during an interview on 7/30/13 at 11:35 a.m. with Resident #17's daughter, Resident #17's daughter stated CNA #10 told her Resident #17's gait belt was used and CNA #11 stated it was not. Resident #17 also told her daughter that her gait belt was not used.</p> <p>f. The investigation stated resident #17 was "being transferred onto the shower chair from her bed...The resident was being transferred appropriately using her transfer pole with two staff</p>	F 225	<p>Resident #20 was re interviewed and the interview documented. The resident stated that the abdominal area was bumped on the walker while in the bathroom and that may have caused the bruise to the resident's abdominal apron on the right side on 7/15/13. Staff who worked during the 24 hours prior to the discovery of the bruise were interviewed and the interviews documented. It was determined that the most probable cause of the bruise was the bump on the walker.</p> <p>Resident #17 was re interviewed and a new abuse investigation was conducted based on the resident's statements. The licensed nurse and the two nursing assistants involved in the incident were interviewed. The resident's daughter was interviewed. The allegation of abuse was reported to the Bureau of Facility Standards based upon the new interviews and information provided.</p> <p>Residents # 11, 17 and 20 were assessed by Social Services on or before 9/5/13 to ensure that there are no adverse psychosocial impact on the residents.</p>	

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F 225	<p>Continued From page 5</p> <p>members...The staff transferred her appropriately according to her care plan." The investigation did not contain information related to how these conclusions were reach, as the gait belt use was not investigated (see above example).</p> <p>Further, the investigation documentation included an Interdisciplinary Progress Notes entry, dated and timed 1/28/13 at 7:45 a.m. and signed by LN #8, that stated one CNA went to transfer Resident #17 from her bed to her shower chair and Resident #17 "began to slide and CNA called for help from other CNA." The investigation did not clarify how this procedure was transferring "appropriately...with two staff members."</p> <p>2. An investigation, dated 3/15/13, documented an allegation of neglect to Resident #18.</p> <p>a. The investigation stated, "The Director of Nursing and Administrator were notified and initiated the investigation." However, the investigation did not include the date and time the allegation was submitted or who reported the allegation. Additionally, the date the investigation was completed was not documented.</p> <p>b. The investigation stated "Three cna's [sic] and one licensed nurse were scheduled and assigned to the 400 hall." However, the investigation report did not include the names of the staff working or statements from anyone.</p> <p>3. An investigation, dated 5/31/13, documented an allegation of abuse to Resident #19.</p> <p>a. The investigation stated, "While talking with staff, the resident said that the staff were too fast during transfers and that he was not turned for 15</p>	F 225	<p><u>Identification of Other Residents</u></p> <p>A review of resident incidents for the last 30 days was completed by the Director of Nursing and Administrator on or before 9/5/13 to ensure that a thorough investigation was completed. Incidents that needed to be reported to the Bureau of Facility Standards were called in and investigations completed.</p> <p>A skin sweep was completed by nurse management on or before 9/5/13 to ensure that all skin issues were identified and investigated.</p> <p><u>Systematic Changes</u></p> <p>The IDT was re-educated on abuse prevention, reporting and investigations by the Regional Nursing Consultant on or before 9/5/13. Staff in the facility were re-educated on abuse prevention, reporting and investigations by the administrator or Staff Development Coordinator on or before 9/5/13.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/02/2013
NAME OF PROVIDER OR SUPPLIER TWIN FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301		
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F 225	<p>Continued From page 6</p> <p>hours one day." Additionally, the investigation stated, "During an IDT review of notes in [Resident #19's] chart, it was discovered that the statement was made that staff were too fast..." However, the investigation did not include any information related to who the staff was that Resident #19 reported to or if the staff was retrained on proper reporting.</p> <p>b. The investigation stated "Staff were also interviewed..." However, no details regarding the name of the staff, how many were interviewed or their statements, were included with the investigation.</p> <p>4. An investigation, dated 7/15/13, documented a bruise of unknown origin on Resident #20 "under her abdominal apron on her right side."</p> <p>a. Next to "Probable Root Cause," the investigation stated, "bump on her walker when turning to sit on toilet." However, the investigation did not include any documentation of how the conclusion was reached (i.e. staff interview, interview with Resident #20, etc.).</p> <p>When asked about the Probable Root Cause during an interview on 8/1/13 from 9:48 - 10:16 a.m., the DON stated the Unit Coordinator interviewed Resident #20, who stated she was in the bathroom and turned, with her walker, which hit her causing the bruise. The DON stated no documentation of the actual investigative process for the incident existed.</p> <p>When asked about the investigations, during an interview on 8/1/13 from 3:51 - 4:08 p.m., the Administrator stated she did not have any additional documentation to evidence the</p>	F 225	<p><u>Monitoring</u></p> <p>Beginning the week of 9/7/13, an audit of 5 incident investigations will be completed by the Administrator or designee weekly for 4 weeks, then monthly for 2 months to ensure completeness. 3 residents will be assessed weekly for 4 weeks and then monthly for 2 months by the Director of Nursing or designee for any uninvestigated skin conditions. Results of audits will be reported to the Performance Improvement Committee monthly for 3 months.</p> <p>The administrator is responsible for monitoring and follow up. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months.</p> <p><u>Date of Compliance</u></p> <p>9/6/13</p>		

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F 225	<p>Continued From page 7</p> <p>thoroughness of the investigations.</p> <p>The facility failed to ensure all allegations of abuse, neglect or injuries of unknown origin were thoroughly investigated.</p> <p>5. Resident #11 was admitted to the facility 10/1/11 and readmitted on 4/17/12 with diagnoses of after care traumatic fracture of the hip, traumatic fracture of the upper arm, dementia; unspecified with behavioral disturbance, and Parkinson's disease.</p> <p>The most recent quarterly MDS, dated 7/17/13, documented the resident:</p> <ul style="list-style-type: none"> - had short and long term memory problems, - had severe impairment for decision making abilities, - required extensive assistance of one for transfers, dressing, eating, personal hygiene and bathing. <p>During review of the resident's medical record on 7/31/13, a physicians order, dated 3/25/13, was found that documented, "monitor discoloration to left wrist/hand til [until]resolved - Day Shift every 2 days discoloration to left wrist." The resident's medical record was reviewed, the facility incident and accident reports were reviewed, nothing was found about the bruises. The DON was interviewed on 8/1/13 at 9:45 a.m. and said he would look into the bruise.</p> <p>On 8/1/13 at 11:00 a.m. the RN Consultant provided a "Non-Pressure Wound and Skin Condition Documentation Form," dated 3/24/13, that identified the area as a left hand/wrist "discoloration" and measured 5 cm by 5 cm. The facility tracked the area until 5/8/13 where the</p>	F 225			

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F 225	Continued From page 8 size was 0.75 cm by less than 0.1 cm in size. On 8/1/13 at 3:00 p.m. the facility provided an incident report for the discoloration that the LN# 6 created that day at 8/1/13 at 1:09 p.m. The information that the nurse documented was; the discoloration was "2 cm by 3 cm" and to the "right wrist." There was no incident report or investigation for an injury of unknown origin, for the left wrist 5 cm by 5 cm discoloration, provided by the facility.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on policy review and staff interview, it was determined the facility failed to sufficiently develop and operationalize policies and procedures that prohibited mistreatment, neglect, and abuse of residents and misappropriation of resident property for 5 residents (Residents #11, #17 - #19 and #20) involved in significant incidents, with the potential to affect all residents residing in the facility. That failure resulted in potential harm by not clearly specifying how staff were to handle allegations of abuse, neglect or mistreatment. The findings include: 1. The facility's abuse policy, dated 1/2008, was	F 226	<u>F226</u> <u>Specific Residents Identified</u> Residents # 18 and # 19 have been discharged from the facility. Residents # 11, 17 and 20 were assessed for signs or symptoms of abuse or neglect by the Director of Nursing or designee on or before 9/5/13. No issues were noted. The facility's abuse policy was updated and adopted by the facility Performance Improvement Committee on or before 9/5/13. The updated policy includes the required sections per the state and federal regulations.	

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F 226	<p>Continued From page 9</p> <p>reviewed and was not sufficient to ensure residents were not subjected to mistreatment, neglect, abuse, and misappropriation of their property as follows:</p> <p>a. Under the section titled Training, it stated "Train employees, through orientation and ongoing sessions..."</p> <p>The policy did not contain information related to how ongoing training would be conducted, at what frequency, or who was responsible for training staff.</p> <p>b. Under the section titled Protection, it stated prevention of further abuse during investigation could include:</p> <ul style="list-style-type: none"> - Removing the accused employee from the resident care area immediately pending investigation. - Removing the staff member from the schedule until the results of an investigation were known. - Temporary room re-assignments when resident to resident incidents occur. <p>The policy did not include information related to who was authorized to make these decisions.</p> <p>c. Under the Physical Abuse definition, it referred to corporal punishment. Corporal punishment was not defined.</p> <p>Additionally, the definition included "signs of being restrained" as a symptom of abuse. However, "signs of being restrained" was not defined in policy.</p> <p>Further, when five staff were asked about the</p>	F 226	<p><u>Identification of Other Residents</u></p> <p>A review of all resident incidents for the last 30 days was completed by the Director of Nursing and Administrator on or before 9/5/13 to ensure that a thorough investigation was completed. Incidents that needed to be reported to the Bureau of Facility Standards were called in and investigations completed.</p> <p><u>Systematic Changes</u></p> <p>Staff have been educated by the Administrator or designee regarding the new abuse policy on or before 9/5/13.</p>

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F 226	<p>Continued From page 10</p> <p>signs of being restrained, during interviews on 7/31/13 and 8/1/13, staff stated the following:</p> <ul style="list-style-type: none"> - Inability to function properly from medications, hand restraints or seat belts. - Change of behavior, some people get angry, tiredness or hands tied. - Oversedation, being tied to a chair, wheelchair brakes locked, left in an area they can't get out of or being in bed without the call light in reach. - The way they act. - Bruises, if skiddish around people, scratches or new marks. <p>Staff knowledge was not consistent with the reporting requirements specified in the facility policy.</p> <p>d. Under the section titled "Reporting of the allegation includes," it stated all alleged violations were to be immediately reported to the Administrator and DON.</p> <p>The policy did not include information as to what to do if the alleged staff were the Administrator and DON.</p> <p>e. The section titled "Reporting of the allegation includes" stated the following:</p> <ul style="list-style-type: none"> - Investigate the alleged incident immediately, - Evaluate the resident for injuries, - Remove/protect the resident from danger, - Conduct interviews of resident(s) and witnesses and obtain written statements, - Notify the DON and Administrator, - Suspend/remove the employee immediately - pending results of the investigation, - Instruct the employee not to return to the center 	F 226	<p><u>Monitoring</u></p> <p>Beginning the week of 9/7/13, 5 staff members will be interviewed weekly for 4 weeks and the monthly for two months by the Administrator or designee regarding the new abuse policy to ensure their understanding of the new policy. In addition at least one abuse investigation will be reviewed weekly times 4 weeks and then monthly for 2 months to ensure that the abuse policy is followed. Re-education to be completed as needed. The results of the audits will be submitted to the Performance Improvement Committee monthly for 3 months. The administrator is responsible for monitoring and follow up. The Performance Improvement Committee will re-evaluate the need for further monitoring after three months.</p> <p><u>Date of Compliance</u></p> <p>9/6/13</p>	

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F 226	<p>Continued From page 11</p> <p>until they have spoken with the director of nursing and/or administrator,</p> <ul style="list-style-type: none"> - Notify the physician, - Notify the family or legal representative, - Notify law enforcement officials as appropriate, as directed by Administrator, - Notify the State Department of Health and other regulatory agencies according to individual state reporting requirements, - Notify appropriate department heads, - Notify the resident care plan coordinator of potential care plan needs, - Notify the social worker to provide counseling and support to the residents and/or families involved. <p>For instructions not specified "immediately," associated timeframes for implementation were not included. Additionally, the policy did not include information related to who was authorized to make these decisions.</p> <p>f. Under the section titled "Regardless of the specific allegation, interview:," it specified details of who to interview during an investigation.</p> <p>The policy did not include information related to who was authorized to conduct interviews and associated timeframes for implementation.</p> <p>g. Under the section titled Final Investigation Report, it stated the summary, conclusions, and outcomes were to be submitted to the state within 5 days of the event.</p> <p>The policy did not include information related to who was responsible for report submission.</p> <p>h. The policy was written to cover only residents</p>	F 226		

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F 226	<p>Continued From page 12</p> <p>older than their staff. Examples included the following:</p> <ul style="list-style-type: none"> - Under the section titled Reporting/Response, the definition of sexual abuse was defined as "sexual contact with an elder..." - Examples of sexual abuse included "showing the elder pornographic material" and "spying on the elder in the bathroom or bedroom." - Examples of mental/emotional abuse included "ignoring the elder" and "treating an elder like an infant." - Examples of misappropriation of property included "using the elder's charge card number...", "withdrawing cash from a resident's bank account with an ATM card, without the elder's permission" and "forging the senior's signature." <p>When asked, the Administrator stated during an interview on 8/1/13 from 3:51 - 4:08 p.m., the new ownership had different policies that were scheduled to be implemented the week of survey. Further, the Administrator stated she would not implement the new policy until she ensured these specifics were included.</p> <p>2. Refer to F225 as it relates to the facility's failure to operationalize the policy to ensure thorough investigations of abuse, neglect and injuries of unknown origin.</p> <p>The facility failed to ensure policies and procedures that prohibited mistreatment, neglect, and abuse of residents and misappropriation of resident property were sufficiently developed and operationalized.</p>	F 226		
F 242	483.15(b) SELF-DETERMINATION - RIGHT TO	F 242		

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F 242 SS=D	<p>Continued From page 13 MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interview, it was determined the facility failed to provide the choice and length of mealtime for a resident. This affected 1 of 16 residents (Resident #9) whose records were reviewed and had the potential to affect all residents at the facility. The facility's failure to ensure a resident's meal choices were recognized created the potential reduced meal intake and weight loss. The findings include:</p> <p>1. Resident #9 was admitted to the facility on 7/4/13 with diagnoses including lower limb amputation, above knee, hypertension, and chronic pain.</p> <p>a. Resident #9's record was reviewed and included an Interdisciplinary Communication to Nutrition Services form, dated 7/15/13 and signed by an LPN. The form stated "Early trays all meals."</p> <p>When asked about the early tray process, the Administrator stated during an interview on 7/30/13 from 1:45 - 2:00 p.m., if a resident requests early trays, they should be served</p>	F 242	<p><u>F-242</u></p> <p><u>Specific Residents Identified</u></p> <p>Resident #9 was interviewed by the Administrator or designee on or before 9/5/13 regarding the choice of meal times and her care plan was updated by the IDT on or before 9/5/13 to reflect her choices. CNA #9, #12 and #13 and LN #14 were re-educated by the Director of Nursing or designee on or before 9/5/13 on not removing the residents' meal tray until they are done with their meal.</p> <p><u>Identification of Other Residents</u></p> <p>Resident interviews have been completed by the Administrator or designee of residents who eat in their rooms regarding their choice of meal times on or before 9/5/13. Changes have been implemented per resident request.</p> <p>Rounds were completed on 9/4/13 by the administrator or designee to ensure that resident meal trays are not removed until the resident verbalizes that they are finished with their meal.</p>		

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F 242	<p>Continued From page 14 before anyone in the dining room.</p> <p>However, during an observation on the morning of 7/30/13, the dining room service for breakfast began at approximately 8:20 a.m. Resident #9 did not receive her breakfast until approximately 10:05 a.m.</p> <p>Additionally, during an observation on 7/31/13, early trays went out for delivery at 5:49 p.m. Resident #9 was not observed to receive an early tray. Resident #9 received her tray at approximately 7:00 p.m.</p> <p>During an interview on 8/1/13 from 5:01 - 5:27 p.m., the DON stated it was the nurses' responsibility to ensure residents received the early trays as requested. He stated early tray requests are never declined and Resident #9's request not being honored had been an oversight.</p> <p>b. During an observation on 7/30/13 at approximately 10:40 a.m., it was noted that someone was inside of Resident #9's room with the door closed. That person was heard saying Resident #9's breakfast tray needed to be removed because she only was allotted a certain amount of time to eat. Resident #9 replied something that was inaudible through the door and the person responded to Resident #9 by telling her she could have water now.</p> <p>When the door opened, CNA #13 appeared carrying Resident #9's breakfast tray. CNA #12 came out of the room with CNA #13 and while they conversed this surveyor recognized CNA #12 as the person who spoke when the door was closed.</p>	F 242	<p><u>Systematic Changes</u></p> <p>Staff have been re-educated on or before 9/5/13 by the Administrator or designee regarding residents choices of meal times and resident meal trays are not to be removed until the resident verbalizes that they are finished with their meal.</p> <p><u>Monitoring</u></p> <p>Beginning the week of 9/7/13, audits of residents receiving meal trays will be completed by the administrator or designee 3 times a week for 4 weeks and then weekly for 2 months to ensure that residents are receiving their meals per their choice and trays are not being removed before the resident is finished. Residents will be asked in resident council regarding their choice of meal times and if they are able to complete their meal before their tray is removed for three months.</p>

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F 242	<p>Continued From page 15</p> <p>At 10:43 a.m. Resident #9 was interviewed regarding the situation. Resident #9 stated she wanted her tray but the nurse told her it was too old. Resident #9 said the nurse told her she is allowed 30 minutes to eat, but Resident #9 stated that is not enough time for her.</p> <p>When asked about the removal of trays during an interview on 7/31/13 at 11:24 a.m., CNA #12 stated it depends on when the resident is done eating, but the tray can only sit for so long. CNA #12 stopped LN #14 and asked her what the required time for tray removal was. LN #14 told her 35 minutes to 1 hour.</p> <p>When asked about the removal of Resident #9's tray during an interview on 7/31/13 at 11:30 a.m., CNA #13 stated she went in Resident #9's room once before and Resident #9 stated she was not finished. CNA #13 stated the observation of the tray removal was the second visit to Resident #9's room, during which she told Resident #9 her food was cold and removed the tray. CNA #13 stated she did not know where the "30-minute rule" came from.</p> <p>The Administrator stated during an interview on 7/30/13 from 1:45 - 2:00 p.m., there is no rule related to the amount of time a resident can have their meal tray. She stated if food has been sitting for 15 - 20 minutes she would expect a nurse to offer to place the tray in the fridge to be reheated later, but if a resident was eating their food there was no time limit.</p> <p>The facility failed to recognize and honor Resident #9's request to receive and retain her meal trays as desired.</p>	F 242	<p>Results of the audits will be submitted to the Performance Improvement Committee monthly for three months. The Administrator is responsible for monitoring and follow up. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months.</p> <p><u>Date of Compliance</u></p> <p>9/6/13</p>	

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F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, it was determined the facility failed to ensure that the resident's call light was within reach. This was true for 1 of 6 (# 21) random residents. This practice had a potential harm because the resident's needs may not be met. Findings include:</p> <p>During the initial tour of facility on 07/29/12 at 1:30 p.m., it was observed Res #21 was reclining in her recliner. Her call light was attached to her bed which was across the room. After interview the resident disclosed that she was not able to reach her call light.</p> <p>On 7/29/13 at 2: p.m., CNA #4 was interviewed about the call light. His response was, "I will take care of it, thank you."</p> <p>On 08/01/13 at 7:30 p.m. the Administration, DON and RN Consultant were notified and no response was given.</p>	F 246	<p><u>F-246</u></p> <p><u>Specific Residents Identified</u></p> <p>Resident #21 has a call light attached to the bed and to the recliner. The resident's call light will be in reach at all times when she is in her room.</p> <p>Resident #21 was assessed for signs or symptoms of adverse effects post incident by the Director of Nursing or designee on 9/3/13 with none noted.</p> <p><u>Identification of Other Residents</u></p> <p>Resident rooms have been checked by maintenance staff on or before 9/5/13 to ensure that call lights can be placed within reach of residents when they are in recliners in their room. Resident call lights are within the reach of residents when they are in their rooms at all times. Any findings were corrected.</p>		
F 272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically</p>	F 272			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 08/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/02/2013
NAME OF PROVIDER OR SUPPLIER TWIN FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 17 a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by:	F 272	<u>Systematic Changes</u> Facility staff re-educated on or before 9/5/13 by the administrator or designee that call lights must be within reach of each residents at all times. If the call light cannot be reached, maintenance is notified. <u>Monitoring</u> Beginning the week of 9/7/13, audits will be completed by the IDT, as assigned by the administrator or designee, three times a week for 4 weeks and then weekly for 2 months to ensure that call lights are within reach of the residents. A report of the audits will be submitted to the Performance Improvement Committee monthly for 3 months. The Performance Improvement Committee will re-evaluate the need to further monitoring after 3 months. The administrator is responsible for monitoring and follow up. <u>Date of Compliance</u> 9/6/13	

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F 272	<p>Continued From page 18</p> <p>Based on observation, medical record review, and staff interview, it was determined the facility failed to ensure siderails were assessed as safe for resident use. This affected 2 of 5 (#s 2 & 4) sampled residents. This practice placed the residents at risk for entrapment and potential harm should the residents become entrapped in the siderails. Findings included:</p> <p>1. Resident #4 was originally admitted to the facility on 11/16/11, and most recently readmitted on 4/2/13, with multiple diagnoses including bilateral above the knee amputation (AKA) and dementia.</p> <p>Resident #4's 4/9/13 significant change MDS coded intact cognition, two or more person total assistance for bed mobility, and two person extensive assist for transfers.</p> <p>Resident #4's care plan, printed 7/19/13, identified a focus area, Risk for falls related to AKA. One of the interventions was, "Side rails up x 2 [2 side rails up] while in bed as an enabler."</p> <p>The resident's 7/8/13 Device Evaluation (siderail evaluation) did not identify or document the use of the 1/2 siderails were assessed as "safe for the resident." The Evaluation documented the resident used one, 1/2 partial side rail on the upper left side of the bed.</p> <p>On 7/30/13 at 7:40 a.m., 8:42 a.m. and again at 9:15 a.m., Resident #4 was observed in her bed with the 1/2 siderails in the upright position.</p> <p>2. Resident #2 was admitted to the facility on 8/23/10 with multiple diagnoses including abnormal posture and lack of coordination.</p>	F 272	<p><u>F-272</u></p> <p><u>Specific Residents Identified</u></p> <p>Resident # 2 and resident #4 were assessed by the Director of Nursing or designee on 9/3/13 with no adverse effects related to side rail usage. A new device evaluation was completed on or before 9/5/13 by the Director of Nursing or designee for Residents #2 and #4. The new evaluation includes documentation that the side rails are safe for use by the resident.</p> <p><u>Identification of Other Residents</u></p> <p>Residents in the facility with side rails have had a new device evaluation completed on or before 9/5/13 by the Director of Nursing or designee. The new evaluations includes documentation that the side rails are safe for use by the resident.</p>

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F 272	<p>Continued From page 19</p> <p>Resident #2's 5/7/13 significant change MDS coded intact cognition, two person extensive assist for bed mobility, and one person extensive assist for transfers.</p> <p>Resident #2's care plan, printed 6/28/13, identified:</p> <ul style="list-style-type: none"> - focus area, Self care deficit related to weakness and physical limitations. One of the interventions was, "Resident uses a positioning device: 2 1/2 side rails." - focus area, Risk for falls related to use of psychotropic medications, generalized weakness, and history of multiple falls. One of the interventions was, "2 1/2 side rail {sic} while in bed as an enable {sic} [two 1/2 siderails while in bed as an enabler]." <p>The resident's 4/30/13 Device Evaluation (siderail evaluation) did not identify or document the use of the 1/2 siderails were assessed as "safe for the resident." The Evaluation documented the resident used upper left and right side 1/2 side rails when in bed.</p> <p>On 7/30/13 at 10:20 a.m., 11:30 a.m., and on 7/31/13 at 10:30 a.m., Resident #2 was observed laying in bed with the upper left and right siderails in the upright position.</p> <p>On 7/31/13 at 4:48 p.m., the surveyor informed the DON and the RN Consultant the siderail device evaluation forms did not include the residents were assessed as safe to use the devices. The Consultant stated, "We consider the device evaluation a safety assessment. We have not included the verbiage [assessed as safe] on the forms." The DON stated, "If you review other</p>	F 272	<p><u>Systematic Changes</u></p> <p>Licensed nursing staff were inserviced on or before 9/5/13 by the Director of Nursing or designee regarding use of side rails and completion of the evaluations for safety.</p> <p><u>Monitoring</u></p> <p>Beginning the week of 9/7/13, audits will be completed two times a week for 4 weeks and the weekly for 2 months by the Director of Nursing or designee on new admits and current residents with side rails to ensure that evaluations include documentation that the side rails are safe for use by the resident. Results of audits will be reported to the Performance Improvement Committee monthly for three months. The Director of Nursing is responsible for monitoring and follow up. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months.</p> <p><u>Date of Compliance</u></p> <p>9/6/13</p>

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F 272	Continued From page 20 residents' device evaluation forms, you should see a handwritten entry the device was determined as safe for the resident to use."	F 272			
F 280 SS=D	On 8/2/13 at 12:30 p.m., the Administrator was informed of the finding. The facility did not provide any additional information related to the finding. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, the facility failed to update resident care plans in a timely manner after changes in the residents' status occurred. This was found to be	F 280	<u>F-280</u> <u>Specific Residents</u> Residents #5 and #8 were assessed by the Director of Nursing or designee on 9/3/13 with no adverse effects noted. Resident # 5 and # 8's care plans have been reviewed and updated on or before 9/5/13 by the Interdisciplinary Team to ensure that current conditions are reflected and interventions are implemented. <u>Identification of Other Residents</u> Resident care plans were reviewed by the Interdisciplinary Team by 9/5/13 to ensure that care plans accurately reflect the current resident conditions and interventions.		

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F 280	<p>Continued From page 21</p> <p>true for 2 of 13 (#s 5 & 8) sampled residents. There was a potential for harm when the facility had two different levels of assistance for transferring a resident. If staff used the lowest level of assistance and the resident fell he could sustain an injury. Findings include:</p> <p>1. Resident #5 was admitted to the facility on 5/20/10 and readmitted 4/22/13, with diagnoses of abnormal gait, muscular wasting and disuse atrophy, edema, and chronic kidney disease stage III.</p> <p>The most recent quarterly MDS, dated 7/12/13, documented the resident: - was cognitively intact with a BIMS of 15, - required extensive assistance for transfers, dressing, personal hygiene and bathing.</p> <p>A review of the resident's comprehensive care plan for urinary tract infections, dated 4/17/13, revealed there were three interventions found related to a catheter. These were: "Catheter Care as per order, Change catheter collection bag per protocol and PRN, and Change indwelling catheter as ordered by MD." The resident did not have a catheter. The DON was interviewed about the catheter and on 8/1/13 at 10:45 a.m. and informed the surveyor the catheter was discontinued when the resident was in the hospital in April 2013.</p> <p>A review of the resident's comprehensive care plan for falls, dated 8/20/10, revealed there were two interventions found related to transfers. These were: "Resident will be a Hoyer lift transfer related to increased weakness" [dated 4/13/13] and "Assist resident getting in and out of bed with 2 person assistance." [dated 7/17/13] The</p>	F 280	<p><u>Systematic Changes</u></p> <p>The Licensed Nurses and the IDT were educated by the Director of Nursing or designee on or before 9/5/13 on accuracy of care plans that need to reflect the current condition and interventions used for each resident and that the care plan is updated and revised as needed.</p> <p><u>Monitoring</u></p> <p>Beginning the week of 9/7/13, 5 care plans will be audited by the Director of Nursing or designee weekly for 4 weeks and monthly for 2 months to ensure resident care plans reflect current resident needs. A report will be submitted to the Performance Improvement Committee monthly for 3 months for review. The Director of Nursing is responsible for monitoring and follow up. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months.</p> <p><u>Date of Compliance</u></p> <p>9/6/13</p>		

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F 280	Continued From page 22 resident was interviewed on 7/30/13 at 11:15 a.m. and said the staff helped him transfer but sometimes did it himself. 2. Resident #8 was admitted to the facility on 11/9/12 and readmitted on 2/25/13 with diagnoses of congestive heart failure, rheumatoid arthritis, disorders of neurohypophysis and cervical spondylosis with myelopathy. The most recent quarterly MDS, dated 5/17/13, documented the resident: - was cognitively intact with a BIMS of 15, - required total care for transfers, dressing, personal hygiene and bathing. The resident's comprehensive care plan for potential for mood impairment, anxiety, dated 2/25/13, had an intervention, dated 1/3/13 which documented, "[Resident #8] enjoys having one to one visits in her room, her husband is usually there and very friendly." The resident's husband died 7/12/13 and the care plan was not changed. The Administrator, DON and Nurse consultant were informed of the care plan issues on 8/1/13 at 7:15 p.m. No further information was obtained.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		

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F 281	<p>Continued From page 23</p> <p>Based on medical record review, grievance review, and staff interviews, it was determined the facility failed to ensure nursing staff followed accepted standards of practice when administering medications. This affected 1 of 14 (#14) sampled residents. This failure created the potential for the resident's pain to not be managed and controlled. Findings included:</p> <p>Resident #14 was admitted to the facility on 12/28/12 with multiple diagnoses including history of falls at home, left proximal humerus fracture, generalized pain, and muscular wasting and disuse atrophy. The resident discharged from the facility on 1/10/13.</p> <p>Resident #14 did not reside in the facility long enough for completion of the Resident Assessment Instrument process.</p> <p>Resident #14's 12/28/12 Pain Evaluation form documented the resident experienced internal frequent pain ranging from 5-6 and 7-8, moderate-severe pain and severe/horrible pain, respectively. Pain location, left arm. Onset and duration, occasional/intermittent on a daily basis. Pain description, generalized, sore, and throbbing.</p> <p>In addition to as needed pain medication, the resident's physician ordered Norco 1 tablet by mouth three times a day for pain on 1/4/13. The physician clarified the Norco order as follows. - 1/7/13, "Norco 5/325 mg tabs (hydrocodone-acetaminophen) 1 by mouth at 8 am, 2 pm and 8 pm and my {sic} give additional one every 6 hours as needed (max 6/day)."</p> <p>The resident's "Schedule for January 2013" form</p>	F 281	<p><u>F-281</u></p> <p><u>Specific Residents Identified</u></p> <p>Resident # 14 has been discharged from the facility.</p> <p><u>Identification of Other Residents</u></p> <p>The Director of Nursing or designee reviewed the medication cart and observed a medication pass on the 100 hall on or before 9/5/13 to ensure facility policy for medication pass meets standards of practice including timing and destruction of medications. Any findings will be immediately corrected with education provided.</p> <p><u>Systematic Changes</u></p> <p>Licensed nurses including LN #8 were re-educated by the Director of Nursing or designee on or before 9/5/13 on the accepted standards of practice and facility policy when administering medications to residents including timing and destruction of medications.</p>

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F 281	<p>Continued From page 24</p> <p>(Medication and Treatment Record) contained the 1/7/13 Norco order in the far left hand column and in the hours column, 8:00 a.m., 2:00 p.m., and 8:00 p.m. for medication administration times. On 1/8/13 nursing staff documented the Norco 5/325 medication was administered at 8:00 a.m., 2:00 p.m., and at 8:00 p.m.</p> <p>On 1/8/13 a Grievance/Complaint Report form that appeared to be completed by the Administrator on behalf of a concerned family member was reviewed. One of the concerns the family member expressed was, "The nurse signed off that she gave a pain medication early - it was not given..."</p> <p>The facility conducted an investigation into the family member's concern about the pain medication. The following information was attached to the 1/8/13 Grievance/Complaint Report form.</p> <p>- LN #8's 1/8/13 statement, in part, "...I started my noon med [medication] pass at 1110 [11:10 a.m.] and noted that res [Resident #14's] Norco for [room number] was not scheduled until 1400. I had already 'popped' the med out. So I put it [Norco] into a med cup and made a note - on my information sheet to give the med at 1400 [2:00 p.m.]. Just after this happened [Resident #14's family member] approached the med cart and asked to see [Resident #14's] MAR. [Resident #14's family member] was upset at the occurrence."</p> <p>- ADON's 1/8/13 1230 (12:30 p.m.) statement, in part, "Was made aware of a family member by LN #9 @ 1200 [at noon]... Went to investigate @ 1210 [12:10 p.m.], noted LN #8 did sign for pain med Norco, which was to be given @ 1400...the pill...was in a labeled med cup & covered [with]</p>	F 281	<p><u>Monitoring</u></p> <p>Beginning the week of 9/7/13, the Director of Nursing or designee will complete 3 med pass audits per week for 4 weeks and then 1 audit weekly for 2 months. Results of audits will be reviewed monthly by the Performance Improvement Committee for 3 months or until resolved. The Director of Nursing is responsible for follow up and monitoring.</p> <p><u>Date of Compliance</u></p> <p>9/6/13</p>	

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F 281	Continued From page 25 another med cup. Verified med against med card and med count." On 8/1/13 at 4:47 p.m. the DON, ADON, and Administrator were interviewed about the Norco administration on 1/8/13. The ADON stated, "I saw the med [Norco] in the cup, labeled and dated. I saw a dot [.] on the MAR for 1/8/13 at 2:00 p.m., not the LN's initials." The surveyor informed the ADON the statement completed by her on 1/8/13 at 12:30 p.m. documented LN #8 "did sign" for pain med Norco. The DON stated, "LN #8 did the right thing by not giving the Norco when she popped it into the cup." The Bureau of Facility Standards Informational Letter #97-3 dated 4/17/97, indicated, "...when the Board of Nursing received information that long term care facility staff were signing medications as given at the time of medication preparation, not after the residents actually had taken the medication...the Board's expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do. Upon checking with Idaho nursing education programs, it was confirmed that the schools continue to instruct students to document what they have done, seen or heard, after these events occur..." On 8/2/13 at 12:15 p.m., the Administrator and the DON were informed of the finding. The facility did not provide any additional information related to the finding.	F 281		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		

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F 309	<p>Continued From page 26</p> <p>provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interviews, it was determined the facility failed to ensure physician orders were followed, care plan interventions were implemented, and initial care plans were complete. This affected 5 of 14 (#s 4, 7, 9, 10 & 14) sampled residents. This practice created the potential for harm related to unmet resident needs, not having the catheter changed could potentially cause a urinary tract infection, cares not provided as ordered, and not receiving all ordered antibiotics could contribute to infection. Findings included:</p> <p>1. Resident #4 was originally admitted to the facility on 1/10/13, and readmitted on 4/2/13, with multiple diagnoses including atrial fibrillation, hypertension, and dementia.</p> <p>Resident #4's care plan, printed 7/15/13, included the focus area, hypertension related to cardiac disease. One of the interventions was, "Obtain blood pressure as ordered..."</p> <p>The resident's "All Active Orders for July 2013" (recapitulation) contained the order, 6/28/13, "BP and Pulse daily - day shift everyday [determine blood pressure and pulse daily on day shift everyday]."</p>	F 309	<p><u>F-309</u></p> <p><u>Specific Residents</u></p> <p>Resident #4's blood pressure and pulse were assessed and found to be within normal limits by the Licensed Nurse on 8/29/13. The resident's blood pressures and pulse for the last 30 days were reviewed with the physician including the omissions by the Director of Nursing or designee on 9/3/13 with no new orders received.</p> <p>Resident #10 was re evaluated by physical therapy on or before 9/5/13 related to ambulation needs. The resident's care plan and physician orders have been reviewed by the IDT and physician orders are being followed for ambulation. The care plan has been updated to reflect current physician orders on or before 9/5/13.</p> <p>Resident #14 has been discharged from the facility.</p>		

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F 309	<p>Continued From page 27</p> <p>Resident #4's 7/13 "Schedule for July 2013" form (Medication and Treatment Record) identified in the far left hand column, BP and Pulse Daily. Review of the form provided evidence the resident's BP and Pulse were not determined on 7/13, 7/18, 7/19, and 7/21/2013. The identified date blocks on the form were blank. In addition, the 7/28/13 date block contained a handwritten "X" for BP and a handwritten "X" for Pulse.</p> <p>On 7/31/13 at 3:00 p.m., the surveyor informed the DON and the RN Consultant of the dates in July 2013 when Resident #4's BP & Pulse were not determined and the "Xs" entered on 7/28/13 on the form as identified above. The RN Consultant reviewed the form and stated, "X is not an acceptable entry for BP or Pulse."</p> <p>On 7/31/13 at 10:30 a.m., Resident #4's physician stated, "I review BP & Pulse to find trends. When a patient is on a heart medication, I may have to set parameters for when to hold a medication. I use BP & Pulse to monitor for a consistently low pulse."</p> <p>On 8/2/13 at 12:30 p.m., the Administrator was informed of the finding. The facility did not provide any additional information.</p> <p>2. Resident #10 was admitted to the facility on 11/8/12 with multiple diagnoses including dementia and depression.</p> <p>Resident #10's 11/14/12 admission MDS coded: - moderate cognitive impairment, - one person extensive assistance for walk in room and in corridor, - one person limited assistance for locomotion on and off unit,</p>	F 309	<p>Resident #7's catheter bag and indwelling catheter was changed by the Licensed Nurse on 8/3/13. Resident #7 was assessed for signs and symptoms of adverse effect by the licensed nurse on 9/3/13 with none noted.</p> <p>Physician orders and the care plan for resident #9 have been reviewed by the IDT and physician orders are being followed for medications. Resident #9's physician was contacted by the Director of Nursing or designee on or before 9/5/13 related to the missed doses of medication for follow up. No new orders were received.</p>	

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F 309	<p>Continued From page 28</p> <ul style="list-style-type: none"> - no upper or lower functional limitations in range of motion (ROM), - walking, turning around, and facing the opposite direction not steady only able to stabilize with human assistance, and - mobility devices walker and wheelchair <p>Resident #10's most recent 5/16/13 quarterly MDS coded the same as the admission MDS except for:</p> <ul style="list-style-type: none"> - no assistance required for locomotion on and off unit. <p>The resident's Care Plan, printed 4/25/13, identified the focus area of difficulty walking related to: weakness. The goal was "...will ambulate BID w/walker x 15 minutes [two times a day with walker for 15 minutes] as able and tolerated." One of the interventions was, "Remind [Resident #10] to ambulate BID x15 minutes w/walker."</p> <p>On 7/30/13 at 9:20 a.m., Resident #10 was in a wheelchair propelled by staff. Resident #10 stated, "I am going to the dentist." Note: During the survey process, the resident was not observed walking independently.</p> <p>On 7/31/13 at 4:44 p.m., the surveyor asked the DON about Resident #10 ambulating two times a day with a walker for 15 minutes. The DON stated, "I believe we tried and the resident refused to participate." The surveyor asked the DON for evidence the facility tried and the resident refused to ambulate two times a day with the walker for 15 minutes.</p> <p>On 8/1/13 at 6:20 p.m., the surveyor asked the DON about Resident #10 refusing to ambulate</p>	F 309	<p><u>Identification of Other Residents</u></p> <p>Physician orders and care plans have been reviewed and updated by the IDT regarding blood pressures and pulses, ambulation, immobilizers, catheters and antibiotics on or before 9/5/13. A review of the facility MARs and TARs was completed on or before 9/5/13 by the Director of Nursing or designee to ensure that physician orders including antibiotic orders were followed and transcribed accurately. Follow up was completed as indicated.</p> <p><u>Systematic Changes</u></p> <p>Licensed nurses were re-educated by the Director of Nursing or designee on or before 9/5/13 regarding following physician orders and care plans.</p>

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F 309	<p>Continued From page 29</p> <p>two times a day with the walker for 15 minutes. The DON said, "I forgot, I will check into it."</p> <p>On 8/2/13 at 12:30 p.m., the Administrator and the DON were informed of the finding. The DON stated, "We do not have a current physician's order for ambulating two times a day with the walker for 15 minutes." The facility did not provide any other additional information related to the finding.</p> <p>3. Resident #14 was admitted to the facility on 12/28/12 with multiple diagnoses including history of falls at home and left proximal humerus fracture. The resident discharged from the facility on 1/10/13.</p> <p>The resident's 12/28/12 Admission Orders contained the order, "Keep left shoulder immobilizer on except to bathe or change clothes, then remove when patient upright allowing left arm to hang at side."</p> <p>Resident #14's initial care plan identified the focus area of pain/potential for pain related to: fracture of left arm. Review of the resident's initial care plan, revealed the care plan did not include the use of the immobilizer or interventions for the use of the immobilizer to the resident's left arm.</p> <p>On 8/1/13 at 3:20 p.m., the surveyor informed the ADON the care plan did not include the use of the immobilizer. The ADON reviewed the care plan and stated, "I do not see the immobilizer on the care plan."</p> <p>On 8/2/13 at 12:30 p.m., the DON and the Administrator were informed the care plan did not include the use of the immobilizer. The facility did</p>	F 309	<p><u>Monitoring</u></p> <p>Starting the week of 9/7/13, audits of MARs and TARs for 5 residents as compared to physician orders will be completed by the Director of Nursing or designee to ensure that physician orders are being followed. Audits will be completed 3 times a week for 4 weeks and weekly for two months. A report will be submitted to the Performance Improvement Committee monthly for 3 months for review and follow up. The Director of Nursing is responsible for monitoring and follow up. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months.</p> <p><u>Date of Compliance</u></p> <p>9/6/13</p>

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F 309	<p>Continued From page 30</p> <p>not provide any additional information related to the finding.</p> <p>4. Resident #7 was readmitted on 03/4/13 from hospitalization for a urinary tract infection and sepsis. Resident #7 also had diagnoses of diabetes and right sided hemiplegia. Resident #7 had a supra pubic catheter.</p> <p>Physician orders dated 03/4/13 stated, "Change foley bedside drainage bag every 2 weeks-night shift every 15 days," and "indwelling catheter 24 French with 30 cc balloon to bedside drainage. Change catheter monthly."</p> <p>The Comprehensive care plan, dated 04/18/13, documented the catheter drainage bag was to be changed every 2 weeks on the night shift. The foley catheter was to be changed monthly on the night shift, the 10th of every month. Catheter site care was ordered to be done every shift.</p> <p>Treatment administration record review documented in the month of April and June 2013 the catheter was not changed. The catheter was changed 05/02/13 and 07/10/13.</p> <p>Treatment administration records revealed the drainage bag was changed on April 24, May 24, and June 9, 2013.</p> <p>On 07/31/13 at 2:15 p.m., LN #5 and the ADON were interviewed. They indicated that a licensed nurse was responsible for the catheter site care and the changing of the catheter monthly. The CNA was responsible for changing the drainage bag every 2 weeks. LN #5 stated that if the catheter was not changed on the night shift then the day shift would be responsible to change it. If the catheter was not changed on the day shift</p>	F 309		

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F 309	<p>Continued From page 31 then the evening shift would change it.</p> <p>On 08/01/13 at 7:30 p.m. the Administrator, DON and Nurse consultant were informed. No further information was provided.</p> <p>5. Resident #9 was admitted to the facility on 7/4/13 with diagnoses including muscle weakness, lower limb amputation, above knee, and fitting and adjustment of urinary device.</p> <p>Resident #9's Interdisciplinary Progress Notes included an entry, timed and dated 7/18/13 at 11:30 a.m., which stated "Res[ident] [complained of] suprapubic pain urine dark odorous clean catch taken and sent for UA. Dr notified."</p> <p>A physician's order was received the same day that stated Resident #9 was to receive Macrobid (an antibiotic drug) 100 mg by mouth twice a day for 14 days.</p> <p>However, Resident #9's 7/2013 MAR was reviewed and documented Macrobid had been blocked out for and administered on 7/18/13 at 8:00 p.m. through 7/25/13 at 8:00 a.m., a total of 7 days.</p> <p>During an interview on 8/1/13 from 5:01 - 5:27 p.m., the DON stated when the physician's order is entered into the electronic system, the MAR page is generated with the designated time blocked out. He checked the entry in the electronic system and verified the nurse who entered the order set the duration of administration for 7 days. The DON stated the nurse entered the order incorrectly and the error should have been caught by the nurse or during</p>	F 309		

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F 309	Continued From page 32 any of the medication passes that did occur.	F 309		
F 314 SS=D	<p>The facility failed to ensure Resident #9 received Macrobid per physician's orders.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure that residents who entered the facility without a pressure ulcer did not develop pressure ulcers for 3 of 4 sample residents (#s 1, 5 and 9) reviewed for pressure ulcers. This resulted in residents developing avoidable pressure ulcers. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 5/18/12 and readmitted 9/8/12, with diagnoses including osteoporosis, contracture of joint of multiple sites and pressure ulcer. Additionally, Resident #1's record contained an office visit note, dated 3/19/13, which stated her past medical history included decubitus ulcer.</p> <p>Resident #1's record contained a Physical</p>	F 314	<p><u>F-314</u></p> <p><u>Specific Residents Identified</u></p> <p>Residents # 1, 5 and 9 pressure ulcer development risk was re assessed by the Director of Nursing or designee on or before 9/5/13 and their care plan reviewed by the Interdisciplinary Team on or before 9/5/13 to ensure current interventions and resident condition are reflected to include prevention of skin breakdown including moisture related skin breakdown. The residents' care plan and orders were updated as needed.</p> <p><u>Identification of Other Residents</u></p> <p>An audit of residents at high risk for skin breakdown was completed by the Director of Nursing or designee on or before 9/5/13 to ensure interventions for preventative measures are in place and that the residents' care plan reflects the current condition and interventions.</p>	

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F 314	<p>Continued From page 33</p> <p>Therapy Evaluation, dated 9/9/12, which stated, "if no skilled PT [increase] pressure ulcers." On 11/8/12, the physical therapist documented the exercises placed Resident #1 at "high risk to develop worse contractures," therefore, to maintain Resident #1's exercises in some form, he recommended, "Daily range of motion to [both] knees."</p> <p>NOTE: Refer to F318 as it relates to the facility's failure to provide ROM therapy.</p> <p>Further, a Daily Notes and Weekly Progress Summary from the occupational therapist (OT) documented Resident #1's OT goals were related to proper positioning for pressure relief to reduce skin breakdown. However, this service was discontinued 4/25/13 as it was documented Resident #1 had achieved the goals and no longer needed the assistance.</p> <p>Resident #1's care plan, dated 4/10/13, documented, "at risk for impaired skin integrity [related to] pressure ulcer secondary to: incontinence, cognitive impairment. She has [history] of wounds 03/02/13 stage 2 to left lateral foot [related to] poor positioning in [wheelchair] and decreased extremity [sic] strength." The interventions were:</p> <ul style="list-style-type: none"> - 3/2/13: sage boots, therapy to evaluate for wheelchair positioning and strength, treatment as ordered, family to bring new shoes and weekly wound measurements - Float heels while in bed - Pillow for comfort - Report any new skin issues to Licensed Nurse - Ensure that briefs/attends are of proper fit/size and placement 	F 314	<p><u>Systematic Changes</u></p> <p>Education was provided to the facility nursing staff by the Director of Nursing or designee on the implementation of preventative interventions for residents at risk for skin breakdown and that interventions and care plans reflect the residents' current skin condition on or before 9/5/13.</p>	

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F 314	<p>Continued From page 34</p> <ul style="list-style-type: none"> - Barrier cream to peri area as needed - Check for incontinence and provide pericare as needed - Cleanse peri area well with each incontinence episode - Keep skin clean and dry - Pressure reducing cushion to wheelchair if not ambulatory - Turn and reposition as every 2 hours and as needed - Low air loss mattress - Document on flow sheet skin status, intact or not - Give medication as ordered for wound healing, signs and symptoms of infection, pain with dressing changes - Monitor healing process and notify physician and responsible family if no improvement. Change treatment as indicated. - Weekly skin assessment and measure pressure ulcers <p>Resident #1's Nursing Assessment, dated 2/5/13, documented "former scratches" on Resident #1's back. No other skin concerns were documented on the assessment.</p> <p>Physician's orders in place at the time included:</p> <ul style="list-style-type: none"> - Beginning 9/8/12 - Pressure reducing mattress to bed - Beginning 10/30/12 - To be showered every other day - Beginning 11/30/12 - Weekly skin check by a licensed nurse - Beginning 4/19/13 - Release wheelchair seatbelt every 2 hours and offload pressure for 4 minutes - Beginning 5/28/13 - Increase skin checks to peri-rectal area to every hour until skin issues resolved. Apply barrier cream and provide peri 	F 314	<p><u>Monitoring</u></p> <p>Beginning 9/5/13, the Director of Nursing or designee will audit 3 residents at risk for skin breakdown weekly for 4 weeks and then monthly for 2 months to ensure that residents at high risk for skin breakdown have preventive interventions implemented and care planned. A summary of the audits will be submitted to the Performance Improvement Committee for review and recommendations for 3 months to ensure that compliance is maintained. The PI committee will reevaluate the need for further monitoring after 3 months. The Director of Nursing is responsible for monitoring and follow up.</p> <p><u>Date of Compliance</u></p> <p>9/6/13</p>	

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F 314	<p>Continued From page 35 care as needed.</p> <p>Resident #1's 6/2013 MAR was reviewed and documented during the weekly skin checks on 6/1/13, 6/5/13, 6/8/13, 6/12/13 and 6/15/13, Resident #1's skin was intact.</p> <p>However, a physician notification, dated 6/19/13 at 10:05 p.m. stated, "Notified by CNA that she noticed a problem area on resident's [lower left] buttock during attends change. 1 cm round denuded area noted lower [left] buttock resident states doesn't hurt. Hydrocollaid placed for protection until area can be assessed by wound care coordinator."</p> <p>Further, an Interdisciplinary Progress Notes entry, dated 6/20/13 at 9:00 a.m., stated "[Follow-up] RN assessment of open area to [left] buttocks, measuring approximately 1 x 1 cm round, easily blanchable wound and noted [bilateral] buttocks red [and] irritated. Also blanchable easily. Family notified. MD aware. Continue to use Barrier cream." A second entry for the same date and time stated, "Open area is 100% epithelial. Also will eval[uate] bowel and bladder] x 72 hours to determine any unmet toileting needs."</p> <p>The resident's Bowel and Bladder Continence Evaluation for 6/20/13 - 6/23/13 was reviewed. The form documented one episode of bowel incontinence and one episode of bladder incontinence during that time.</p> <p>On 6/20/13, the hourly skin checks were discontinued and the following order was implemented: - Apply barrier cream to coccyx, buttocks, peri-area after every toileting episode (every 2</p>	F 314		

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F 314	<p>Continued From page 36 hours)</p> <p>Resident #1's record included a Skin Integrity Report which documented the wound as "MASD [Moisture Associated Skin Damage]" that was "Incontinence related."</p> <p>A handwritten entry on Resident #1's care plan, undated and unsigned, stated "MASD to [left] buttocks." The only handwritten interventions, also undated and unsigned, were "Every other day bathing and z-guard every shift and every two hours."</p> <p>No other care plan changes related to moisture associated skin disorders could be found.</p> <p>The resident's most recent MDS, dated 7/5/13, documented Resident #1 required extensive assistance for transfers, dressing, toilet use, personal hygiene and bathing.</p> <p>Interdisciplinary Progress Notes continued to document the wound, as follows: - 6/29/13 at 6:45 p.m.: "open area to [left] coccyx area dressing [changed]." - 7/3/13 at 7:00 p.m.: "Dressing remains intact to [left] coccyx area - 7/6/13 at 9:25 p.m.: "open area to [left] coccyx area. Dressing intact."</p> <p>On 7/11/13, the physician visited and documented on a Nursing Home Note, "one area at approximately the ischial tuberosity that is developing an opening/ulceration. This was about 1/2 cm in diameter, very shallow at this time...Likely encouraged by the increased incontinence and skin irritation, Controlling the urine should be helpful for this. We will also have</p>	F 314		

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F 314	<p>Continued From page 37</p> <p>physical therapy evaluated for wheelchair to see if there are other cushions that can be attempted to reduce the risk of breakdown. She has had problems with ulcerations and particularly ulcerations on this leg previous, so we will need to monitor this closely." On the date of the visit, the physician ordered "please dress wound [and] follow as needed." However, an Interdisciplinary Progress Notes entry, dated 7/27/13 at 7:35 p.m., stated "open area to [left] coccyx that is open to air."</p> <p>No order for the use of dressing prior to 7/11/13 could be found in Resident #1's record. Additionally, no documentation of the order could be located on Resident #1's 7/2013 MAR/TAR, therefore, consistent documentation of dressing use and changes could not be found.</p> <p>On 8/1/13 from 11:15 - 11:25 a.m., the facility's physician was interviewed regarding the wound. He stated it was a shallow wound on her former graft line. The physician wrote a Progress Note, also on 8/1/13, which stated, "The correct diagnosis is a moderate to severe irritant incontinence associated dermatitis."</p> <p>On 8/1/13 at 1:35 p.m., Resident #1's left buttock was observed by the nurse surveyor and ADON. The resident's buttocks were covered in a white cream that the ADON had to wipe off to observe the open area. The area was on the gluteal fold around an area that had scar tissue from a previous skin graft. The opening was about 0.5 cm in diameter. The depth was not measured, it had white cream in it. The edges of the sore were well defined. The ADON pushed on the area and it blanched well and she commented that it was not a pressure sore because the area "blanched."</p>	F 314		

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F 314	<p>Continued From page 38</p> <p>The facility submitted a typed document, 8/5/13, which stated, "This moisture-related skin damage occurred despite the fact that the resident was receiving appropriate and comprehensive care including barrier creams, routine toileting, and frequent bathing. Among other things, the risk for skin breakdown was addressed by using a low air-loss mattress, frequent repositioning, high protein snacks, and other measures."</p> <p>However, despite Resident #1's history of skin issues, the facility failed to implement sufficient preventative treatments (i.e. ROM, OT, comprehensive care plan related to MASD, consistent dressing orders and changes, etc.) to ensure that Resident #1 did not develop skin wounds.</p> <p>2. Resident #9 was admitted to the facility on 7/4/13 with diagnoses including lower limb amputation, above knee, hypertension, and chronic pain.</p> <p>Additionally, Resident #9's record included an order for a foley catheter, dated 7/4/13, for diagnoses of urinary retention and urinary incontinence.</p> <p>The most recent MDS, dated 7/31/13, documented Resident #9 required extensive assistance for transfers, dressing, toilet use, personal hygiene and bathing.</p> <p>Resident #9's care plan, dated 7/4/13, documented, "Potential for skin breakdown related to: immobility, incontinence, chronic progressive disease." The interventions were:</p>	F 314		

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F 314	<p>Continued From page 39</p> <ul style="list-style-type: none"> - Administer supplements as ordered - Administer vitamins/minerals as ordered - Apply moisture barrier cream after each incontinence episode - Complete Bowel and Bladder Assessment based on frequency of incontinence - Complete skin assessment on admission, quarterly, annually and with significant change in condition - Elevate heels off of bed - Evaluate for signs and symptoms of UTI - Evaluate need for restorative dining program - Monitor input and output as ordered - Obtain food preferences - Provide restorative ROM program as ordered (NOTE: Refer to F318 for the facility's failure to provide ROM therapy) - Weekly weights - Apply protective barrier to skin every shift - Assist to turn and reposition every 2 hours and as needed - Keep skin clean and dry - Use positioning devices as ordered - Toilet resident frequently to discourage incontinence - Pressure reducing devices as ordered - Provide pericare if incontinence occurs - Observe skin every shift for signs and symptoms of potential breakdown (e.g. redness/discoloration or open areas). Alert charge nurse if observed for notification of physician as needed for treatment orders. - Labs as ordered - Weekly skin assessment <p>Resident #9's admission Nursing Assessment, dated 7/4/13, documented a blanchable reddened area on Resident #9's buttock.</p>	F 314			

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F 314	<p>Continued From page 40</p> <p>Physician's orders in place upon admission included:</p> <ul style="list-style-type: none"> - Float heels with pillows while in bed as resident will allow - Complete a skin assessment upon admission, weekly for 4 weeks and quarterly <p>On 7/9/13, the physician ordered the following:</p> <ul style="list-style-type: none"> - Apply Z-guard to buttocks every shift to promote skin integrity - Turn every 2 hours and as needed to promote skin integrity <p>Resident #9's record documented that she developed a wound on her buttock via an Interdisciplinary Progress Notes entry, dated 7/18/13 at 10:30 a.m., which stated, "Denuded area on left buttocks noted 3 cm x 2 cm cleansed and moisture barrier applied."</p> <p>Resident #9's 7/2013 MAR documented Resident #9's next skin assessment took place on 7/25/13. The MAR documented coding for "Other / See Nurse Notes." However, no nursing note from 7/25/13 could be found.</p> <p>Additionally, no other nursing or physician notes specifically related to the denuded area on Resident #9's buttock could be located in her record.</p> <p>A handwritten entry on Resident #9's care plan, dated 7/9/13, stated "apply zguard [sic] every shift to promote skin integrity." Additionally, a second handwritten entry, undated and unsigned, stated, "check and change."</p> <p>No other care plan changes related to Resident #9's buttock wound care could be found.</p>	F 314		

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F 314	<p>Continued From page 41</p> <p>The facility submitted a document, dated 8/5/13, which stated Resident #9 had "repeated refusals of care and treatment by the therapy team and nursing."</p> <p>Resident #9's record was reviewed for refusals. It was documented for 7/2013 Resident #9 refused care four times as follows:</p> <ul style="list-style-type: none"> - Weekly skin check on 7/15/13 - Weekly skin check on 7/22/13 - Turned and repositioned on 7/26/13 at 7:15 p.m. (found in Interdisciplinary Progress Notes) - Turned and repositioned on 7/27/13 at 7:45 a.m. (found in Interdisciplinary Progress Notes) <p>Resident #9's 7/2013 MAR did not include any documentation of refused 2 hour turns. Additionally, the MAR did not show any refusals of the application of Z-guard each shift.</p> <p>Further, none of Resident #9's MDSs (7/11/13, 7/15/13, 7/17/13, 7/24/13 or 7/31/13) coded for behavior symptoms that "interfere with resident care."</p> <p>During an observation on 07/31/13 at 3:00 p.m., Resident #9 was lying on her left side, her buttock area was covered in a white cream. The nurse surveyor requested that cream be removed so the sore could be visualized. The coccyx area was noted to have a 2.5 cm circular open area. The first layer of dermis tissue was missing from the sore.</p> <p>The facility failed to implement preventative care to ensure that Resident #9 did not develop a pressure ulcer after admission.</p>	F 314		

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F 314	<p>Continued From page 42</p> <p>3. Resident #5 was admitted to the facility on 5/20/10 and readmitted 4/22/13, with diagnoses of abnormal gait, muscular wasting and disuse atrophy, edema, and chronic kidney disease stage III.</p> <p>The most recent quarterly MDS, dated 7/12/13, documented the resident:</p> <ul style="list-style-type: none"> - was cognitively intact with a BIMS of 15, - required extensive assistance for transfers, dressing, personal hygiene and bathing. - did not have a pressure sore, had moisture associated skin damage [MASD] <p>The resident's comprehensive care plan, dated 3/21/12, documented, "Potential for skin breakdown related to: impaired mobility, obesity, chronic progressive disease. [Resident #5] has history of multiple lacerations, cuts, skin tears, bruising, cellulitis, dermatitis." The interventions were:</p> <ul style="list-style-type: none"> * Complete Bowel and Bladder Assessment based on frequency of incontinence. * Complete Norton Plus Scale on admission, quarterly, annually and with significant change in condition. * Complete nutritional assessment. * Ensure left side of w/c near brake and brake extension will be padded. * Ensure that footwear is of appropriate size. * Ensure that [Resident #5] has footwear when propelling self in w/c. * Float heels while in bed. * Low air loss mattress. * Offer to use slippers when boots are off. * Pedi eggs to dry heels after showering on Saturday evening shift as per resident request. * [Resident #5] will keep pants loose or 	F 314		

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F 314	<p>Continued From page 43</p> <p>unbuttoned while tucking in shirt.</p> <ul style="list-style-type: none"> * Staff to snap/fasten suspenders. * Ted hose on in am off at hs. * Use a draw sheet for lifting and repositioning. * When resident gets up at night to use toilet use manual wheelchair not electric w/c [wheelchair]. * Apply protective/preventative barrier to skin every shift prn. * Assist to turn and reposition as [sic] every 2 hours as scheduled. * Keep skin clean and dry. * Use pillows for positioning and comfort. * Toilet resident frequently to discourage incontinence. * Pressure reducing cushion in w/c assure cushion is in w/c. * Provide pericare if incontinence occurs. * Observe skin every shift for s/s [sign/symptom] of potential skin breakdown...Alert charge nurse if observed for notification of physician as needed for tx orders. * Tx [treatment] as ordered. Notify physician of problems or s/sx of infection. * Weekly skin assessment." <p>The resident had skin issues after he was readmitted from the hospital on 4/17/13. The hospital removed the catheter and the resident was admitted with skin issues. The resident's comprehensive care plan, dated 4/17/13, documented a problem of, "Resident has impaired skin integrity r/t [related to] pressure ulcer secondary to: impaired mobility. [Resident #5] readmitted [with] stage I to right buttock." The interventions that the facility had in place were:</p> <ul style="list-style-type: none"> * Complete Norton Plus Scale on admission, quarterly, annually and with significant change. * Elevate heels off bed with pillow(s)/other flotation devices. 	F 314			

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F 314	<p>Continued From page 44</p> <ul style="list-style-type: none"> * Evaluate need for Urology consult. * Treatment as ordered. * Use a draw sheet for lifting and repositioning. * Use mechanical lifting devices as needed. * Keep skin clean and dry. * Pressure relieving devices on bed and wheelchair. * Turn and reposition with skin care q [every] 2 hrs and pm. * Use two person transfer and use turn sheet to avoid friction/shearing of resident skin. * Registered Dietician evaluation as needed/indicated. * Evaluate pain. Medicate per orders if pain present. * Record percentage of meal consumed. * Weekly skin assessments and measure pressure ulcers." <p>The resident's care plan did not address MASD.</p> <p>Interdisciplinary Progress Notes (IPN) documented: 1/30/13 at 2:00 a.m. "While assessing residents skin for weekly skin check it was noted that resident's groin are was red and rashed. No apparent open areas noted. Resident stated, 'he had stopped using his gold bond powder and it got red.' applied Inzo antifungal powder to areas. Also noted some redness to buttocks/cheek right side. Applied Inzo powder. Skin warm and dry."</p> <p>The resident went to the hospital from 3/30/13 until 4/8/13. There was no documentation about the resident's skin. The resident went back to the hospital from 4/16/13 to 4/22/13. When the resident was readmitted back to the facility the 4/22/13 Nursing Assessment documented the resident's left buttock and medial thigh was</p>	F 314		

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F 314	<p>Continued From page 45 "red/purple."</p> <p>The 6/2/13 Pain Evaluation form documented the resident had an "open area right gluteal/thigh crease. The form documented the resident had a Stage II pressure ulcer. A Skin Integrity Report (SIR) form was started. The description was: Pressure Ulcer Stage, II; Pain, no; Appearance, granulation; length, 1 cm; width, 0.5 cm; depth, 0.1 cm; drainage, bloody; and surrounding tissue, inflamed/indurate.</p> <p>IPNs and SIRs documented: IPN 6/3/13 at 2:00 p.m. - "Observed skin breakdown to right thigh. Noted blanchable denuded opening to right inner thigh/gluteal fold. Surrounding area is slightly red but easily blanchable stage I ulceration resolved to right buttock/thigh. denuded area related to IAD [incontinence associated dermatitis] measures approx[imately] 1.1 cm x 1.5 cm 0.1 cm. Noted urinary incontinence at time of assessment with history of chronic incontinence. Pt has poor mobility with some right side weakness resulting in poor positioning at times...." IPN 6/4/13 at 11:20 p.m. - "Res[ident] skin assessment completed this shift, Res continues with same skin breakdown to right thigh, right inner thigh, gluteal fold, right buttocks/thigh...." SIR 6/11/13 - The description was: Pressure Ulcer Stage, N/A; Pain, no; Appearance, epithelial; length, 1 cm; width, 0.5 cm; depth, 0.1 cm; drainage, N/A; and surrounding tissue, healthy." IPN 6/29/13 6:45 p.m. - "Resident continues with skin breakdown to right thigh, right inner thigh and gluteal fold,..." SIR 7/2/13 The description was: Pressure Ulcer Stage, N/A; Pain, no; Appearance, Epithelial and</p>	F 314		

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F 314	Continued From page 46 intact/deep purple; length, closed; width, closed; depth, closed; drainage, none; and surrounding tissue, healthy. IPN 7/23/13 at 10:30 p.m. "Resident continues with red areas to groin and inner thighs...." On 7/30/13 at 3:15 p.m. the resident's skin was observed. No open areas were noted. There was a red/purple scar area on the right gluteal fold. The resident's buttocks and groin areas were covered in a white cream. On 8/1/13 at 8:00 a.m. the DON was asked about Resident #5's skin problems and he referred the surveyor to the ADON [Assistant Director of Nursing] because she was the skin nurse. On 8/1/13 8:55 a.m. the ADON was interviewed about the sore on the residents gluteal fold. She stated the area was "denuded skin" and was "blanchable" therefore it was not a pressure sore. When asked about the sore with a depth of 0.1 cm that was present, she indicated that it was blanchable, so not a pressure sore; the resident was incontinent and this caused the skin to get denuded, it was not from pressure but was associated with moisture. However, the wound met the CMS definition for a pressure sore and had been assessed by the facility as a Stage 2.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		

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F 315	<p>Continued From page 47</p> <p>who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a resident who was admitted to the facility with an indwelling catheter received the appropriate care and services to prevent infections. This affected 1 of *** residents (Resident #9) reviewed for indwelling catheters. This resulted in a resident developing a symptomatic urinary tract infection (UTI) after admission. The findings include:</p> <p>1. Resident #9 was admitted to the facility on 7/4/13 with diagnoses including lower limb amputation, above knee, hypertension, and chronic pain.</p> <p>During the initial tour on 7/29/13 from 1:10 - 1:45 p.m., the DON stated Resident #9 was admitted with a UTI that was found a couple of days after her admission.</p> <p>However, Resident #9's 7/11/13 MDS was reviewed, and stated she had not had a UTI in the last 30 days. Further, Resident #9's MDS' dated 7/15/13 and 7/17/13 did not code for a UTI in the last 30 days.</p> <p>Resident #9's care plan, dated 7/4/13, included instruction to "Evaluate for [signs and symptoms] of UTI." However, no documentation related to the UTI from admission through 7/18/13 could be found in Resident #9's record.</p>	F 315	<p><u>F-315</u></p> <p><u>Specific Residents Identified</u></p> <p>Resident #9 has been reassessed by the licensed nurse on 9/3/13 with no adverse effects noted. The physician was updated by the Director of nursing or designee on 9/3/13 with no new orders received. Resident #9's antibiotic treatment was completed on 8/30/13. The resident's care plan was updated by the Director of Nursing or designee on 9/3/13 to include catheter care.</p> <p><u>Identification of Other Residents</u></p> <p>Physician orders and care plans for residents with catheters have been reviewed by the IDT on or before 9/5/13 and updated to reflect their current condition.</p> <p>Review of residents with UTI's was completed by the Director of Nursing or designee on 9/3/13 to ensure that physician orders are being followed.</p>	

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F 315	Continued From page 48 Additionally, Resident #9's record included an order for a foley catheter, dated 7/4/13, for diagnoses of urinary retention and urinary incontinence. However, no documentation related to catheter care could be located in her record from admission through 7/20/13. Resident #9's record included a Nursing Home Note, dated 7/10/13, completed by her physician, which stated he visited Resident #9 that day. However, the note did not include any information related to a UTI. On 7/18/13 at 11:30 a.m., a nurse made an Interdisciplinary Progress Notes entry which stated, "Res[ident] [complained of] of [sic] suprapubic pain urine dark odorous clean catch taken and sent for UA. Dr notified." A Nursing Home Note, dated 7/22/13, from Resident #9's physician stated, "The urinalysis has been collected. This did show a result of E. coli with multiple sensitivities." The physician wrote the following orders in response to the laboratory results, dated 7/18/13: - 7/18/13: Macrobid 100 mg by mouth twice a day for 14 days - 7/20/13: Change catheter bag every 2 weeks - 7/20/13: Indwelling catheter...change monthly - 7/20/13: Indwelling catheter care every shift - 7/20/13: May change catheter if occluded or removed as needed During an interview on 8/1/13 from 9:48 - 10:16 a.m., the DON again stated the, "massive" and "raging," UTI was present upon admission.	F 315	<u>Systematic Changes</u> Nursing staff educated on or before 9/5/13 by the Director of Nursing or designee regarding the catheter care, urinary tract infection signs and symptoms and treatment. <u>Monitoring</u> Beginning the week of 9/7/13, audits of catheter care will be completed 3 times a week for 4 weeks and then weekly for 2 months to ensure compliance. Beginning the week of 9/7/13, an audit will be completed by the Director of Nursing or designee of 3 residents with catheters for signs and symptoms of a UTI will be completed weekly times 4 weeks and then monthly times 2 months. A report will be submitted to the Performance Improvement Committee monthly for 3 months. The PI Committee will determine the need for ongoing audits after 3 months. The Director of Nursing is responsible for monitoring and follow up. <u>Date of Compliance</u> 9/6/13	

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F 315	Continued From page 49 However, the DON did not provide any information related to why the UTI would go uncharted or untreated for 14 days. The facility was unable to provide any care plans regarding the indwelling catheter, documentation regarding catheter management, including catheter care, or documentation of the UTI, prior to 7/18/13. The facility did not ensure physician orders and a care plan regarding indwelling catheters were in place when Resident #9 was admitted to the facility with an indwelling catheter in place. And, fourteen days after admission to the facility, the resident developed a symptomatic UTI. The facility failed to ensure Resident #9 receive the proper care to prevent the occurrence of a UTI.	F 315			
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review and observation, it was determined the facility failed to ensure residents that had limited	F 318			

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F 318	<p>Continued From page 50</p> <p>range of motion received services to prevent further declines in range of motion (ROM). This affected 6 of 13 (#s 1, 2, 3, 5, 7, & 9) sampled residents. Not providing range of motion could potentially harm residents who have arthritis and contractures by causing further limitations in joint mobility. Findings include:</p> <p>1. Resident #5 was admitted to the facility on 5/20/10 and readmitted 4/22/13, with diagnoses of abnormal gait, muscular wasting and disuse atrophy, edema, and chronic kidney disease stage III.</p> <p>The most recent quarterly MDS, dated 7/12/13, documented the resident:</p> <ul style="list-style-type: none"> - was cognitively intact with a BIMS of 15. - required extensive assistance for transfers, dressing, personal hygiene and bathing. - had upper and lower extremity range of motion impairment on both sides of his body. - did not receive range of motion. <p>The most recent significant change assessment, dated 4/15/13, documented the resident:</p> <ul style="list-style-type: none"> - had only upper extremity range of motion impairment on both sides of the body. - did not receive range of motion. <p>The resident's care plan was reviewed. There was lacking documentation for the resident to receive range of motion.</p> <p>The medical record was reviewed and there was lacking any documentation the resident had received active or passive range of motion.</p> <p>The resident was interviewed on 7/30/13 at 11:15 a.m. When asked about the resident's right hand</p>	F 318	<p><u>F-318</u></p> <p><u>Specific Residents Identified</u></p> <p>Residents #1, 2, 3, 5, 7 and 9 were reassessed for a range of motions program by the Director of Nursing or designee on 9/4/13. Programs were implemented as indicated.</p> <p><u>Identification of Other Residents</u></p> <p>A review of the MDS for current residents as compared to the prior MDS has been completed on or before 9/5/13 by the Director of Nursing or designee to identify residents who have had a decline in range of motion, are at risk for contractures or have limitations in range of motion. Rounds have been completed by the Director of Nursing or designee and therapy staff to identify residents who have had a decline in range of motion, are at risk for contractures or have limitations in range of motion. Residents who are identified will have services/treatments provided as needed.</p>

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F 318	<p>Continued From page 51</p> <p>he indicated that the fingers were bent and the facility had not done any ROM on them. He showed the surveyor and he had a limited ability to extend his fingers. He also indicated that his hip and knee were getting stiffer.</p> <p>The DON was interviewed on 8/1/13 at 3:00 p.m. and indicated there were several residents doing "walk to dine." There were no residents getting specific ROM programs. No further information was obtained.</p> <p>2. Resident #7 was admitted to the facility on 04/23/1996 and readmitted on 03/04/13 with a diagnosis of right hemiplegia, Diabetes Mellitus, muscle weakness and urinary tract infection.</p> <p>The most recent quarterly MDS, dated 05/02/13, documented the resident: -was moderately impaired, cognitively, with a BIMS of 09. -required expensive assist with transfers, bed mobility, dressing, eating, personal hygiene and bathing. -had upper and lower range of motion impairment on the right side of body. -did not receive range of motion.</p> <p>The resident's plan of care, dated 05/03/12 was reviewed. There was documentation that, "Facility will provide: position of comfort. Range of motion to comfort."</p> <p>The medical record was reviewed and was lacking documentation the resident received active or passive range of motion.</p> <p>The resident was interviewed on 07/31/13 at 2:15 p.m. He stated he could not use the right side of his body. Resident was not able to answer any</p>	F 318	<p><u>Systematic Changes</u></p> <p>Nursing staff was educated on or before 9/5/13 by the Director of Nursing or designee on procedures to follow when functional decline is noted or there is a potential for functional decline based on range of motion or contractures including notifying the physician and therapy as needed.</p>

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F 318	<p>Continued From page 52 further questions.</p> <p>The DON was interviewed on 08/01/13 at 3:00 p.m. and indicated there were no residents receiving specific range of motion programs. No further information was obtained.</p> <p>3. Resident # 3 was admitted to the facility on 11/18/11 and readmitted 02/17/12, with diagnoses of congestive heart failure, hypertension, peripheral vascular disease and Alzheimer's disease.</p> <p>The most recent quarterly MDS, dated 07/11/13, documented the resident: -was severely cognitively impaired, with a BIMS of 6. -required total assistance for transfers, dressing, toilet, personal hygiene and extensive assistance for bathing.</p> <p>The most recent physician office exam, dated 05/28/13, revealed: -multiple sites of osteoarthritis, left hand. -joint pain, multiple sites.</p> <p>The resident's care plan dated 12/17/12 was reviewed. There was no documentation the resident had received active or passive range of motion.</p> <p>The resident's wife was interviewed 07/30/13 at 10:45 a.m. When asked about range of motion for the resident, she stated that he did not receive any therapies.</p> <p>Resident #3 was observed in the dining room on 07/31/13 at 5:55 p.m. He seemed to have difficulty bending the fingers of both hands to eat.</p>	F 318	<p><u>Monitoring</u></p> <p>Beginning the week of 9/7/13, audits of 3 residents with functional range of motion loss will be completed by a member of the therapy staff and nursing management weekly for 4 weeks and then monthly for 2 months to ensure that ROM needs are met. A report will be submitted to the Performance Improvement Committee monthly for review for 3 months. The Director of Nursing and Rehab Service Manager are responsible for monitoring and follow up. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months.</p> <p><u>Date of Compliance</u></p> <p>9/6/13</p>		

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F 318	<p>Continued From page 53</p> <p>4. Resident #2 was originally admitted to the facility on 8/23/10 and most recently readmitted on 4/30/12 with multiple diagnoses including rehabilitation procedure, abnormal posture, osteoporosis, Raynaud's syndrome, myalgia, myositis, and muscle spasms.</p> <p>Resident #2's 4/12/13 quarterly and 5/7/13 significant change MDSs both coded cognition intact, upper and lower ROM impairments on both sides of the body, and did not receive restorative nursing program.</p> <p>Resident #2's care plan did not include a focus area or an intervention for ROM. There was no evidence in the medical record to indicate the resident was receiving ROM.</p> <p>On 8/2/13 at 12:30 p.m., the Administrator was informed of the finding. The facility did not provide any additional information related to the finding.</p> <p>6. Resident #9 was admitted to the facility on 7/4/13 with diagnoses including muscle weakness, muscular wasting and disuse atrophy and lower limb amputation, above knee.</p> <p>Her admitting MDS, dated 7/11/13, documented Resident #9:</p> <ul style="list-style-type: none"> - required extensive assistance for transfers, dressing, personal hygiene and bathing. - had lower extremity range of motion impairment on one side. - did not receive range of motion. 	F 318		

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F 318	<p>Continued From page 54</p> <p>Resident #1's care plan, dated 7/4/13, stated "Provide restorative ROM program as ordered." However, the care plan did not include any additional documentation related to range of motion.</p> <p>No documentation stating Resident #9 received active or passive range of motion could be located in Resident #9's medical record.</p> <p>The DON was interviewed on 8/1/13 at 3:00 p.m. and indicated there were several residents doing "walk to dine." There were no residents getting specific ROM programs. No further information was obtained.</p> <p>7. Resident #1 was admitted to the facility on 5/18/12 and readmitted 9/8/12, with diagnoses including osteoporosis, contracture of joint of multiple sites and pressure ulcer.</p> <p>Resident #1's most recent MDS, dated 7/5/13, documented she required extensive assistance for transfers, dressing, personal hygiene and bathing.</p> <p>Resident #1's record contained a Physical Therapy Evaluation, dated 9/9/12, which stated, "If no skilled PT [increase] pressure ulcers." On 11/8/12, the physical therapist documented the exercises placed Resident #1 at "high risk to develop worse contractures," therefore, to maintain Resident #1's exercises in some form, he recommended, "Daily range of motion to [both] knees."</p> <p>However, her care plan and MDS did not include any additional documentation related to range of motion.</p>	F 318		

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F 318	Continued From page 55 No documentation stating Resident #1 received active or passive range of motion could be located in Resident #1's medical record. The DON was interviewed on 8/1/13 at 3:00 p.m. and indicated there were several residents doing "walk to dine." There were no residents getting specific ROM programs. No further information was obtained.	F 318			
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329			

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F 329	<p>Continued From page 56</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record reviews and staff interviews, it was determined the facility failed to ensure residents' drug regimens were monitored for hours of sleep, duplicate therapy, and non-pharmacological interventions were implemented prior to administering medications. This affected 4 of 7 (#s 2, 9, 10, & 13) residents sampled for psychoactive medication use. This practice created the potential for harm should the medication regimen result in or contribute to an unanticipated decline or newly emerging or worsening symptoms. Findings included:</p> <p>1. Resident #10 was admitted to the facility on 11/8/12 with multiple diagnoses including dementia and depression.</p> <p>Resident #10's 11/14/12 admission MDS coded moderate cognitive impairment, minimal depression, and antidepressant use.</p> <p>The resident's most recent 5/16/13 quarterly MDS coded moderate cognitive impairment, no depression, and antidepressant use.</p> <p>Resident #10's 7/13 "All Active Orders for July 2013" (recapitulation) contained two orders for antidepressants. - 11/8/12 Bupropion (Wellbutrin) 100 milligrams (mg) tablet by mouth daily for depression - Mirtazapine (Remeron) 7.5 mg tablet by mouth at bedtime every day for depression and decrease in appetite</p> <p>On 8/1/13 at 11:26 a.m., the surveyor informed the DON of the antidepressant duplicate therapy.</p>	F 329	<p><u>F329</u></p> <p><u>Specific Residents Identified</u></p> <p>Medications for Resident # 10 have been reviewed by the physician and the antidepressant duplicate therapy has been addressed on or before 9/5/13. One of the antidepressants was discontinued. The resident's care plan was reviewed and updated by the IDT on or before 9/5/13 to accurately reflect the resident's current condition and orders.</p> <p>Resident # 2 has hours of sleep being monitored as indicated on or before 9/5/13 by the Director of Nursing or designee.</p> <p>Resident # 13 has been discharged from the facility.</p>	

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F 329	<p>Continued From page 57</p> <p>At 2:15 p.m., the DON stated, "I cannot find clinical rationale from the doctor for the antidepressant duplicate therapy." The DON provided the surveyor with a "Consultation Report" form from the pharmacy that identified, to the resident's physician, the use of two antidepressant medications, "Mirtazapine and Bupropion" concomitantly (at the same time). The "Recommendation" section of the form documented, "Please re-evaluate continued use of this combination." However, review of the resident's medical record did not provide evidence the antidepressant duplicate therapy or use concomitantly was addressed by the resident's physician.</p> <p>Federal guidance at F329 indicated, "...'Duplicate therapy' refers to multiple medications of the same pharmacological class/category or any medication therapy that substantially duplicates a particular effect of another medication that the individual is taking... Under these regulations, medication management includes consideration of...III. Dose (including duplicate therapy)... A documented clinical rationale for the benefit of, or necessity for, the dose or for the use of multiple medications from the same pharmacological class... Documentation is necessary to clarify the rationale for & benefits of duplicate therapy & the approach to monitoring for benefits & adverse consequences..."</p> <p>2. Resident #2 was originally admitted to the facility on 8/23/10 and most recently readmitted on 4/30/12 with multiple diagnoses including bipolar disorder and muscle spasms.</p> <p>Resident #2's most recent 4/12/13 quarterly and 5/7/13 significant change MDS coded cognitively</p>	F 329	<p>Resident # 9 has been reassessed on or before 9/5/13 by the Licensed Social Worker or designee for other interventions to address insomnia and depression. Hours of sleep are being monitored as indicated on or before 9/5/13 by the Director of Nursing or designee. The care plan was updated as indicated.</p> <p><u>Identification of Other Residents</u></p> <p>An audit has been completed by the Director of Nursing or designee on or before 9/5/13 of residents receiving antidepressants. The physicians of those residents identified as receiving duplicate therapy were updated and follow up was completed as needed.</p> <p>A review of residents taking hypnotic medications was completed by the Director of Nursing or designee on 9/4/13 to ensure that hours of sleep are monitored and non pharmacologic interventions were implemented.</p>

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F 329	<p>Continued From page 58</p> <p>intact and received no hypnotic medications.</p> <p>Resident #2's 6/13 "All Active Orders for June 2013" (recapitulation) contained two orders for Ambien.</p> <ul style="list-style-type: none"> - 6/3/13 Ambien by mouth 5 mg prn may give as needed on odd numbered days for insomnia - 6/4/13 Ambien by mouth 5 milligrams (mg) at bedtime give on even numbers days for insomnia. <p>On 6/26/13 both of the above Ambien orders were discontinued and the resident's physician ordered, "Ambien (Zolpidem Tartrate) 5 mg tablet by mouth (oral) - at bedtime everyday...for insomnia"</p> <p>Resident #2's 7/13 Recapitulation orders contained the same 6/26/13 Ambien order as identified above. The resident's 7/13 "Schedule for July 2013" form (Medication and Treatment Record) provided evidence the resident was administered Ambien as ordered.</p> <p>NOTE: Review of the resident's medical record did not provide evidence the hours of sleep were monitored for the hypnotic Ambien.</p> <p>On 7/31/13 at 10:30 a.m., Resident #2 stated, "I do not sleep well. I saw my physician yesterday and told him I am not sleeping well. He made some changes in my medications."</p> <p>On 7/31/13 at 3:00 p.m. the surveyor informed the DON and the RN Consultant the resident's chart did not include monitoring for hours of sleep for Ambien. At 4:48 p.m. the RN Consultant stated, "We missed monitoring hours of sleep for Resident #2."</p>	F 329	<p><u>Systemic Changes</u></p> <p>Nursing staff was re- educated on or before 9/5/13 by the Director of Nursing or designee regarding monitoring hours of sleep, implementation of non pharmacologic interventions and duplicate antidepressant therapy.</p> <p><u>Monitoring</u></p> <p>Beginning the week of 9/7/13, an audit will be completed by the Director of Nursing or designee of 5 residents receiving medications for insomnia to ensure that hours of sleep are being monitored and non pharmacological interventions, duplicate antidepressant therapy is addressed by the physician and alternatives are attempted prior to starting antidepressants and medications for insomnia. Audits completed 3 times a week for 4 weeks and weekly for 2 months. Results of audits reported to the PI Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and follow up. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months.</p>	

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F 329	<p>Continued From page 59</p> <p>On 7/31/13 at 5:35 p.m., the surveyor informed Resident #2's physician the facility did not monitor hours of sleep for the medication Ambien. The physician stated, "I have been monitoring Resident #2's Ambien closely. I can write an order to monitor hours of sleep when I write a hypnotic order. Resident #2 did tell me yesterday she has not slept well."</p> <p>3. Resident #13 was admitted to the facility on 5/24/13 with multiple diagnoses including obstructive sleep apnea and dementia.</p> <p>The resident's 7/13 "All Active Orders" (recapitulation) contained a 6/27/13 order for Zolpidem (Ambien) 10 milligram tablet by mouth at bedtime everyday for insomnia.</p> <p>Resident #13's "Behavior Monthly Flow Sheet, July 2013" contained in the far left hand column, "hours of sleep." In addition, the form contained areas for day, evening and night shifts to document hours of sleep. Review of the Flow Sheet provided evidence the hours of sleep were inconsistently monitored during the month of July 2013. Specifically, 7/5 -7/7, 7/12 - 7/15, 7/24 - 7/26, and 7/29 - 7/31/13.</p> <p>On 8/1/13 at 11:24 a.m., the surveyor informed the DON Resident #13's hours of sleep were inconsistently monitored for the month of July 2013. The DON nodded his head in an up and down motion.</p> <p>Federal guidance at F329 indicated, "...Monitoring of the resident's response to any medication(s) is essential to evaluate the ongoing benefits as well as risks of various medications..."</p>	F 329	<p><u>Date of Compliance</u></p> <p>9/6/13</p>	

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F 329	<p>Continued From page 60</p> <p>On 8/2/13 at 12:30 p.m., the Administrator was informed of the above findings. The facility did not provide any additional information related to the findings.</p> <p>4. Resident #9 was admitted to the facility on 7/4/13 with diagnoses including muscle weakness, muscular wasting and disuse atrophy and lower limb amputation, above knee.</p> <p>Resident #9's record included a "Physician's Orders," dated 7/10/13, which ordered Remeron (an antidepressant drug) 15 mg by mouth every evening for insomnia and depression. Additionally, Resident #9 had an order for Celexa (an antidepressant drug) 20 mg one tab by mouth each day, dated 7/8/13, for depression which was replaced by Cymbalta (an antidepressant drug) 30 mg by mouth each day on 7/16/13. Further, Resident #9's record included another "Physician's Orders," dated 7/22/13, which ordered Seroquel (an antipsychotic drug) 12.5 mg by mouth every evening for depression.</p> <p>Resident #9's 7/2013 MAR documented the Cymbalta, Celexa, Seroquel and Remeron were administered as ordered.</p> <p>However, there were no other interventions to address Resident #9's depression or insomnia (i.e. alternative sleep hygiene techniques such as lowering lights, massage, or soft music etc.) included in Resident #9's record. Additionally, sleep tracking for Resident #9 could not be found in her record.</p> <p>During an interview on 8/1/13 from 5:01 - 5:27</p>	F 329		

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F 329	Continued From page 61 p.m., the DON stated he did not think that nonpharmalogical interventions would be effective for Resident #9 and they were not attempted. He provided a Behavior Monthly Flow Sheet for 7/2013 which only tracked anxiety as it related to a medication that had been discontinued at the time of survey. The DON stated the anxiety tracking was the only tracking in place for Resident #9.	F 329		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a	F 425		

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F 425	<p>Continued From page 62</p> <p>physician ordered antibiotic was obtained for a resident with a history of frequent urinary tract infections (UTIs). This affected 1 of 10 (#4) sampled residents. This practice created the potential for harm as UTI complications could have occurred when the antibiotic was not available. Findings included:</p> <p>Resident #4 was originally admitted to the facility on 11/16/11, and most recently readmitted on 4/2/13, with multiple diagnoses including bilateral above the knee amputation, atrial fibrillation, hypertension, and dementia.</p> <p>Resident #4's 1/17/13 admission, 4/9/13 significant change, and 7/8/13 quarterly coded no UTIs within the past 30 days, respectively.</p> <p>The resident's care plan, printed 7/15/13 contained a focus area, at risk for UTI related to history of frequent/chronic UTI. One intervention was, "Administer medications as ordered."</p> <p>The resident's "All Active Orders for July 2013" (recapitulation) contained the order, 7/23/13, "Tetracycline HCL 500 milligrams [hydrochloride 500 mg] capsule by mouth (Oral) - Every six hours for 6 days, UTI, End Date: 7/29/13."</p> <p>Resident #4's 7/13 "Schedule for July 2013" form (Medication and Treatment Record) identified in the far left hand column, Tetracycline by mouth 500 mg Start Date: 7/23/13 every six hours every day for UTI. The administration hours were 0000 0600, 1200, and 1800 (midnight, 6:00 a.m., noon, and 6:00 p.m.). The first dose was to be administered 7/23/13 at 6:00 p.m.</p> <p>Review of the above identified form provided the</p>	F 425	<p><u>F-425</u></p> <p><u>Specific Residents</u></p> <p>Resident # 4 was assessed by the physician and medications have been ordered and given as needed on or before 9/5/13.</p> <p><u>Other Residents</u></p> <p>An audit of residents on antibiotics has been completed by the Director of Nursing or designee on or before 9/5/13 to ensure that their medications have been administered as ordered. Physicians were contacted if follow up was required.</p> <p><u>Systematic Changes</u></p> <p>The licensed nurses were re-educated by the Director of Nursing or designee on or before 9/5/13 regarding following physician orders for medications and the policy on obtaining medications.</p>	
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F 425	Continued From page 63 following evidence: -7/23/13 6:00 p.m., Tetracycline administered. * 7/24/13 midnight and 6:00 a.m., Tetracycline not administered either time. The form contained handwritten entries for 7/24/13 at 0000 and 0600 (midnight and 6:00 a.m.) that appeared to be initials with a circle around the initials and another set of letters "NA" below the circled initials. -7/24/13 noon, Tetracycline administered. The form documented the resident received the remaining doses of Tetracycline on the dates and times as ordered. On 7/31/13 at 3:05 p.m., the surveyor informed the DON Tetracycline was not administered to the resident at midnight and at 6:00 a.m. on 7/23/13 as the nurse circled the initials. The DON stated, "The resident's physician ordered the medication. We ordered the medication from the pharmacy. Our pharmacy is located in Utah and delivers medications every day. We administered the Tetracycline first dose on 7/23/13 at 1800 [6:00 p.m.] from the facility's pyxis system. We did not receive the medication, from the pharmacy located in Utah, to give the resident for the midnight and 6:00 a.m. administration times [on 7/24/13]. We went to a local pharmacy and obtained enough of the medication so the resident would not go without any other missed dosages. Two medication administration times were missed." On 8/2/13 at 12:30 p.m., the Administrator was informed of the finding. The facility did not provide any additional information related to the finding.	F 425	<u>Monitoring</u> Beginning the week of 9/7/13, audits will be completed by the Director of Nursing or designee three times a week for 4 weeks and then weekly for two months to ensure that residents receive their medications as ordered. A report will be submitted to the Performance Improvement Committee for 3 months for review and follow up as needed. The Director of Nursing is responsible for monitoring and follow up. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months. <u>Date of Compliance</u> 9/6/13	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	<p>Continued From page 64</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 441	<p><u>F-441</u></p> <p><u>Specific Residents Identified</u></p> <p>Residents # 2,3,4,5,7,8 and 10 were assessed for signs and symptoms of infection related to this incident by the Director of Nursing or designee on 9/3/13. The scoop is being placed in a plastic container when not in use by staff. The ice scoop is not being left in the ice container in the main dining room. The scoop is being placed in a plastic container when not in use by staff.</p> <p><u>Identification of Other Residents</u></p> <p>A facility round was completed to ensure that ice scoops were stored correctly by the administrator on 9/3/13 with no issues noted.</p>	

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F 441	<p>Continued From page 65</p> <p>Based on observations and staff interviews it was determined that the facility failed to ensure:</p> <ul style="list-style-type: none"> -Ice scoop was not left in ice container in main dining room. -Ice scoop was not left in ice chest in hallway. <p>This affected 7 of 13 residents in the dining room, the residents (#s 2, 3, 4, 5, 7, 8 and 10) on the 400 hall. This failed practice could potentially harm residents by cross contamination of bacteria, viruses and other microorganisms. Findings include:</p> <ol style="list-style-type: none"> 1. On 7/30/13 at 9:22 a.m. in the 400 hallway, there was a cart with an ice chest on it and a clear plastic container located next to the ice chest. CNA #4 was observed scooping ice from the ice chest into thermos type mugs. The CNA placed the ice scoop inside the ice chest, closed the ice chest lid, and took the thermos type mug into a resident's room. <ul style="list-style-type: none"> - At 9:45 a.m., the surveyor asked the CNA how many times a day water and ice were passed. The CNA replied, "Two times a shift." - At 10:02 a.m., the ice scoop was inside the ice chest with the handle resting against the inside surface of the ice chest. On 7/31/13 at 12:09 a.m., the surveyor spoke with CNA #4 about the ice scoop left in the ice chest. The CNA stated, "The plastic container by the ice chest is where I should place the plastic ice scoop. I left the scoop in the ice chest before when you saw me." On 8/2/13 at 12:30 p.m., the Administrator and the DON were informed of the observation. 2. During the 7/31/13 dinner observation in the main dining room starting at 5:40 p.m. a cart (fluid cart) was located near the entrance to the 	F 441	<p><u>Systematic Changes</u></p> <p>Facility staff educated on or before 9/5/13 by the Director of Nursing or designee regarding storing the scoop during the passing of ice.</p> <p><u>Monitoring</u></p> <p>Beginning the week of 9/7/13, audits will be completed by the director of Nursing or designee 3 times a week for 4 weeks and weekly for 2 months to ensure that infection control practices are being followed for the passing of ice in the facility. Results of the audits will be submitted to the Infection Control Committee monthly for review for three months to ensure compliance. The Director of Nursing is responsible for monitoring and follow up.</p> <p><u>Date of Compliance</u></p> <p>9/6/13</p>	

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F 441	Continued From page 66 kitchen. A large rubber tub filled with ice and bottles of liquid refreshments was on the top of the cart. Also, on the top of the cart was a clear plastic container filled with ice (ice tub) and a different and smaller clear plastic container (holder) that did not contain any ice, food, or refreshments. CNA #1 was observed dispensing juice to residents. The CNA scooped up ice from the ice tub, put the ice in a cup, put the scoop back into the ice tub, poured juice and delivered the juice to a resident. The CNA did not place the ice scoop in the holder. She did this and left the scoop in the ice tub for 5 serving observations. At 5:55 p.m. LN #2 was observed scooping up ice from the ice tub, putting the ice in a cup, and placing the scoop back into the ice tub. The LN then poured juice into the cup and delivered it to a resident.	F 441	<u>F-463</u> <u>Specific Residents Identified</u> The residents in rooms 407,410,411, 420, and 422 were interviewed and assessed by the Director of Nursing or designee on 9/3/13 with no adverse effect noted. The Maintenance Director changed the call light cords on 8/29/13 and they are no longer tied around the grab bar. <u>Identification of Other Residents</u> The call light cords in the bathrooms of other residents in the facility have been replaced by the Maintenance Director on or before 9/5/13. The administrator conducted a tour on 9/3/13 for call lights being wrapped around the hand rails with no further findings.
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to ensure a reliable communication system from resident toilet areas to the nursing station. This affected 5 out of 24 rooms (407, 410, 411, 420 and 422) in the 400 hall. This failed practice could potentially harm residents because they would not be able to contact the nursing station for assistance when needed.	F 463	

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F 463	Continued From page 67 Findings included: During tour of the facility on 7/29/13 at 1:00 p.m., the following was observed: 1. The call cord in the bathroom of room #420 was wrapped around the grab bar. The surveyor tugged on the cord and it did not activate because it was wrapped around the grab bar. 2. The bathroom in room #422 did not have a cord attached to the call light mechanism. Instead, there was a 2 inch chain that hooked to the call system. The surveyor tried to activate the call system. It required a tight grasp and was much harder to activate than those with a call cord. 3. The bathroom call light cords in rooms 407, 410 and 411 were observed to be wrapped and tied around the hand rail. When the end of the string was pulled it failed to activate the call light. The hand rail was 3 feet from the floor. On 8/1/13 at 8:10 a.m. the surveyor and DON rechecked the rooms and the pull cords were still wrapped and tied to the hand rail so the call light did not activate when the end was pulled. When the cords were untied and left to hang they would reach to within 4 inches of the floor.	F 463	<u>Systematic Changes</u> Nursing staff were educated by the Administrator or designee on or before 9/5/13 regarding the requirement that call light cords in resident bathrooms must hang freely so that when pulled, the call light activates. Staff was also educated to notify maintenance staff on the maintenance board if a call light pull cord is not working or needs to be replaced. <u>Monitoring</u> Beginning the week of 9/7/13, facility rounds will be completed three times a week for four weeks and then weekly for two months by maintenance staff and facility managers to ensure that call light cords are hanging freely and easily activated in resident bathrooms. A report will be submitted to the Performance Improvement Committee monthly for 3 months. The Maintenance Director is responsible for monitoring and follow up. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514		

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F 514	<p>Continued From page 68</p> <p>standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure resident records contained comprehensive information for 2 of 16 residents (Resident #6 and #9) whose records were reviewed. This resulted in the potential for a lack of sufficient information being present on which to base treatment decisions. The findings include:</p> <p>1. Resident #6's record included a 7/23/13 admission form which documented she was admitted to the facility on 7/23/13 for rehabilitation after a left leg fracture.</p> <p>Resident #6's Admission Orders/Medication Reconciliation form, dated 7/23/13, documented her allergies included "Aspirin (Otic Nerve Damage)." The form also documented she was to receive ASA (an NSAID drug) 160 mg twice daily for four weeks for pain and her 7/2013 MAR documented she received 81 mg of Aspirin twice daily from 7/24/13 through the morning of 7/31/13.</p> <p>Resident #6's record did not include information</p>	F 514	<p><u>Date of Compliance</u></p> <p>9/6/13</p> <p><u>F-514</u></p> <p><u>Specific Residents Identified</u></p> <p>Residents # 6 and #9 have had their list of allergies reviewed by their physician for accuracy and the Director of Nursing or designee reviewed the medical record for any allergies with the facility records updated on or before 9/5/13 to reflect the changes. Resident #6 and #9 were assessed for adverse effects with none noted by the Director of Nursing or designee on 9/3/13. Their medications were reviewed by the Director of Nursing or designee on or before 9/5/13 to ensure that they are not receiving any medications that they have listed as allergies.</p>	

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F 514 Continued From page 69 regarding why she received a medication which she was allergic to.

When asked about the medication on 8/1/13 at 3:09 p.m., the DON stated he would look up why she was taking the medication. On 8/1/13 at 4:29 p.m., the DON handed this surveyor his cell phone and stated Resident #6's physician was on the line.

At that time, her physician stated Resident #6 only experienced allergic reactions when she received large doses of Aspirin and he felt a small dose was acceptable to hopefully help prevent thrombosis. The physician stated the ADON was present and informed during the discussion of his rationale to use Aspirin.

However, no documentation regarding the rationale for the Aspirin use was present in Resident #6's record.

The facility failed to maintain a complete record related to Resident #6's medication use and allergies.

2. Resident #9 was admitted to the facility on 7/4/13 with diagnoses including muscle weakness, muscular wasting and disuse atrophy and lower limb amputation, above knee.

a. Resident #9's record included a neon orange sticker on the first page which documented her allergies for quick reference. The sticker listed sulfa, aspirin, Cipro, penicillin, compazine and codeine.

However, Resident #9's record did not consistently document her allergies, as follows:

F 514

Identification of Other Residents

An audit has been completed by the Director of Nursing or designee on or before 9/5/13 of resident allergies in the medical record as compared to the medications that residents have ordered to ensure that residents are not receiving medications that they have listed as allergies with no further findings. Physicians were contacted and medication changes made as needed.

Systematic Changes

Nursing staff educated on or before 9/5/13 by the Director of Nursing or designee regarding resident allergies to medications and ensuring that the record is reviewed for all allergies and that follow up is completed with the physician as needed.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/02/2013
NAME OF PROVIDER OR SUPPLIER TWIN FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 70</p> <ul style="list-style-type: none"> - A Vaccination Consent Form, dated 7/4/13, stated "Allergic" next to "Tetanus/Diphtheria [sic] Vaccine." - Final Medication Orders from a hospital, dated 7/3/13, documented allergies of sulfa, Cipro, penicillin, Compazine, codeine, tapentadol, tizanidine and "Tetanus Toxoid Adsorbed." - A Nursing Home Note, dated 7/4/13, listed penicillin, sulfa, Cipro, codeine, tetanus, Compazine, Zanaflex and Pantozol as Resident #9's allergies. - The facility's admission Nursing Assessment, dated 7/4/13, only listed allergies to penicillin, sulfa and aspirin. <p>During an interview on 8/1/13 from 5:01 - 5:27 p.m., the DON checked Resident #9's neon orange sticker and verified that the allergies were listed as described by this surveyor. He asked a nurse, present in the records room, who completed the admission paperwork for Resident #9. The nurse told him she completed the paperwork based on an admission document. The DON stated he would coordinate with the physician to ensure consistent, accurate allergies were identified in Resident #9's record.</p> <p>The facility failed to maintain a complete, accurate record related to Resident #9's allergies.</p> <p>b. Resident #9's care plan, dated 7/4/13, was reviewed and included incomplete handwritten entries, as follows:</p> <ul style="list-style-type: none"> - "Requests female caregivers only," undated - "Check and change," undated and unsigned - "House shakes per MD to promote wound healing," undated and unsigned 	F 514	<p><u>Monitoring</u></p> <p>Beginning the week of 9/7/13, audits of 3 records will be completed 3 times a week for 4 weeks and then weekly for 2 months by the Director of Nursing or designee of resident medication allergies that are listed and resident medication orders. Results of audits will be reviewed by the PI committee monthly for 3 months. The PI committee will then determine a schedule for ongoing audits. Director of Nursing is responsible for monitoring and follow up.</p> <p><u>Date of Compliance</u></p> <p>9/6/13</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 514	<p>Continued From page 71</p> <p>Further, a care plan amendment for nutrition, dated 7/10/13, included incomplete handwritten entries, as follows:</p> <ul style="list-style-type: none"> - "Monitor [signs and symptoms] UTI & worsening, notify MD as needed," undated and unsigned - "Encourage fluids," undated and unsigned - "Fam[ily]/MD aware," undated and unsigned <p>Another care plan amendment for mood and behaviors, dated 7/16/13, included incomplete handwritten entries, as follows:</p> <ul style="list-style-type: none"> - "Give medications as ordered," undated and unsigned - "Behavior/side effect tracking," undated and unsigned - "Cont[inue] to monitor/eval[uate] & notify MD if worsens," undated and unsigned - "Fam[ily] aware of all med [changes]. Consents obtained," undated and unsigned <p>Additionally, the care plan included an amendment for skin breakdown to left buttocks for which all of the information was undated and unsigned.</p> <p>During an interview on 8/1/13 from 5:01 - 5:27 p.m., the DON stated all handwritten entries should have included the date and author's initials.</p> <p>The facility failed to maintain a complete record related to Resident #9's care plan.</p>	F 514		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER TWIN FALLS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the State licensure and complaint investigation survey conducted at your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Karen Marshall, MS, RD, LD Team coordinator Arnold Rosling, BSN, RN, QMRP Debra Bernamonti, RN Ashley Henscheid, QIDP</p>	C 000		
C 147	<p>02.100.05,g Prohibited Uses of Chemical Restraints</p> <p>g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician.</p> <p>This Rule is not met as evidenced by: Refer to F329 as it relates to the use of medications without justification.</p>	C 147	<p><u>C147</u></p> <p>See POC for F329</p> <p><u>Date of Compliance</u></p> <p>9/6/13</p>	<p>RECEIVED</p> <p>SEP - 3 2013</p>
C 175	<p>02.100.12,f Immediate Investigation of Incident/Injury</p> <p>f. Immediate investigation of the cause of the incident or accident</p>	C 175	<p>FACILITY STANDARDS</p>	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Lou Bentler

TITLE

Administrator

(X6) DATE

8/29/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001800	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/02/2013
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C 175	Continued From page 1 shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Refer to F225 as it relates to failure to investigate injuries. Refer to F225 as it relates to investigations of abuse, neglect and injuries of unknown origin.	C 175	<u>C175</u> See POC for F 225 and F226 <u>Date of Compliance</u> 9/6/13	
C 393	02.120,04,b Staff Calling System at Each Bed/Room b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Refer to F463 as it relates to call system in residents bathrooms.	C 393	<u>C393</u> See POC for F463 <u>Date of Compliance</u> 9/6/13	
C 645	02.150,01,a,ii CARE OF EQUIPMENT ii. Care of equipment. This Rule is not met as evidenced by: Refer to F441 as it relates to care of equipment to prevent transmission of infections.	C 645	See POC for F441 <u>Date of Compliance</u> 9/6/13	

Bureau of Facility Standards

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C 778	Continued From page 2	C 778		
C 778	02.200,03,a PATIENT/RESIDENT CARE 03. Patient/Resident Care. a. A patient/resident plan of care shall be developed in writing upon admission of the patient/resident, which shall be: This Rule is not met as evidenced by: Please refer to F279 as it related to the resident's initial care plan.	C 778	<u>C778</u> See POC for F279 <u>Date of Compliance</u> 9/6/13 <u>C779</u>	
C 779	02.200,03,a,i Developed from Nursing Assessment i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Please refer to F272 as it related to assessing siderails as safe for residents to use.	C 779	See POC for F272 <u>Date of Compliance</u> 9/6/13 <u>C782</u>	
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it relates to revising a care plan.	C 782	See POC for F280 <u>Date of Compliance</u> 9/6/13 <u>C789</u>	
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for	C 789	See POC for F314 <u>Date of Compliance</u> 9/6/13	

Bureau of Facility Standards

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	TWIN FALLS, ID 83301

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C 789	Continued From page 3 exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 as it relates to pressure sores.	C 789		
C 796	02.200,03,b,xii Rehabilitative Nursing Standards xii. Rehabilitative nursing current with acceptable professional practices to assist the patient/resident in promoting or maintaining his physical functioning. This Rule is not met as evidenced by: Refer to F318 as it relates to rehabilitative services.	C 796	<u>C796</u> See POC for F318 <u>Date of Compliance</u> 9/6/13	
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Please refer to F425 as it related to a resident not receiving an antibiotic as ordered by the resident's physician.	C 798	<u>C798</u> See POC for F425 <u>Date of Compliance</u> 9/6/13 <u>C881</u> See POC for F514	
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and	C 881	<u>Date of Compliance</u> 9/6/13	

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C 881	Continued From page 4 signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 as it relates to accuracy of records.	C 881		
C 882	02.203,02,a Resident Identification Requirements a. Patient's/resident's name and date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service (if applicable); name, address and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and disposition, signed by the attending physician, shall be part of the medical record. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure resident records included discharge summaries containing the cause of death or final diagnosis for 1 of 3 residents (Resident #16) reviewed, who were discharged from the facility. This resulted in a lack of documentation in a resident's record. The findings include: 1. Resident #16's record included a 5/6/13 admission form which documented he was	C 882	<u>C882</u> <u>Specific Residents</u> Resident # 16 has been discharged from the facility. <u>Other Residents Identified</u> An audit has been completed on or before 9/5/13 by the Health Information Manager of residents who have died in the facility since 8/2/13 to ensure that there is a cause of death or final diagnosis in the record.	

Bureau of Facility Standards

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C 882	<p>Continued From page 5</p> <p>admitted to the facility on 5/2/13 with diagnoses that included stroke and hypertension. He expired on 5/10/13.</p> <p>Documentation regarding his cause of death or final diagnosis was not present in his record.</p> <p>During an interview on 7/31/13 from 4:25 - 4:30 p.m. with the DON and RN Consultant, the missing documentation was requested. The RN Consultant stated she would look for the documentation. On 8/1/13, an "Unofficial Death Certificate Abstract" was faxed to the facility at 11:20 a.m. and was given to this surveyor.</p> <p>The facility failed to maintain documentation including a cause of death or final diagnosis in Resident #16's record.</p>	C 882	<p><u>Systematic Changes</u></p> <p>The Health Information Manager has been educated on or before 9/5/13 by the administrator on obtaining documentation that lists a cause of death or final diagnosis for residents who die in the facility.</p> <p><u>Monitoring</u></p> <p>Beginning the week of 9/7/13, the medical record of residents who die in the facility will be audited weekly for three months by the Health Information Manager to ensure that there is documentation of the cause of death or final diagnosis. Audit results will be submitted to the Performance Improvement Committee monthly for 3 months. The Health Information Manager is responsible for monitoring and follow up. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months.</p> <p><u>Date of Compliance</u></p> <p>9/6/13</p>	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, ID 83720-0009
PHONE 208-334-6626
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August 30, 2013

Lori A. Bentzler, Administrator
Twin Falls Center
674 Eastland Drive
Twin Falls, ID 83301-6846

Provider #: 135104

RE: COMPLAINT FINDINGS FOR TWIN FALLS CENTER

Dear Ms. Bentzler:

On **August 2, 2013**, a Complaint Investigation survey was conducted at Twin Falls Center. Karen Marshall, R.D., Ashley Henscheid, Q.M.R.P., Arnold Rosling, R.N., Q.M.R.P. and Debbie Bernamonti, R.N. conducted the complaint investigation. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey.

The closed medical record of the identified resident was reviewed. The medical records of fourteen other residents were reviewed as part of the survey process.

Interviews were conducted with four individual residents, seven residents who attended the group interview and family members of two different residents. There were no concerns voiced by residents or family members of residents regarding medication administration timeframes. There were no concerns voiced by residents or family members of residents regarding services received by residents from the therapy department at the facility.

Interviews were conducted with the Director of Nursing, the Assistant Director of Nursing, the Administrator, the Director of Therapy, one Occupational Therapy Assistant, one Physical Therapist, the Activities Director and another licensed nurse.

Incident and Accident reports were reviewed dated from January 2013 through July 2013. There

Lori A. Bentzler, Administrator
August 30, 2013
Page 2 of 4

were no concerns regarding medication administration timeframes or services provided to residents from the therapy department at the facility.

Grievances from April 29, 2013, through July 29, 2013, were reviewed. There were no concerns voiced by residents, family members or interested parties of residents regarding medication administration timeframes or concerns regarding services received by residents from the therapy department at the facility.

Grievances for January 2013 were reviewed and included a grievance dated January 8, 2013, related to the identified resident.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005859

ALLEGATION #1:

The complainant stated an identified resident was scheduled to receive a pain medication at 2:00 p.m. A family member was at the facility at 11:00 a.m. on January 8, 2013, reviewed the resident's Medication Administration Record and found the 2:00 p.m. pain medication administration was signed as given.

FINDINGS:

The identified resident was admitted to the facility on December 28, 2013, and discharged from the facility on January 11, 2013.

A Grievance/Complaint Report dated January 8, 2013, was reviewed and appears to have been completed, handwritten by the Administrator. One of the concerns was on January 8, 2013, at 11:00 a.m., the identified resident's January 2013 Medication Administration Record (MAR) documented nursing staff initialed the administration of a medication scheduled for 2:00 p.m. that afternoon. The investigation showed that the nurse did initial the medication as given; however, the nurse realized the medication was not to be administered at that time. Instead of "circling" the initials, discarding the medication and documenting what happened on the back of the MAR, the nurse put the medication in a covered cup, labeled it and left it on top the medication. Standards of practice related to medication administration and documentation were not followed.

The facility was cited at F281 for non-compliance.

Lori A. Bentzler, Administrator
August 30, 2013
Page 3 of 4

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated an identified resident was admitted with a left arm fracture and an immobilizer sling for the left arm. On one occasion, the resident was not wearing the sling. On another occasion, the sling was on the resident's right arm, not the left arm. On another occasion, the sling was being used during physical therapy.

FINDINGS:

The identified resident's chart contained documentation from the local hospital documentation that the resident fell several times at home, and the last fall resulted in a fracture left proximal humerus.

The identified resident's December 28, 2012, Admission Orders contained the order: keep left shoulder immobilizer on except to bathe or change clothes; then remove when patient is upright allowing left arm to hang at side.

The resident's Treatment Sheets Schedules for December 2012 and January 2013 contained in the far left column the order: keep left shoulder immobilizer on except to bath or change clothes. May remove when patient is upright, allowing left arm to hang at side. The Treatment Sheets contained nursing staff documentation that the resident was monitored on day, evening and night shifts for use of the left shoulder immobilizer. Interdisciplinary Progress Notes routinely documented that the immobilizer was in place on the left arm.

Review of the resident's closed record did not provide evidence that the resident was not wearing the sling when the resident should have been wearing the sling, or that staff placed the sling on the right arm of the resident, not the left arm.

A Care Conference for the identified resident was held on January 2, 2013. A family member attended the Care Conference. One of the topics of discussion was to have a physical therapist train staff on how to place the sling on the resident, as the sling needed to be exactly right. According to the Care Conference documentation, a physical therapist did provide training to four Certified Nurse Aides and one Licensed Nurse. Interviews were conducted with five of the seven facility staff who attended the Care Conference. None of the facility staff remembered a concern that the resident was seen not wearing the sling or the sling was placed on the resident's right arm, not the left arm.

Lori A. Bentzler, Administrator
August 30, 2013
Page 4 of 4

On December 28, 2012, the resident's physician ordered skilled physical therapy services six times a week, for twelve weeks, to include gait training and mobility for left shoulder pain.

A handwritten grievance dated January 8, 2013, that appeared to have been written by the Administrator was reviewed. One of the concerns was that the therapist was watched as the therapist worked with the resident and the therapist did not know what he was doing. Physical Therapy did not understand what to do with the brace - they were incompetent.

A statement was attached to the grievance and was signed by the Physical Therapist on January 8, 2013. The therapist reiterated the physician's order to remove immobilizer when upright and allow the left arm to hang at side. The immobilizer had three components, a waist belt, an upper arm strap and wrist strap. On January 8, 2013, the therapist ambulated the resident in the physical therapy department. The upper arm strap was loosely fastened while the resident ambulated. The resident was seated in a wheelchair after ambulating. A family member entered the physical therapy department at this time and requested the resident perform Codman pendulum exercises. The family member also asked the physical therapist to remove the upper arm strap. The resident was not able to perform Codman pendulum exercises correctly.

The survey team determined the facility complied with Federal guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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August 30, 2013

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The Director of Nursing, Assistant Director of Nursing and Business Office Manager were interviewed, and the resident's medical record was reviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005903

ALLEGATION #1:

The resident was admitted to the nursing home in August 2012. She did not remember when she was discharged and taken to the hospital, but she thought it was in September or October 2012.

The resident was admitted, because she fell at home and fractured her wrist and was to receive therapy and then be discharged. She was to be there only two to three weeks.

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She said she was medicated with drugs that "Drove me out of my mind." She said as a result of using the drugs, she can't remember much of what happened, and she did not go home when she was supposed to. She did not know what the medications were. She said she heard a nurse say, "If you have a resident that is a pain in the ass, give her drugs to keep her in bed."

She said they would not let her leave. One day, she took her scooter and tried to leave, the facility took it away from her. They were holding her against her will.

She got up and fell and had to go to the hospital to be seen. She said, she wrote a note to the hospital nurses that said she was being kept against her will so they admitted her.

She feels that the four life threatening infections she has had were related to her stay at the Nursing home; one was a UTI, but she wasn't sure what the rest were.

FINDINGS:

The resident was admitted to the facility October 12, 2011, after a fall where she sustained a pelvic fracture and a fractured lower arm. Along with the aftercare for the injuries, the resident had diagnoses of paranoia with hallucinations, depressive disorder, diabetes type II and renal failure. The resident was discharged to a local hospital on November 16, 2011. The resident never returned to the facility after hospitalization.

Pain:

For pain the resident was ordered to receive Lortab 7.5 - 500 milligrams, one tablet as needed every 4 to 6 hours, and Oxycodone HCL 5 milligrams as needed every 4 to 6 hours. On October 28, 2011, the physician ordered the resident to have a Durgesic patch 50 micrograms/hour change every 72 hours. This was discontinued on November 4, 2011.

Paranoia and depression:

For depression with anxiety, the resident was to receive Paroxetine HCL 20 milligrams every day. On November 4, 2011, the resident was started on Seroquel 50 milligrams every day because she was hallucinating. The resident also had Diazepam 2.5 milligrams as needed three times a day for muscle spasms. This was used one time when the resident had anxieties.

The resident went for dialysis three days a week; she had end stage renal disease.

Review of the interdisciplinary progress notes in the medical record revealed:

- The resident initially had pain issues. The staff was medicating her to try to get control of her pain. There was documentation of the resident's pain not being controlled well and the resident requesting more medication than was ordered.
- On October 29, 2011, the nurse documented the physician ordered a Fentanyl (Duragesic) patch for her pain.
- On October 31, 2011, and November 2, 2011, the resident was hallucinating.
- On the November 4, 2011, dialysis visit, the physician discontinued the Fentanyl patch and started the resident on Seroquel 50 milligrams.
- On November 5, 2011, the physician was contacted because the resident had refused medications and meals. The resident was more confused. The physician ordered a urinalysis with culture and sensitivity. The resident had end stage renal disease; as a result, the facility had trouble getting a urine sample.
- On November 9, 2011, the physician discontinued the Seroquel because the resident refused to sign the consent form to use the medication.
- On November 10, 2011, the resident was screaming out for her son. She was short of breath due to anxiety and denied any pain. The resident was given a diazepam, and this helped the resident to relax and decrease anxiety. The resident refused all of her other medications.
- On November 11, 2011, the resident got herself into the wheelchair and the nurses' notes documented that she was speeding up and down the hallways yelling, "I want out of here." The resident hit a nurse with the wheelchair and knocked her down, causing the nurse to hit her head. The resident tried to exit the building, another nurse tried to stop her, and the resident hit her in the face. The family was contacted and the son visited with her. After the family member visited with her, she still said, "If I stay here, I won't be alive in the morning." The resident wanted to go to the hospital. The resident was transported by ambulance to the local hospital. The resident returned from the hospital on Cipro; she had a urinary tract infection.
- On November 15, 2011, the resident fell attempting to use the bathroom independently. The physician ordered x-rays of the resident's arms and legs. The resident was transported to the local hospital for x-rays. While in x-ray, the resident began having paranoid ideations and hallucinations. The resident said to the x-ray staff that the long term care facility was "being awful and poisoning her." The resident was admitted to the hospital. The resident never returned to the facility.

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Neither the medical record nor the physician documentation had an explanation as to the changes in behaviors that the resident had exhibited. During the survey, the nurses were not heard to use derogatory statements about medicating residents. The Director of Nursing and Assistant Director of Nursing were interviewed on August 1, 2013, and they vaguely remember the resident and her behaviors because it was past the previous Recertification and State Licensure timeframe, two years old (2011.)

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The resident was on Medicaid and said she received a bill for \$500 from the facility for her care, but does not know what it is for.

FINDINGS:

The business office manager was interviewed on August 1, 2013, about the \$500. She indicated this was the resident's share of the Medicaid bill. The State of Idaho, Medicaid division makes the determination, not the facility. The resident was receiving social security income (SSI) and the Medicaid reimbursement to the facility was decreased by the SSI amount. The bill was actually \$428. The resident did not pay her portion. The facility sent collection letters on May 24, 2012, June 14, 2012, and September 25, 2012. The resident did not respond to the letters; so, the bill was turned over to a collection agency on September 28, 2012. The facility never received any of their money and on May 29, 2013, the debt was written off by the company.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj