



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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CERTIFIED MAIL: 7012 1010 0002 0836 1505

August 22, 2014

Paul McVay, Administrator
LaCrosse Health & Rehabilitation Center
210 West Lacrosse Avenue
Coeur d'Alene, ID 83814-2403

Provider #: 135042

Dear Mr. McVay:

On **August 8, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at LaCrosse Health & Rehabilitation Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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" (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 the 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 4, 2014**. Failure to submit an acceptable PoC by **September 4, 2014**, may result in the imposition of civil monetary penalties by **September 24, 2014**.

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 will you make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice does 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 have 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 (X5).

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 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.

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- 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 12, 2014 (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 12, 2014**. A change in the seriousness of the deficiencies on **September 12, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 12, 2014** includes the following:

Denial of payment for new admissions effective **November 8, 2014**. [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 8, 2015**, 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, they will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; 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 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

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Office or the State Medicaid Agency beginning on **August 8, 2014** 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 4, 2014**. If your request for informal dispute resolution is received after **September 4, 2014**, 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, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care 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 # 135042	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 8/8/2014
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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 281	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure licensed nurses (LNs) did not pre-initial the wasting of used fentanyl patches before the controlled schedule II long-acting pain medication was actually wasted. This was true for 1 of 1 used fentanyl patches observed to be wasted. This failure created the potential for diversion of the potent pain medication fentanyl. Findings included:</p> <p>Informational Letter #97-3, dated April 16, 1997: The Medication Distribution Technique Clarification To Informational Letter, 96-14, from the Bureau of Facility Standards, stated, "...the Board's [of Nursing] expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do."</p> <p>On 8/7/14 at 10:05 a.m., LN #4 was observed as she exited Resident #19's room with a patch in hand and asked LN #1 to waste a used fentanyl patch with her. LN #1 agreed and right then, both LN's initialed Resident #19's MAR at "2 nurses to waste old patch" below, "Fentanyl Patch 75 mcg [micrograms] [change every] 72 [hours]." After that, the 2 nurses' wasted the used fentanyl patch in the toilet in the 600 Hall Shower room.</p> <p>On 8/7/14 at 10:07 a.m., when asked, LN #4 confirmed that she and LN #1 had pre-initialed Resident #19's MAR before they actually wasted his used fentanyl patch. When asked what if the nurses had been distracted on their way to waste the used fentanyl patch, LN #4 stated, "I wouldn't be distracted." When asked what if a resident was on the floor, the LN said she would put the used fentanyl patch in the medication cart and waste it after she helped the resident. When asked what if she forgot about the used fentanyl patch in the medication cart, the LN stated, "I don't forget."</p> <p>On 8/7/14 at 6:10 p.m., the Administrator and DON were informed of the issue. The facility's policy regarding used fentanyl patches was requested.</p> <p>On 8/8/14 at 11:00 a.m., the DON provided a Destruction of Controlled Drugs policy and procedure (P&P) which included, "2. Destroy used transdermal patches, (eg, Fentanyl), following removal from the resident. a. Two licensed nurses must sign for the destruction of the used patch on the resident's Medication Administration Record."</p>
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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

The above isolated deficiencies pose no actual harm to the residents

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/08/2014
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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were conducted during the recertification and complaint survey of your facility. The survey team entered the facility on August 4 and exited on August 8, 2014.</p> <p>The surveyors were: Nina Sanderson LSW BSW, Team Coordinator Linda Kelly RN Lauren Hoard RN BSN Michael Case LSW BSW QIDP Linda Hukill-Neil RN</p> <p>Survey Definitions: BPSD = Behavioral or Psychological Symptoms of Dementia BIMS = Brief Interview of Mental Status CAA = Care Area Assessment CHF = Congestive Heart Failure CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disorder CVA = Cerebrovascular Accident DNS/DON = Director of Nursing IDT = Interdisciplinary Team MAR = Medication Administration Record MDS = Minimum Data Set LN = Licensed Nurse LPN = Licensed Practical Nurse mg = milligrams RDO = Regional Director of Operations RN = Registered Nurse SSA = Social Services Assistant SSD = Social Services Director TAR = Treatment Administration Record</p>	F 000	<p>"This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not a submission of our agreement of the deficiencies or conclusions contained in the Departments inspection report."</p> <p>F-155</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice</p> <p>Resident #9 had CPR status and POST reviewed and changes made to meet regulations</p> <p>Resident #16 no longer resides at the facility.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p>	
F 155 SS=D	<p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>The resident has the right to refuse treatment; to</p>	F 155		

RECEIVED
SEP 08 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Paul McVay, NHA 9-9-14</i>	TITLE	(X6) DATE
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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 155	<p>Continued From page 1</p> <p>refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</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 information related to advanced directives was accurately and appropriately represented in residents' records. This was true for 2 of 12 (#s 9 and 16) sample residents. This failure resulted in a resident having an inappropriate DNR and a resident's record lacking a copy of the LW/DPAHC, and had the potential to result in more than minimal harm if the residents were to have treatment either withheld or provided. Findings included:</p> <p>1. Idaho Statute Title 66, Chapter 4 - Treatment and Care of the Developmentally Disabled, states "No guardian appointed under this chapter shall</p>	F 155	<p>Resident medical records were reviewed for accuracy related to advanced directives.</p> <p>Documentation was received and changes were made as appropriate</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur</p> <p>Education was provided to facility social service staff regarding regulations related to advanced directives. This education included CPR status with diagnosis of mental retardation and communication and development of advanced directives with residents</p> <p>How the corrective action will be monitored to ensure the deficient practice does not recur</p>		

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F 155	<p>Continued From page 2</p> <p>have the authority to refuse or withhold consent for medically necessary treatment when the effect of withholding such treatment would seriously endanger the life or health and well-being of the person with a developmental disability...No physician or caregiver shall withhold or withdraw such treatment for a respondent whose condition is not terminal and whose death is not imminent."</p> <p>The Statute further states that artificial life-sustaining procedures can only be withheld or withdrawn if the individual has "an incurable injury, disease, illness or condition, certified by the respondent's attending physician and at least one (1) other physician to be terminal...and where both physicians certify that death is imminent..."</p> <p>Resident #9 was admitted to the facility 9/13/12 with a primary diagnosis of lack of normal physiological development unspecified.</p> <p>Resident #9's annual MDS assessment, dated 9/11/13, included: - Intellectual Disability ("mental retardation" in federal regulation), and - BIMS = 00 (severely cognitively impaired).</p> <p>Resident #9's record included a DPAHC, notarized 6/14/00, appointing her sister as her health-care agent. However, the form was unsigned.</p> <p>Resident #9's record also included an Idaho Physician Orders for Scope of Treatment (POST), signed 9/25/12 by both the resident's primary care physician and sister, which was marked "Do Not resuscitate (No Code): Allow Natural Death; Patient does not want any heroic or life-saving measures."</p>	F 155	<p>The facility will review resident advanced directives for accuracy in conjunction with the MDS schedule. Negative findings will be tracked by the Social Service Department and reported through facility QAPI for 3 months for further education and training opportunities</p> <p>Individual to ensure compliance and date of compliance</p> <p>The Social Service Director or designee will ensure ongoing compliance</p> <p>Date of Compliance <u>9/12/14</u></p> <p><i>per conversation with facility administrator 9/15/14 2:00 pm [Signature]</i></p>		

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F 155	<p>Continued From page 3</p> <p>NOTE: Resident #9 did not meet the requirement for a DNR and the DNR present in the record did not meet the requirements per Idaho Statute.</p> <p>During an interview on 8/7/14 at 1:05 p.m., the Social Worker stated Resident #9's DNR was in place at the time of admission, and said the DNR should not be in place for Resident #9 and would need to be changed.</p> <p>2. Resident #16 was admitted to the facility on 12/15/13 and re-admitted on 1/14/14 with multiple diagnoses which included hepatic encephalopathy, lung cancer, COPD and CHF. The resident was enrolled in hospice services at the time of admission, and continued to receive hospice services throughout his/her stay in the facility.</p> <p>Resident #16's record contained an Idaho Physician Orders for Scope of Treatment (POST) form, dated 10/8/13, but no other advanced directives.</p> <p>A facility "Advance Directive Policy and Record" form documented the resident had an Advanced Directive, with only the area for the POST checked. The areas for Living Will (LW) and Durable Power of Attorney for Health Care (DPOAHC) were blank. The form documented the facility received the POST form on 1/14/14.</p> <p>A hospice "Patient Consent for Care" form, dated 10/9/13 and documented as received by the facility as received on 1/14/14, documented the resident had both a Living Will and a Durable Power of Attorney for Health Care on file with the hospice agency.</p>	F 155			

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F 155	Continued From page 4 On 8/7/14 at 3:50 PM, the Social Services Assistant (SSA), Administrator, and RDO were asked about Resident #16's Advanced Directives. The SSA stated she was aware, from the document faxed by hospice at the time of the resident's admission, of the existence of a LW and DPOAHC for Resident #16. The SSA stated she had called hospice at the time to ask them to provide a copy of these documents, but hospice did not provide them. The SSA stated she did not pursue the matter any further before the resident discharged from the facility on 5/8/14. On 8/7/14 at 6:15 PM, the Administrator, DNS, and RDO were informed of the surveyor's findings. The facility offered no further information.	F 155	F-157 What corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #10 had notification made to responsible party post incident How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents residing within the facility have the potential to be effected by this practice. Resident with changes in condition and/or incidents within the last 14 days were reviewed for proper notification. Notifications were made as indicated. What measures will be put in place or what systemic change will	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157		

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F 157	<p>Continued From page 5</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, it was determined the facility failed to notify the resident's physician and family member when Resident #10 received a burn on her left inner thigh from spilt hot coffee. This had the potential for harm when the resident's physician and family were not able to make decisions and initiate treatments based on the resident's needs. Findings included:</p> <p>Resident #10 was admitted to the facility on 7/31/2014. The resident had diagnoses which included muscle weakness, atrial fibrillation, end stage renal disease with peritoneal dialysis (ESRD), anemia, hypertension, hypothyroidism, coronary artery disease, and diabetes.</p> <p>On 8/4/2014 at 1:45 PM, Resident #10 stated that right around dinner time the day after being admitted (8/1/2014 at approximately 7:00 PM), that she had spilt hot coffee between her thighs</p>	F 157	<p>you make to ensure that the deficient practice does not recur</p> <p>Licensed Nurses were educated by the facility DETD (District Education and Training Director) on notification requirements related to changes in condition, incidents and events.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not recur</p> <p>The facility will review physician orders, 24-hour report and incidents/accidents Monday through Friday at daily clinical meeting for notification of responsible parties. Findings of these reviews will be reviewed by the Director of Nursing, Monday through Friday X 30 days then weekly X 8. Negative trends will be sent to the QAPI meetings for 3 months for further education and training opportunities.</p>		

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F 157	<p>Continued From page 6</p> <p>and had received a burn to her left inner thigh. The resident said she had turned on her call light and it seemed liked "2 hours" before anyone came to check on her. The resident proceeded to provide her own first aid. She used her glass of ice water and a washcloth retrieved from the sink and held this cold compress between her thighs.</p> <p>The resident's Care Delivery Guide dated 8/1/2014 documented: *Locomotion/Transfer/Positioning-Weight bearing status as tolerated; special equipment-walker and wheelchair; assist with transfers with 1 person assist; bathing/dressing/grooming with 1 person assist; cognition-alert and oriented; comments/special needs-fall risk with previous falls at home.</p> <p>On 8/5/2014 at 9:30 AM, the DON was interviewed regarding Resident #10's burn, treatment, and the incident and accident report. The DON stated, "The resident spilt her hot coffee on 8/1 and said she turned on her call light and it took up to an hour to get help. It happened at the change of shift. The night nurse provided first aid, charted about the accident, and gave report to the next shift nurse, but did not follow through from there." On 8/2 the same night nurse assessed the site and the area was a darker pink with a blister, so she placed a Tegaderm over the site without an order. The DON said the resident's physician and her daughter were not notified of the burn until 8/4 and the Incident and Accident report was not completed until 8/4 either.</p> <p>On 8/4/14 at 6:00 PM, the Physician's Telephone Order documented: "...Burn tx [treatment] Alocane burn gel TID [three</p>	F 157	<p>Individual to ensure compliance and date of compliance</p> <p>The Director of Nursing or designee will ensure on-going compliance.</p> <p>Date of Compliance <u>9-12-14</u></p>	

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F 157	Continued From page 7 times a day] to affected area (L) [left] inner thigh (Please stat [immediately])...	F 157	F167 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice	
F 167 SS=C	On 8/7/14 at 6:15 PM, the Administrator, DNS, and RDO were informed of the surveyor's findings. The facility offered no further information. 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, it was determined the facility did not ensure the results of the annual recertification survey were readily accessible to residents. This deficient practice was true for any resident or their representative who may want to review the survey results, including 15 of 15 sampled residents (#s 1-15) and 9 of 9 residents in the group interview with surveyors. Findings included: On 8/5/2014 at 8:30 AM, 2 surveyors located the survey result binder at the front desk. The binder was behind a container with stationery and envelopes under loose paperwork. The binder	F 167	Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, and 15 have been re-educated to the survey binder location How you will identify other residents having the potential to be affected by the same deficient practice Residents residing within the facility have the potential to be effected by this practice. The residents were educated through Resident Council on the modification to the survey binder location. What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur	

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F 167	Continued From page 8 was not easily found without searching for it. On 8/5/2014 at 8:35 AM, the Administrator was asked about the most recent survey results. The Administrator located the survey result binder at the front desk under the loose paperwork. When the Administrator was asked about the survey book not being easily accessible, he said that he would fix that right away. On 8/5/2014 at 10:00 AM, during the group interview, 9 of 9 residents said they would have liked to look at the survey results and did not know where the survey binder was located. By the afternoon on 8/5/2014, the survey binder was observed in a wall pocket in the dining room hallway.	F 167	The facility modified the location of the survey binder to promote resident access. Residents were educated through Resident Council. Residents admitted to the facility will be given information to the survey binder location with the admission intake. How the corrective action will be monitored to ensure the deficient practice does not recur		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure residents were treated with dignity and respect. This was true for 1 of 10 residents (#9) sampled. The deficient practice had the potential to cause psychosocial harm if the resident became embarrassed by having her incontinence brief exposed. Findings included:	F 241	The Activities Director will audit resident satisfaction with survey binder location weekly X 4 and then monthly X 3. Audits will be presented to the QAPI committee monthly X 3 for further education and training opportunities Individual to ensure compliance and date of compliance The Administrator will ensure on-going compliance		

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F 241	<p>Continued From page 9</p> <p>1. Resident #9 was admitted to the facility 9/13/12 with a primary diagnosis of lack of normal physiological development unspecified.</p> <p>The resident's annual MDS assessment, dated 9/11/13, included the following:</p> <ul style="list-style-type: none"> - Intellectual Disability ("mental retardation" in federal regulation) - BIMS = 00 (severely cognitively impaired) <p>During an observation on 8/6/14 at 6:15 p.m., Resident #9 was observed in the main dining room sitting in her wheelchair near a table. Resident #9's dress had ridden up around her hips and exposed her blue incontinent brief. A male resident was sitting at the table with a clear view of Resident #9's exposed brief. Additionally, no fewer than 5 other residents were seated in the dining room at the time, along with no fewer than 1 family member and facility staff.</p> <p>At 6:19 p.m., Resident #9 propelled her wheelchair into the assisted dining room, stopped midway through facing the door to the hallway. Several residents were present in the assisted dining room. LN #15 was standing in the hallway by the door facing Resident #9, but did not address the exposed brief. A kitchen staff placed Resident #9's plate on the table in the main dining room, then entered the assisted dining room and asked Resident #9 if she was ready for dinner. The kitchen staff did not address the exposed brief.</p> <p>Resident #9 then began to propel herself toward the door to the hallway. LN #15 walked down the hallway toward the nursing station without assisting Resident #9 with her exposed brief.</p>	F 241	<p>Date of compliance <u>9-12-14</u></p> <p>F-241</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice</p> <p>Resident #9 was evaluated for negative outcomes and none were noted. Resident is allowing pants to be worn during waking hours when she is up and about in facility. Care plan and care delivery guide have been updated to reflect change.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <p>Residents residing in the facility have the potential to be effected by this practice. No other</p>

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F 241	<p>Continued From page 10</p> <p>At 6:25 p.m., Resident #9 entered the hallway outside the assisted dining room. LN #6 and LN #16 assisted Resident #9 to adjust her position in her wheel chair and fixed her dress to cover her incontinence brief.</p> <p>During an interview on 8/6/14 at 7:17 p.m., LN #15 stated Resident #9 did not like her and would hit her if she attempted to assist her. LN #15 stated she went to the nursing station to locate assistance for Resident #9.</p> <p>During an interview on 8/7/14 from 4:57 - 5:30 p.m., the DON stated the LN should have addressed Resident #9's exposed attends at the time she first noted it and not left the area to seek other staff. The DON stated any staff noting the exposed attend should have assisted Resident #9.</p> <p>On 8/7/14 at 6:05 p.m., the Administrator and DON were informed of the issue. No further information was provided.</p>	F 241	<p>residents were identified at this time</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur</p> <p>Facility staff was educated to the resident right to dignity and to be covered properly. Education was provided by facility DETD and included interventions to correct identified issues.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not recur</p>	
F 244 SS=E	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION</p> <p>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident group interview, review of the facility's Resident Council Meeting minutes, report</p>	F 244	<p>Caring Partners will audit resident dignity through daily Caring Partner rounds. These audits will be presented to the Administrator Monday through Friday during daily management meeting. Administrator will review audits daily Monday through Friday X 30 days and then weekly X 8. Audits</p>	

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F 244	<p>Continued From page 11 from the Ombudsman's office, and staff interview, it was determined the facility did not provide documentation regarding how the concerns brought forward by the Resident Council had been addressed. This was true for 9 of 9 residents in the resident group interview, and had the potential to impact any resident participating in the Resident Council. The deficient practice had the potential to cause harm to those residents for whom their concerns were not resolved. Findings included:</p> <p>On 8/5/14 at 10:00 AM, during the resident group meeting, the residents stated while the facility ensured the Resident Council had a place to meet monthly, and staff would attend when invited, the Council did not receive feedback from the facility as to the status of their concerns. One resident stated, "The only time we have gotten a follow-up report from the facility was after our meeting on July 3rd (2014). And we just got that yesterday afternoon. Over a month had gone by."</p> <p>On 8/5/14 at 4:50 PM, the Administrator was asked for the last 6 months of Resident Council meeting minutes, documentation of the facility's response to identified concerns, and documentation of follow-up provided to the residents regarding their concerns.</p> <p>On 8/6/14 at 2:10 PM, the Ombudsman's office reported verbally to the survey team they had requested the facility to provide a written response to Resident Council concerns but the issue continued to be an ongoing concern.</p> <p>On 8/6/14 at approximately 3:00 PM, the Administrator provided the requested copies of the monthly Resident Council minutes for March</p>	F 244	<p>will be presented at QAPI monthly X 3 for further education and training opportunities.</p> <p>Individual to ensure compliance and date of compliance</p> <p>The Administrator will ensure ongoing compliance</p> <p>Date of compliance <u>9-12-14</u></p> <p>F-244</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice</p> <p>No individual residents were noted outside of "group interview"</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <p>Residents who attend resident council have the potential to be</p>	

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F 244	Continued From page 12 through July of 2014. Attached to each was a list of resident concerns, along with the facility's plan to follow up on the concerns. However, there was no documented date of implementation or completion of the follow-up, nor any documentation the Resident Council members had been informed or agreed with the facility's plan. There was no documentation from the Resident Council the concerns had been successfully addressed to the Council's satisfaction.	F 244	impacted by this practice. Residents were notified (by written responses) to prior 3 months of resident council concerns as indicated at the September meeting.	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to perform maintenance services necessary to maintain in good repair the tiled flooring at the front of the main nursing station and in the 100 and 200 hallways. This failure had the potential to impact any resident or visitor that utilized these hallways. Findings included: During the survey, there were noted 10-14 raised bubbled and cracked floor tiles in front of the main nursing station and in the 100 and 200	F 253	Education was provided to the Facility Administrator and Activity Director regarding the Resident Concern process. Written response will be provided to the council with each monthly meeting. <i>DEPT provided education per conversation of facility administrator 9/15/14 2:00 PM</i> How the corrective action will be monitored to ensure the deficient practice does not recur The Activity Director will audit for written responses to resident council with each monthly	

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F 253	Continued From page 13 hallways. The largest raised tiled area measured 6.5" X 4" and height of 1/2" to 3/4". On 8/7/2014 at 1:30 PM during the environmental tour, it was brought to the attention of the Maintenance Director of the raised bubbles and cracked tiles. The Maintenance Director was interviewed regarding the cracked and bubbled up tiling and stated, "Been talking about getting it repaired for the last couple of years. Well aware of it." On 8/7/14 at 6:15 PM, the Administrator, DNS, and RDO were informed of the issue. The facility offered no further information.	F 253	meeting. The audits will be reviewed through the daily management meeting following the council meeting and presented at QAPI monthly X 3 for further education and training opportunities Individual to ensure compliance and date of compliance The Administrator or designee will ensure ongoing compliance. Date of Compliance <u>9-2-14</u> F-253 What corrective action will be accomplished for those residents found to have been affected by the deficient practice No residents were identified How you will identify other residents having the potential to	
F 258 SS=D	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure comfortable sound levels in the resident living environment. This was true for 1 of 15 (#8) residents sampled for sound levels. The deficient practice had the potential to cause harm when the noise levels in the 300 hallway prevented facility staff from hearing a resident who was calling out for assistance. Findings included: Resident #8 was admitted to the facility on 12/6/13 with multiple diagnoses which included advanced dementia, anemia, chronic kidney	F 258		

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F 258	<p>Continued From page 14 disease, and hypertension.</p> <p>Resident #8's most recent quarterly MDS assessment, dated 6/9/14, coded: *Moderately impaired cognitive skills; *Behavioral symptoms 1 to 3 days out of the past 7 days; *Extensive assistance of 1 for transfers and toilet use; and *Frequently incontinent of bowel and bladder.</p> <p>Resident #8's care plan documented, for "Mood and Behavior Symptom Assessment/Plan of Care," **"Resident frequently yells out," under the assessment column. The corresponding "Interventions" column documented, "Ask resident to please be quiet." * "Calling out, yelling for staff/not using call light," and "May smear feces on self/bedding," under the assessment column. The corresponding "Interventions" column documented, "...offer toileting or to go lay down, frequent checks for needs."</p> <p>These updates were hand-written on Resident #8's care plan, but not signed or dated, so it was not possible to tell when they had been implemented. Please see F 280 as it pertains to care plan revisions.</p> <p>On 8/5/14 at 1:40 PM, Resident #8 was lying in bed her room. As the surveyor approached the room, Resident #8 was heard yelling, "Please help me here. Help me. Please come and clean me up. Pretty please. I need to go so bad." The resident repeated this several times. Several staff were visible at the nurse's station, approximately 125 feet away from the resident's room, but none</p>	F 258	<p>be affected by the same deficient practice</p> <p>Residents residing within the facility have the potential to be effected by the flooring. Residents were notified of the upcoming flooring replacement through the September Resident Council meeting.</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur</p> <p>Facility has initiated process to replace flooring in front of nursing station.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not recur</p> <p>Facility Maintenance Director will monitor identified flooring area for noted changes prior to</p>	

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F 258	<p>Continued From page 15</p> <p>were responding to the resident. The surveyor walked away from the resident's room towards the nurse's station. As the surveyor walked, the sound from electric fans running in each resident room could be heard, as well as one in the hallway. Two resident televisions were on. There was an overhead page for a staff member who had a telephone call. Many staff were conversing with each other. An automatic paper towel dispenser dispensed a sheet of towel with a loud whirring sound every time a person passed, which included staff, residents, and visitors. By the time the surveyor arrived at the nurse's station, Resident #8's cries were no longer audible. The surveyor moved back down the hallway towards Resident #8's room, with her requests for help intermittently audible from approximately 50 feet away, depending on the waxing and waning of the noise in the hallway, and only consistently audible from approximately 25 feet away.</p> <p>On 8/5/14 at 1:52 PM, LN #6 entered room 303, approximately 10 feet from the entrance to Resident #8's room. At 1:53 PM, LN #6 exited room 303, heard Resident #8's cries, then entered the room to assist the resident.</p> <p>On 8/5/14 at 2:00 PM, LN #6 was interviewed about Resident #8. LN #6 stated when she responded to Resident #8, the resident identified the need to use the toilet. LN #6 stated, "I went in there as soon as I heard her." When informed the resident had been calling out for 13 minutes before staff responded, LN #6 stated, "That surprises me." When asked if the noise level in the area could have impacted the staff's ability to hear the resident, LN #6 stated, "Yeah, it's pretty noisy here. Like I said, I went in there as soon as</p>	F 258	<p>replacement through daily rounds. Safety markings will be placed if changes noted. Flooring is actively being replaced</p> <p>Individual to ensure compliance and date of compliance</p> <p>The Maintenance Director will ensure on-going compliance.</p> <p>Date of compliance <u>9-2-14</u></p> <p>F-258</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice</p> <p>Resident #8 was reviewed for negative outcomes related to issue and note were noted. Care plan was reviewed for needed changes.</p> <p>How you will identify other residents having the potential to be affected by the same deficient</p>	

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F 258	Continued From page 16 I heard her." LN #6 stated the facility used the fans in the resident rooms as that part of the building lacked air conditioning. On 8/7/14 at 9:00 AM, the DNS was asked about noise levels in the facility. The DNS stated, "Oh, it's terribly noisy here." The DNS stated she had presented suggestions as to minor environmental changes which could reduce the amount of noise in the facility, but they had not yet been implemented. The DNS also stated she had been working with the staff to conduct their interactions with one another more quietly, "but it does need to improve still."	F 258	practice and what corrective action will be taken Residents who reside within the facility have the potential to be effected by noise levels. Caring Partners conducted a satisfaction audit with residents to identify concerns of needs not being met related to noise. None were noted. What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur		
F 280 SS=E	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	F 280	Education was provided to the facility associates by the Administrator and/or designee on noise levels, routine rounds and reporting on residents needs/calling out through the 24 hour report and behavior tracking system. Residents identified will be reviewed by IDT and plan of care will be updated to meet individual needs.		

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F 280	<p>Continued From page 17</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident group interview, staff interview, and record review, it was determined the facility failed to ensure residents were invited to participate in their care planning meetings, and failed to ensure resident care plans were reviewed and revised. This was true for 2 of 9 residents in the resident group, and 6 of 11 residents (#s 3, 4, 8, 9, 12 and 14) sampled for care plan revisions. The deficient practice had the potential to cause harm when care plans for residents were revised without resident input, interventions were not signed or dated, and were not consistent with current physician's orders. Findings included:</p> <p>1. On 8/5/14 at 10:00 AM, during the group interview, 9 of 9 residents present stated they were not aware the facility held care plan meetings to discuss their care, and had not been invited to attend those meetings.</p> <p>On 8/7/14 at 1:15 PM, the Social Services Director (SSD) was interviewed about resident participation in care plan meetings. The SSD stated she had only started working in the facility recently, but would expect that each resident and/or their surrogate decision maker would be</p>	F 280	<p>How the corrective action will be monitored to ensure the deficient practice does not recur</p> <p>The facility Caring Partners will conduct weekly audits X 12 on resident satisfaction/needs being met related to noise level. Findings will be presented to QAPI monthly X 3 for further education and training opportunities.</p> <p>Individual to ensure compliance and date of compliance</p> <p>The Administrator will ensure compliance</p> <p>Date of compliance <u>9-12-14</u></p> <p>F-280</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice</p>	

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F 280	<p>Continued From page 18</p> <p>invited to attend care plan meetings at least quarterly. The SSD stated she was not sure if residents had been invited to their care plan meetings prior to her starting work at the facility.</p> <p>On 8/7/14 at approximately 2:00 PM, the Administrator was asked to provide documentation the residents in resident group had been invited to their care plan meetings. The Administrator provided a, "Comprehensive Care Plan Review Summary" for each resident in the resident group. The form contained a space to check if the resident and/or family had been invited to a resident care conference, and whether or not they had accepted or declined the invitation. For two of the residents, this area of the form was blank. The Administrator stated the residents in question had indicated, when asked by the facility on 8/7/14, they did not want to attend care conferences. However, the facility did not provide documentation the residents had been invited and declined the invitation when conferences had been scheduled in the past.</p> <p>2. Resident #8's care plan contained pre-printed pages for falls, safety devices, mood and behavioral symptoms, pain management, communication, urinary continence, bowel elimination, cognition, CHF, potential for infection, diabetes, ADLs and mobility, nutrition, skin integrity, and advanced directives. Each of these pages had pre-printed columns labeled either "Problem," or, "Assessment," "Goal;" and "Interventions." There was a blank column for "Date" next to the Assessment/Problem column, and a blank column for "Due Date" next to the Goal column. A series of dates was listed in each of these columns, with all but the most recent date crossed out. The individual problems, goals,</p>	F 280	<p>Resident #3, 4, 8, 9, 12 and 14 have been invited to and/or attended a care conference related to their care plan.</p> <p>Residents #3, 4, 8, 9, 12 and 14 had their care plans reviewed for accuracy and completion. Changes were made as indicated.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <p>The IDT completed a house audit of care plans to ensure completion (including dates) for active residents.</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur</p> <p>Education was provided by the DETD/designee to the interdisciplinary team regarding</p>		

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F 280	<p>Continued From page 19 and interventions checked did not have dates as to when they were identified or implemented, or if whether or not they had been resolved. Additionally, there were some hand-written additions to these columns, with these additions being neither dated nor signed as to when or by whom they had been added.</p> <p>On 8/7/14 R 9:00 AM, Resident #8's care plan was reviewed with the DNS. Upon review, the DNS stated, "That care plan is not specific. And you can't tell who made those additions or when. I'll fix that right away."</p> <p>On 8/7/14 at 6:15 PM, the Administrator, DNS, and RDO were informed of the surveyor's findings. The facility offered no further information.</p> <p>3. Resident #12 was admitted to the facility on 5/1/06 and readmitted on 11/24/11 with diagnoses including aphasia due to cerebrovascular disease, hypertension, and diabetes type II.</p> <p>Resident #12's Safety Device Plan of Care, dated 5/28/14, included an undated hand-written entry which documented, "Resident request seat belt for comfort not used as safety device just resident preference."</p> <p>On 8/7/14 at 11:20 a.m., Resident #12's wheelchair was observed and did not have a seat belt in place. RCM #2, who was present when the wheelchair was observed, stated the resident had a seat belt in the past but it was removed "a couple of months ago."</p> <p>On 8/7/14 at 6:05 p.m., the DON was interviewed</p>	F 280	<p>care plan updates and thorough completion. Education was provided to Social Services and the IDT to invite resident/responsible party to care conferences for input related to care plan development with the initial care conference, quarterly and with any significant change of condition.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not recur</p> <p>The facility IDT will review care plans for completion and accuracy in conjunction with the resident's MDS schedule. Residents and/or responsible parties will be offered the opportunity to participate in care plan development at the initial care conference, quarterly and with any significant change of condition.</p> <p>Individual to ensure compliance and date of compliance</p>	

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F 280	Continued From page 20 and stated the care plan should have been updated. 4. Residents #3, #4 and #9's care plans were reviewed. The facility utilized care plans that consisted of pre-printed pages for falls, safety devices, mood and behavioral symptoms, pain management, communication, urinary continence, bowel elimination, cognition, potential for infection, diabetes, ADLs and mobility, nutrition, skin integrity, and advanced directives. Each of these pages had pre-printed columns labeled either "Problem" or "Assessment;" "Goal;" and "Interventions." There was a blank column for "Date" next to the Assessment/Problem column, and a blank column for "Due Date" next to the Goal column. A series of dates were hand-written in each of these columns, with all but the most recent date crossed out. The individual problems, goals and interventions checked did not have dates as to when they were identified or implemented, or whether or not they had been resolved. Additionally, there were some hand-written additions to these columns, some of which lacked dates of when they were added and/or signatures of who had made the addition. On 8/7/14 at 4:57 p.m., the DON was interviewed and stated all entries on care plans should be signed and dated. NOTE: Similar issues existed for Resident #12 and #14.	F 280	The Director of Nursing will ensure compliance. Date of compliance <u>9-12-14</u> F-309 What corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #6 no longer resides in the facility Resident #10 was assessed by the clinical team for negative findings related to blood glucose and urine output collection and none were found. The burn from the coffee spill is resolved. Resident # 9 had meal intake and care plan reviewed for last 14 days. Changes were made as needed to care plan to meet residents needs		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309			

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F 309	<p>Continued From page 21</p> <p>Each resident must receive and the facility must 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, staff and resident interview and record review, it was determined the facility failed to ensure: * Dressing changes were completed as ordered for a resident with bilateral heel wounds; * Blood glucose checks were completed as ordered for a resident with diabetes; * A 24 hour urine collection was obtained per Physician's order; * Physician orders were received for a resident who sustained a burn and monitoring of the burn was performed; * A resident's wheelchair had the foot pedals in place prior to locomotion; * A resident who left the dining room received the dinner meal; and, - * A brace was worn per Physician's order. This affected 5 of 15 (#s 3, 4, 6, 9 & 10) sampled residents. These failures created the potential for the residents to experience complications and/or compromised medical status. Findings included:</p> <p>1. Resident #6 was admitted to the facility on 4/8/14 with multiple diagnoses which included diabetes and polyneuropathy.</p> <p>The most recent quarterly MDS assessment for Resident #6, dated 7/14/14, documented:</p>	F 309	<p>Resident #3 had care plan updated as indicated and a care tracker message (communication to aides) was placed regarding foot rests to wheelchair</p> <p>Resident #4 had orders and care plan review related to splint. Care tracker message was sent related to splinting times and care plan was updated.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <p>Through record review, residents requiring dressing changes, blood glucose checks, urine collection, monitoring of skin issues, utilizing foot rests to their wheelchairs and assistance with meal were identified and have had their plan of care reviewed. Associated standard of practice to these issues are in compliance.</p>	

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F 309	<p>Continued From page 22</p> <ul style="list-style-type: none"> * Intact cognition with a BIMS of 15; and, * Required extensive assistance of 1 person for bed mobility, transfers, dressing, personal hygiene, toileting and bathing. <p>Resident #6's July 2014 recapitulation Physician's orders, dated 6/2/14, documented, "(B) [Bilateral] HEELS: BETADINE TO ESCHAR WITH BULKY DRY DRESSING TO COVER (ABD PAD, KERLIX; DO NOT PULL TIGHT, RISK OF TOURNIQUET EFFECT. CHANGE [sic] DAILY."</p> <p>Resident #6's TAR (Treatment Administration Record) for June, July and August 2014 documented the aforementioned Physician's order for dressing changes to bilateral heels daily. Dressing changes were not completed on 6/9/14, 6/10/14, 7/1/14, 7/2/14, 7/21/14, 7/24/14, 7/26/14, 7/28/14 and 8/5/14.</p> <p>On 8/6/14 at 3:55 p.m., the dressing changes by LN #7 were observed by the surveyor. The date written on the old dressing was 8/4/14. LN #7 was asked if the dressing was to be changed daily and she stated, "Yes."</p> <p>On 8/7/14 at 2:45 p.m., LN #7 was interviewed about the lack of dressing changes for Resident #6 in June, July and August 2014. She said the evening shift was supposed to do the dressing changes and if they were not documented they did not happen.</p> <p>On 8/7/14 at 6:10 p.m., the Administrator and DON were informed of the issues with the dressing changes for Resident #6. No further information or documentation was provided.</p> <p>2. Resident #10 was admitted to the facility on</p>	F 309	<p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur</p> <p>Licensed Nurses have been educated by the DETD related to standards of practice including, dressing changes, blood glucose checks, urine collection, assessment and monitoring of skin issues, meal assistance and splint use. Education was completed by the DETD to nursing assistants to ensure compliance with the plan of care and care delivery guide. Any new issues will be documented on, and reviewed from the 24 hour report/MD orders daily Monday through Friday in the management meeting to ensure necessary care is delivered.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not recur</p>	

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F 309	<p>Continued From page 23 7/31/14. The resident had diagnoses which included muscle weakness, end stage renal disease (ESRD) with peritoneal dialysis, and diabetes.</p> <p>The resident's Care Plan dated 8/1/14 documented: *Care Delivery Guide section: Locomotion/Transfer/Positioning-Weight bearing status as tolerated; special equipment-walker and wheelchair; assist with transfers with 1 person assist; bathing/dressing/grooming with 1 person assist; cognition-alert and oriented; comments/special needs-fall risk with previous falls at home. *Skin Integrity section: Braden Risk Assessment Score-At risk (15-18); At risk related to ESRD and Diabetes Mellitus. *Nutrition section: Diabetes; Renal Disease with peritoneal dialysis *Peritoneal Dialysis section: Assure dialysis center affiliation for monthly appointment; coordinate care with dialysis center/provider.</p> <p>The resident's Care Plan updated 8/4/14, documented in the Skin Integrity Assessment: *Burn to left thigh; see TAR (Treatment Administration Record); and fids on hot beverages.</p> <p>a. Resident #10's Physician Orders dated 7/31/14 documented: "...DM [diabetic mellitus] orders-Humalog Sliding Scale Tier 1 AC [before meals] and HS [at bedtime]. BG [blood glucose] 1- 51-130: 0 units; 131-150: 2 units; 151-200: 3 units..."</p> <p>The resident's undated MAR documented:</p>	F 309	<p>Care audits will be conducted daily X 30 then weekly X8 to ensure that dressing changes are occurring as per order, glucose checks are being completed as per order, urine collection is occurring as per order, any new skin issues have been assessed and monitored as per order, meal intake is being supervised and assisted as needed and ordered splints are in place as per plan of care. Audits will be presented at QAPI monthly for further education and training opportunities.</p> <p>Individual to ensure compliance and date of compliance</p> <p>The Director of Nursing/designee will ensure compliance</p> <p>Date of compliance <u>9-12-14</u></p>	

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F 309	<p>Continued From page 24</p> <p>"...Check CBG [capillary blood glucose] AC and HS..."</p> <p>"...Humalog insulin sliding scale before meals...See diabetic flowsheet..."</p> <p>(Refer to F514 for details regarding undated documents.)</p> <p>On 8/5/14 at 8:10 AM, Resident #10 was observed in her room eating breakfast. The resident stated, "My blood glucose was not checked this morning and I didn't receive any insulin, but it's too late now since I ate breakfast."</p> <p>Resident #10's Diabetic Flowsheet, dated 7/31 through 8/6/14, documented: Daily bedside blood glucoses with a date, time, and amount of Humalog insulin given. On 8/5/14 the first blood glucose recorded was at 12:00 and no entry prior to breakfast was recorded.</p> <p>On 8/5/14 at 4:00 PM, LN #14 was interviewed regarding Resident #10's blood glucose monitoring and sliding scale insulin. LN #14 stated, "I did not check her BG this morning. I didn't know she was a diabetic. It was checked at 12:00 and was 266, so she received 7 units of Humalog."</p> <p>b. Resident #10's Physician Order, dated 8/1/14, documented: "...24 hour urinal collection to start Sun [Sunday] through Mon [Monday] AM also use drain bag on cyclor. Send both with rs [resident] to app [appointment] Mon..."</p> <p>Resident #10 Physician's Order, dated 8/3/14, documented: "...12 hour urine specimen to be sent c [with] resident c appointment on Monday..."</p>	F 309			

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F 309	<p>Continued From page 25</p> <p>On 8/4/14 Resident #10's Physician Order documented: "...24 hour urine collection to start morning of 8-7-14 through morning of 8-8-14. Keep on ice. Send with resident to appt [appointment] on 8-8-14. Drain to be attached to cyclor on 8-7-14 prior to starting..."</p> <p>On 8/6/14 at 12:50 PM, LN #1 was interviewed regarding the multiple lab orders for the 24 hour urine specimen collection. LN #1 stated, "On Sunday the resident had a BM [bowel movement] and the urine specimen was contaminated." The LN said the dialysis center was contacted and a 12 hour urine collection was approved. The LN was asked if the 12 hour urine specimen was completed. She stated, "No, because the dialysate output and urine collection did not go as a unit." When the surveyor asked why they did not go out as a unit, LN #1 stated, "Because the dialysate output was not connected to the tubing to go into the bag and it went into a different container."</p> <p>Review of Nursing Progress Notes, dated 8/3/14 day shift, documented, "...On 24 hour urine..."; Addendum: "Reports of 0 void [urination] this shift [at 4:00 PM]. Spoke to residents [sic: resident] states she urinated X [times] 2 this shift but dumped it out d/t [due to] no one picking it up. Encouraged her to use bedside commode..."</p> <p>c. On 8/4/14 at 1:45 PM, Resident #10 stated that around dinner time on 8/1/14, she had spilt hot coffee between her thighs and had received a burn to her left inner thigh. The resident said she had turned on her call light and it seemed liked "2 hours" before anyone came to check on her. The</p>	F 309		

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F 309	<p>Continued From page 26</p> <p>resident said she proceeded to provide her own first aid treatment. She used her glass of ice water and a washcloth retrieved from the sink and held this cold compress between her thighs.</p> <p>On Nursing Progress Notes the following was documented:</p> <p>*8/1/14 Night-"...Did have hot coffee spill between thighs at shift change and cool compress applied to thighs by resident. Thighs have small, bright pink splotches but does not look as if blistering will form..."</p> <p>*8/2/14 Day-No documentation regarding assessment of burn.</p> <p>*8/2/14 Night-"...Blister noted on left inner thigh due to spilled coffee yesterday. Tegaderm dressing applied..."</p> <p>*8/3/14 Day-No documentation regarding assessment of burn.</p> <p>*8/3/14 Night-No documentation regarding assessment of burn.</p> <p>*8/4/14 11:00 AM-No documentation regarding assessment of burn.</p> <p>*8/4/14 7:30 PM-"...Resident and daughter in room, resident complaining of burning and itching to left inner thigh. Area of burn from coffee incident measuring 5.8 cm X 33 cm X 1.5 cm. Light red around area, darker red inside. Appears to have been blistered at one point, but as of right now appears to have top layer of skin not intact. Accident and incident report completed. Faxed [Physician's name] at 9:30. Called [Physician's name]'s office and left message for return call... Spoke to resident's daughter about plan of care for burn..."</p> <p>On 8/5/14 at 9:30 AM, the DON was interviewed regarding Resident #10's burn, treatment, and the incident and accident report. The DON stated,</p>	F 309		

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F 309	<p>Continued From page 27</p> <p>"The resident spilt her hot coffee on 8/1 and said she turned on her call light and it took up to an hour to get help. It happened at the change of shift. The night nurse provided first aid, charted the accident, and gave report to the next shift nurse, but did not follow through from there." The DON said, the same night nurse assessed the site on 8/2 and the area was a darker pink with a blister so a Tegaderm dressing was placed over the site without an order. The DON said the physician and the resident's daughter were not notified of the burn until 8/4 and the Incident and Accident report was not completed until 8/4 either.</p> <p>On 8/4/14 at 6:00 PM, the Physician's Telephone Order documented: "...Burn tx [treatment] Alocane burn gel TID [three times a day] to affected area (L) [left] inner thigh (Please stat [immediately])..."</p> <p>On 8/7/14 at 6:15 PM, the Administrator, DNS, and RDO were informed of the issues. The facility has provided no additional information to resolve the issues.</p> <p>Refer to F353 regarding insufficient staff to answer call lights.</p> <p>3. Resident #9 was admitted to the facility 9/13/12 with a primary diagnosis of lack of normal physiological development unspecified and diabetes type II.</p> <p>The resident's annual MDS assessment, dated 9/11/13, included: - Intellectual Disability ("mental retardation" in federal regulation); - BIMS = 00 (severely cognitively impaired); and</p>	F 309		

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F 309	<p>Continued From page 28</p> <p>- Required set up help with dining.</p> <p>Resident #9's Nutrition Risk Plan of Care, dated 6/4/14, stated her risk factors included, but were not limited to, the following: diabetes, consumes less than 75% (added 7/18), weight Loss (added 7/22/14), and developmental delay. Goals included: Resident will consume at least 75%. Interventions included: - Monitor intake of meals and offer alternate, and - Assist with meals as needed.</p> <p>On 8/6/14 at 6:15 p.m., Resident #9 was observed in the main dining room. At 6:19 p.m., Resident #9 began wheeling herself through the assisted dining room toward the hallway door. A kitchen staff placed Resident #9's plate on the dining table and asked her if she was ready for dinner. Resident #9 did not respond.</p> <p>Resident #9 continued to wheel herself out of the assisted dining room, into the hallway, and toward her room. At 6:45 p.m., Resident #9 arrived at her room and transferred herself from her wheelchair to her bed.</p> <p>At no time during the observation was meal assistance offered to Resident #9 beyond placing her plate on the table and asking if she was ready for dinner.</p> <p>On 8/6/14 at 7:07 p.m., CNA #12 was interviewed and stated she collected residents' dining slips from the main and assisted dining rooms following meals and recorded information related to what each resident ate. CNA #12 stated if a resident did not eat at least 25%, she informed the resident's nurse.</p>	F 309			

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F 309	<p>Continued From page 29</p> <p>On 8/6/14 at 7:09 p.m., LN #16, who was Resident #9's nurse, stated the CNAs would inform her of residents who did not eat and she would try to get the resident to eat a snack later in the evening. LN #16 stated she was already aware of who did not eat dinner in the dining room. However, LN #16 was not aware Resident #9 had not eaten her meal.</p> <p>On 8/6/14 at 7:30 p.m., the DON stated staff should have made an effort to get Resident #9 to eat, or should have at least taken her plate to her room and assisted her there. The DON stated it was unacceptable to simply allow Resident #9 to return to her room without eating.</p> <p>4. Resident #3 was admitted to the facility on 2/5/09 and had diagnoses which included osteoporosis, gout, unspecified psychosis, and dementia.</p> <p>The resident's annual MDS assessment, dated 7/20/14, included:</p> <ul style="list-style-type: none"> - BIMS = 99 (unable to complete the interview); - Severely impaired cognitive skills for daily decision making; - Utilized a wheelchair; and - Required assistance for locomotion on the unit. <p>Resident #3's Fall/Injury Assessment: Prevention and Management Plan of Care, dated 7/22/14, included the following interventions:</p> <ul style="list-style-type: none"> - A hand-written entry, dated 8/1/14, stating "tell Res before pushing wheelchair and encourage to lift feet." - Foot rests (added 8/2/14), and - A hand-written entry, dated 8/5/14, stating "Foot rest down when pushing Res then raised to allow 	F 309		

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F 309	<p>Continued From page 30</p> <p>Res to negotiat [sic] w/c as able"</p> <p>On 8/5/14 at 8:20 a.m., Resident #3 was observed in the assisted dining room. Foot rests were not present on her wheelchair. At 8:45 a.m., Resident #3 was observed in the activity room. Foot rests were not present on her wheelchair.</p> <p>On 8/5/14 at 11:15 a.m., Resident #3 was observed in the hallway near the dining room. An unidentified staff stated "pick your feet up" and pushed Resident #3 towards her room. Foot rests were not present on her wheelchair.</p> <p>On 8/7/14 at 3:35 p.m., RCM #1 stated foot rests were added to Resident #3's wheelchair after she had bruised her toe. RCM #1 stated foot rests should have been in place and used on 8/5/14 during the observation and staff should not have had to ask Resident #3 to pick up her feet.</p> <p>5. Resident #4 was admitted to the facility on 10/28/08 and readmitted 5/24/14 with a primary diagnoses of dementia.</p> <p>The resident's quarterly MDS assessment, dated 8/4/14, included a BIMS = 04 (severely cognitively impaired)</p> <p>Resident #4's 7/1/14 Recap Physician's Orders documented an order for a splint, dated 10/15/12, which stated "Splint to [left] hand [for 3] hours 2 times daily."</p> <p>Resident #4's ADL/Mobility Plan of Care, dated 7/14/14, documented the resident had CVA with "Quadraporesis [sic]" as evidenced by generalized weakness and contractures to the left upper extremity. Interventions included a splint to</p>	F 309		

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F 309	<p>Continued From page 31</p> <p>the left hand. Hand-written under the interventions was, "Splint to [left] hand BID [for 3] hours."</p> <p>Resident #4's TAR for 6/1/14 - 8/6/14 were reviewed and documented the brace had been left on in excess of 3 hours at a time, as follows:</p> <ul style="list-style-type: none"> - The brace was left on for 4 hours 14 times in June, 15 times in July, and 2 times in August during the AM shift; and 1 time in July during the PM shift. - The brace was left on for 5 hours 3 times in June, and 1 time in July during the AM shift; and 1 time in June and 2 times in July during the PM-shift. - The brace was left on for 6 hours 1 time in July during the PM shift. - The brace was left on for 7 hours 2 times in June and 2 times in July during the AM shift; and 2 times in July during the PM shift. <p>During an interview on 8/7/14 from 8:50 - 9:40 a.m., RCM #2 confirmed Resident #4's Physician's Order was to have the brace on for 3 hours on the AM and PM shifts. RCM #2 stated staff did not document a time on and time off, but only documented the duration of time the brace was being left on. RCM #2 stated the braced should not be left on for more than 3 hours.</p> <p>During an interview on 8/7/14 from 4:57 - 5:30 p.m., the DON confirmed the documentation for Resident #4's showed the brace was left on longer than the Physician's Order.</p>	F 309			

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F 311 F 311 SS=E	Continued From page 32 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on resident group interview, interview with the Ombudsman's office, staff interview, and record review, it was determined the facility failed to ensure residents received assistance with bathing, and at meal times. This was true for 13 of 15 (#s 1-9 and 12-15) residents sampled for bathing and ADL assistance. The deficient practice had the potential to cause harm if residents developed skin breakdown or embarrassment from appearance and odor when they were not clean. Findings included: On 8/5/14 at 10:00 AM, during the resident group interview, 8 of 9 residents present stated they had ongoing difficulty getting bathed regularly. The ninth resident stated she had only been admitted to the facility recently, and was receiving bathing assistance as part of her therapy program. Specifically, the residents reported: *The residents individually, and the Resident Council as a group, had been complaining to the facility for, "about a year and a half," about gaps in the shower schedule. The residents stated the facility had promised to resolve the concerns, but had not provided specific information as to how that was to be accomplished, and no results had been noticed by the group. *One resident stated she had gone for three weeks without a shower, until she was so	F 311 F 311	F-311 What corrective action will be accomplished for those residents found to have been affected by the deficient practice Residents #1, 2, 3, 4, 5, 7, 8, 9, 12, 13, 14 and 15 have had their bathing records reviewed. The above residents were interviewed for shower/bathing preference and care plan and care delivery guide have been updated. The identified residents are receiving bath/showers as per preference and as per schedule of choice. Resident #6 no longer resides in the facility How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents residing in the facility have the potential to be effected	

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F 311	<p>Continued From page 33</p> <p>embarrassed by her appearance and her odor she finally said something to the facility. The resident stated it was not until she had complained to the facility she got a shower.</p> <p>*The residents stated the facility was supposed to have two shower aides daily, which were CNAs assigned only to assist the residents with bathing activities. The residents stated it was not uncommon for the shower aides to get, "pulled to the floor," (assigned other CNA duties) when there were call-ins by other aides, or the facility was otherwise "short staffed." The residents stated when this happened, showers were canceled, and not re-scheduled. One resident stated, "You just have to wait for your next shower day, and hope they don't cancel showers then." Another resident stated, "They are supposed to have two shower aides today, but they pulled one because you guys are here. Frankly, I would rather have my shower."</p> <p>On 8/6/14 at 2:10 PM, the Ombudsman reported to the survey team the residents in the facility had expressed ongoing concern with the lack of showers during routine Ombudsman visits.</p> <p>On 8/6/14, Scheduler #10 and the Regional Nurse Consultant (RNC) were interviewed about the availability of bathing assistance for the residents. Scheduler #10 stated there were usually two shower aides scheduled daily, and they had a schedule of residents to be bathed each day. Scheduler #10 stated the availability of shower aides could be impacted if there were call-ins, or the facility was "short-staffed." The RNC added there may be fewer shower aides if the facility census was low. When asked if there had been two shower aides the previous day, when the residents complained one of the aides</p>	F 311	<p>by this practice. Interviewable residents were interviewed for bathing preferences and their care plans have been updated. Non-interviewable residents have had been reviewed and in conjunction with their decision maker have had their care plan and care delivery guide updated.</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur</p> <p>Education was provided to LN's and IDT by the facility DETD/DON regarding resident bathing preference and schedule. There is a bathing/shower team in place to meet the bathing needs of the residents. Any scheduled baths/showers missed will be re-scheduled/offered and if refused, documented as to resident choice. Bathing/shower team will report to Nursing Supervisor any bathing</p>	

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F 311	<p>Continued From page 34</p> <p>had been re-assigned, Scheduler #10 stated, " I think we had two, I'll have to look." [NOTE: The facility did not provide the survey team with information as to whether the shower aides were scheduled for 8/5/14, or if they had been re-assigned.] The RNC stated the shower aides would document any refusals on a "skin sheet", which would then be given to the nurse for a signature. The RNC stated the nurse should assess the situation if a resident was refusing to be bathed, but was uncertain if or where the results of that assessment would be documented.</p> <p>Review of sample resident bathing records revealed:</p> <p>*Resident #1 was not bathed between 6/23/14 and 6/29/14, between 6/30/14 and 7/11/14, and between 7/25/14 and 8/1/14. The resident was documented to have refused bathing on 3 occasions, however, there was no documentation as to why the resident had refused, whether the facility had attempted to overcome the resident's objections or provide education as to the potential consequences of the refusals, or that the resident had been re-approached in the days following the refusal.</p> <p>*Resident #5 was not bathed between 6/11/14 and 6/18/14, between 6/22/14 and 6/29/14, between 6/30/14 and 7/6/14, between 7/7/14 and 7/13/14, and between 7/23/14 and 8/3/14. Only 1 resident refusal was documented, on 8/2/14. There was no documentation as to why the resident refused, nor that he was re-approached.</p> <p>*Resident #6 was not bathed between 6/5/14 and 6/11/14, 6/13/14 and 6/22/14, 7/9/14 and 7/16/14, 7/17/14 and 7/23/14, and 7/30/14 and 8/6/14. The resident was documented with occasional refusals, but there was no documentation as to why the resident refused, whether the facility had</p>	F 311	<p>refused or not completed for follow-up.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not recur</p> <p>Bathing records will be reviewed by the Resident Care Managers/Director of Nursing daily X 60 Monday through Friday and then weekly X 4. These audits will be presented to QAPI monthly X 3 for further education or training opportunities.</p> <p>Individual to ensure compliance and date of compliance</p> <p>Director of Nursing will ensure compliance.</p> <p>Date of compliance <u>9-12-14</u></p>	

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F 311	<p>Continued From page 35</p> <p>attempted to overcome the resident's objections, offered education, or re-approached. NOTE: Please see F 309 as it pertains to Resident #6's skin issues.</p> <p>*Resident #7 was not bathed between 6/1/14 and 6/12/14 (2 refusals documented in this 12 day period), 6/13/14 and 6/25/14 (2 more refusals documented in this 12 day period), 6/26/14 and 7/3/14 (1 refusal documented), 7/4/14 and 7/17/14 (4 refusals documented), and 7/25/14 and 7/31/14 (no refusals documented). There was no documentation as to why the resident refused, whether the facility had attempted to overcome the resident's objections or offered education. Only once was there documentation of refusals on consecutive days, 7/13/14 and 7/14/14.</p> <p>*Similar results were noted for the residents #s 2, 3, 4, 8, 9, 12, 13, 14 and 15.</p> <p>On 8/7/14 at 8:45 AM, the DNS was asked about resident showers. The DNS stated the facility had been aware of the resident's concerns with bathing, because it had been brought up in Resident Council. The DNS stated in response to the most recent resident concerns, she had instructed her staff unless there was an emergency, the shower aides could not be re-assigned. The DNS stated she had been trying to hire additional staff to be available to cover call-ins, vacations, and other staffing shortages, but had encountered some barriers in implementing that plan. The DNS stated, "It's gotten better in the last month. We have looked at assignments and reasons for disruption in any type of care, from call lights to RNA to showers, but we still have a ways to go and we know that."</p> <p>On 8/7/14 at 6:15 PM, the Administrator, DNS,</p>	F 311		

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F 311	Continued From page 36 and RDO were informed of the surveyor's findings. The facility offered no further information.	F 311	F-314	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review it was determined the facility failed to ensure pressure ulcer measurements were accurate for 1 of 4 residents (#4) reviewed for pressure ulcers. This resulted in the potential for harm if treatment and services were not based upon accurate information related to the pressure ulcer. Findings included: 1. Resident #4 was admitted to the facility on 10/28/08 and readmitted on 5/24/11 and had diagnoses including dementia unspecified with behavioral disturbance. The resident had a stage IV sacral pressure ulcer. The resident's quarterly MDS assessment, dated 8/4/14, documented: - BIMS = 04 (severely cognitively impaired); - Bed mobility required 2+ person physical assist;	F 314	What corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #4 has accurate measurements in the medical record. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken Resident's with pressure areas were identified through record review. Resident's with pressure areas have been assessed by the facility skin team and have accurate measurements/assessments in place. What measures will be put in place or what systemic change will	

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F 314	<p>Continued From page 37</p> <ul style="list-style-type: none"> - Total dependence for bathing; - Impaired range of motion to both lower extremities; - A pressure ulcer; and - At risk of developing pressure ulcers. <p>Resident #4's skin documentation and treatment records related to her stage IV, sacral pressure ulcer, from 7/30/13 - 8/4/14, were reviewed. The facility's method for measuring and documenting the progression of the pressure ulcer was not consistent to ensure accuracy of measurement. Without accuracy of measurement and documentation, the facility would not be able to ensure the efficacy of the treatment or need for treatment revisions. Examples included, but were not limited to, the following:</p> <p>a. A Skin Grid entry, dated 4/14/14, documented the wound was 2.0 cm in length, 1.3 cm in width and 1 cm in depth with undermining between 9 and 12 o'clock of 0.5 cm.</p> <p>A second skin Grid entry, dated 4/14/14 and signed by the same LN, documented the wound was 1.5 cm in length, 1.4 cm in width, and 1.3 cm deep with undermining at the 12 o'clock position at 1 cm.</p> <p>However, there was no documentation to explain how the same LN obtained two different sets of measurements for the wound on the same date. Additionally, the record included a note from the Wound Nurse, dated 4/14/14 at 6:45 p.m., that documented the same measurements as the second entry with the exception of depth (the Wound Nurse documented depth as 0.9 - 1.3 cm).</p>	F 314	<p>you make to ensure that the deficient practice does not recur</p> <p>Licensed Nurses have been educated by the DETD on pressure area assessment/documentation required and updates to wound progression. The DON/skin team will review documentation upon incident and weekly for accuracy and completion.</p> <p>How the corrective action ill be monitored to ensure the deficient practice does not recur</p> <p>DON/skin team will audit pressure area documentation weekly X 12 to ensure accuracy/completion to monitor wound progress for residents with pressure areas. These audits will be presented to QAPI monthly X 3 for further education and training opportunities.</p> <p>Individual to ensure compliance and date of compliance</p>		

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F 314	<p>Continued From page 38</p> <p>The Wound Nurse documented Resident #4's dressing was slightly loose, but did not address the discrepancies in measurements by the facility.</p> <p>b. A Skin Grid entry, dated 4/22/14, documented the wound was 1.5 cm in length, 1.2 cm in depth, and 1.0 cm deep with undermining at the 12 o'clock position of 0.5 cm. No change to treatment was documented.</p> <p>A Skin Grid entry, dated 4/29/14 (7 days later), documented the wound was 4 cm in length, 3 cm in width and 1.5 cm in depth with no undermining noted.</p> <p>However, the documentation did not address the significant increase in length, width and depth. Additionally, the record included a note from the Wound Nurse, dated 5/5/14 (6 days later), which documented the wound was 2.3 cm in length, 1.7 cm in width and 0.7 cm deep. The note stated the wound was stable.</p> <p>The documentation did not address the significant change in size from 4/22/14 - 4/29/14, or the change in size from 4/29/14 - 5/5/14. No other documentation related to the size changes were present.</p> <p>c. A Skin Grid entry, dated 5/5/14, documented the wound was 2.3 cm in length, 1.7 cm in width, and 0.7 cm in depth with undermining at the 12 o'clock position of 1.4 cm. The measurements matched those of the Wound Nurse on the same date.</p> <p>A Skin Grid entry, dated 5/7/14 (2 days later), documented the wound was 3.0 cm in length, 2.0 cm in width, and 2.5 cm in depth with</p>	F 314	<p>The Director of Nursing/designee will ensure compliance.</p> <p>Date of compliance <u>9-12-14</u></p>		

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F 314	<p>Continued From page 39</p> <p>undermining at the 12 o'clock position of 1 cm. The note did not include documentation related to the wound more than doubling in depth over a 2 day period.</p> <p>The next Skin Grid entry, dated 5/13/14 (6 days later), documented the wound was 3.0 cm in length, 1.5 cm in width, and 2.0 cm in depth with no undermining. Documentation from the Wound Nurse, dated 5/19/14 (6 days later), documented the wound was 2.6 cm in length, 1.6 cm in width, and 0.7 - 1.6 cm in depth with undermining at the 12 o'clock position of 1.1 cm.</p> <p>There was no additional documentation addressing the significant changes in size and/or depth of the wound, or discrepancies in measurements.</p> <p>The wound was observed during a dressing change on 8/6/14 at 10:55 a.m. The wound was deep (greater than partial thickness) with a clean red wound bed. No eschar or slough was noted and there were no signs and symptoms of infection. Measurements documented by RCM #2 stated the wound was 3.0 cm in length, 2.0 cm in width, and 1.5 cm in depth with no undermining.</p> <p>On 8/7/14 at 8:50 a.m., RCM #2 was interviewed and stated the size and depth of Resident #4's wound changed depending on how she was positioned when the wound was being measured. RCM #2 stated the facility did not have procedures in place to ensure Resident #4 was in the same position each time the wound was measured, to identify and document discrepancies in wound measurements, or related to re-measuring the wound if discrepancies were identified. When asked how</p>	F 314			

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F 314	Continued From page 40 the facility could determine the efficacy of treatment if measurements were not accurate, RCM #2 stated she did not know. On 8/7/14 at 4:57 p.m., the DON was interviewed and stated the facility nurse would document measurements made by the Wound Nurse on the Skin Grid if measurements had not already been taken. The DON stated there needed to be a consistent protocol regarding measuring Resident #4's pressure ulcer, including how she was positioned, in order to get accurate measurements of the wound.	F 314	F-315 What corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident # 8, 12, and 14 have had their toileting plans for bowel and bladder reviewed and updated.	
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 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review it was determined the facility failed to offer residents the opportunity to use the toilet before becoming incontinent. This was true for 3 of 10 residents, (#s 8, 12 and 14) sampled for toileting assistance. The deficient practice had the potential to cause more than minimal harm if the residents developed	F 315	Refer to F-353 for staffing needs How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents residing in the facility that have incontinence have the potential to be effected by this practice. Through record review residents with incontinence have had their bowel and bladder care plans and care delivery guides updated..	

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F 315	<p>Continued From page 41</p> <p>complications, such as skin breakdown or infections, from becoming incontinent of urine. Findings included:</p> <p>1. Resident #14 was admitted to the facility on 5/19/14 with a primary diagnosis of C5-C7 level with complete lesion of the spinal cord.</p> <p>The resident's admission MDS assessment, dated 6/3/14, included:</p> <ul style="list-style-type: none"> - BIMS = 8 (moderate cognitive impairment); - Range of motion limitations to both upper and lower extremities on both sides; and - Required 2+ persons physical assist for toileting tasks. <p>A Resident Incident report, dated 7/22/14, documented Resident #14 alleged he had been left in his own feces for one and a half to two hours on 7/14/14.</p> <p>On 8/7/14 at 10:50 a.m., Resident #14 was interviewed and stated he required assistance with all toileting tasks due to paralysis. Resident #14 stated he had been left in a soiled incontinence brief for a 2 hour period due to staff being engaged in other tasks and unavailable to attend to him.</p> <p>On 8/7/14 from 4:57 - 5:30 p.m., the DON was interviewed and stated Resident #14 had been left in feces for 2 hours. The DON stated incontinence checks had been increased for Resident #14 as a result of the incident.</p> <p>2. Resident #12 was admitted to the facility on 5/1/06 and readmitted on 11/24/11 with diagnoses including aphasia due to cerebrovascular disease, hypertension, and diabetes type II.</p>	F 315	<p>See F-353 for sufficient staff to meet toileting needs</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur</p> <p>Education related to toileting plans have been completed to LN's and nursing assistants by the DEDT.</p> <p>See F-353 for sufficient staff to meet toileting needs.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not recur</p> <p>Audits will be done on varying shifts by nursing management Monday through Friday X 60 and then weekly X 4 to ensure toileting needs are being met and being met timely. These audits will be presented at QAPI monthly for further education and training opportunities.</p>	

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F 315	<p>Continued From page 42</p> <p>Resident #12's quarterly MDS assessment, dated 6/6/14, documented:</p> <ul style="list-style-type: none"> - BIMS = 07 (severely impaired cognition); - Required 2+ person physical assist with toileting; - Urinary toileting programing trial had not been attempted; and - Always incontinent of urine. <p>The "Problem" section of Resident #12's Alteration in Urinary Continence Plan of Care, dated 5/28/14, documented:</p> <ul style="list-style-type: none"> - Incontinent; - Urge Incontinence; - Moderate to large amounts of urine leakage; - Turin loss on way to bathroom; and - Timing of urine loss is unpredictable. <p>The "Goal" section documented:</p> <ul style="list-style-type: none"> - Will maintain dignity despite incontinence; - Will cooperate with assisted toileting; and - Will be clean and dry with the use of incontinence products. <p>The "Interventions" section documented:</p> <ul style="list-style-type: none"> - Provide adult briefs; - Sit to stand when weak; and - Scheduled check and change upon arising, before and after meals, at bedtime, and individualized times (on odd hours was hand-written). <p>Additionally, "Prompted Voiding" was unchecked under Interventions, but 2 hand-written entries were included:</p> <ul style="list-style-type: none"> - "Offer toileting at beginning [sic] of NOC shift," and - "Resident direct staff when toileting occurs." 	F 315	<p>See F-353 also for sufficient staffing plan.</p> <p>Individual to ensure compliance and date of compliance</p> <p>The Director of Nursing/designee will ensure compliance.</p> <p>Date of compliance <u>9-12-14</u></p>	

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F 315	<p>Continued From page 43</p> <p>Resident #12's record documented a fall from bed on 7/3/14. The IDT note related to the incident, dated 7/8/14, documented, "Fall is reasonably related to resident needing to be toileted." The IDT note stated the care plan was updated to offer toileting.</p> <p>A second fall from bed occurred 7/9/14. The IDT note related to the incident, dated 7/14/14, documented, "Fall reasonable related to residents [sic] behavior and needing changed." The IDT note stated the plan of care was updated with check and changing resident at odd hours.</p> <p>On 8/7/14 at 11:20 a.m., Resident #12's was observed to be in a high-low bed that was placed against the wall. A fall mat, 6 - 8 inches thick, was placed beside the bed. RCM #2, who was present during the observation, stated Resident #12 was only toileted at the resident's request and only made requests when she needed to have a bowel movement. RCM #2 stated Resident #12 would crawl out of bed to the fall mat to indicate she needed to be changed and would sometimes remove her incontinence brief. RCM #12 stated no other toileting process was in place.</p> <p>On 8/7/14 at 6:05 p.m., the DON was interviewed and stated additional information might be available regarding Resident #12's toileting. However, no additional information was provided.</p> <p>3. Resident #8 was admitted to the facility on 12/6/13 with multiple diagnoses which included advanced dementia, anemia, chronic kidney disease, and hypertension.</p> <p>Resident #8's most recent quarterly MDS</p>	F 315			

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F 315	<p>Continued From page 44 assessment, dated 6/9/14, coded: *Moderately impaired cognitive skills; *Extensive assistance of 1 for transfers and toilet use; and *Frequently incontinent of bowel and bladder. *No trial toileting program attempted.</p> <p>Resident #8's care plan for urinary incontinence documented: *The column for "Problem" included pre-printed options for "Self Control Category." The option of, "Occasionally incontinent," was checked. The corresponding column for the date had 12/11/13 and 3/25/14 crossed out, with the date of 5/30/14 remaining. *The areas for, "Bladder and Bowel Assessment indicates resident's incontinence appears related to the following conditions: (List conditions)," and, "Bladder and Bowel Assessment indicates resident's incontinence appears related to potentially revisable causes - Transient: (List conditions)," were both blank. *A list of pre-printed options in the, "Goal" column was checked for the resident to be free from odor and skin breakdown from incontinence, will maintain dignity despite incontinence, and will be cooperative with toileting. The box next to the pre-printed goal of maintaining any level of continence, was blank. *The, "Due Date," under the interventions column documented 3/14 and 6/14 (March and June of 2014), which were both crossed out, and 8/14 (August 2014), which remained. *The boxes next to, "Complete CareTracker 3-Day Elimination Tacking to determine a voiding/incontinence pattern," and, "Complete Bladder Data Collection and Assessment," were both checked. *Other checked interventions included the</p>	F 315			

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F 315	<p>Continued From page 45</p> <p>resident would be provided with an adult brief, to be changed when soiled, and to be assisted with pericare after each incontinent episode.</p> <p>Although the resident was identified of being frequently incontinent of urine, the facility had no documentation had been assessed as to the cause, or to the type of incontinence the resident experienced. There was no documentation as to whether or not the resident's incontinence was considered to be reversible. There was no documentation a toileting plan had been developed or implemented to maintain the resident's current urinary function. There was no documentation in the resident's record as to the type and frequency of physical assistance needed for her to access the toilet. There was no documentation as to whether or not the resident may benefit from bladder re-training, prompted voiding, or pelvic floor exercises, or scheduled voiding.</p> <p>On 8/6/14, between 1:40 PM and 1:53 PM, Resident #8 was observed to be lying in bed in her room, calling out, "Please help me here. Help me. Please come and clean me up. Pretty please. I need to go bad." When LN #6 responded to the resident at 1:53 PM, she stated the resident had been incontinent and needed to be cleaned up.</p> <p>On 8/7/14 at 9:00 AM, the DNS was asked about continence management for Resident #8. The DNS was asked if the results from the resident's bowel and bladder tracking had been incorporated into her care plan. The DNS was unable to clarify, from reviewing the resident's record, any of the details mentioned in the above NOTE. After reviewing the resident's record, the DNS stated, "I don't see that in here. It would</p>	F 315	
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F 315	<p>Continued From page 46</p> <p>have been done before I started working here, but I don't see it." The DNS stated based on the resident's care plan, there was no clearly defined toileting plan for the resident to maintain or improve her current urinary status, but only that the resident's incontinence brief would be changed after the resident had already become incontinent. The DNS stated, "That's awful. I'll fix it right away."</p> <p>On 8/7/14 at 6:15 PM, the Administrator, DNS, and RDO were informed of the surveyor's findings. The facility offered no further information.</p> <p>F 323 SS=E 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure an environment as free from accident hazards as possible. This was true for any resident accessing the 300 hall including 3 of 15 sample residents (#s 8, 11, and 14). The deficient practice had the potential to cause harm if residents needed access to the handrail in the hallway for safety or mobility, or fell tripping over or trying to negotiate around obstacles stored in the hallway. Findings</p>	F 315	<p>F-323</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice</p> <p>Residents #8, 11, and 14 have had their medical records reviewed for incidents related to equipment storage and none were noted</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <p>Residents residing on this hallway had the potential to be impacted by this practice. The facility corrected the findings immediately</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur</p>	

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F 323	Continued From page 47 included: *On 8/4/14 at 9:15 AM, a four-wheeled walker and a wheelchair were observed in the hallway between resident room #s 310 and 312, blocking access to the handrail. *On 8/5/14 at 7:25 AM, the walker and wheelchair were again present between room #s 310 and 312. Additionally, there was a mechanical lift and a wheelchair between resident room #s 306 and 308, a linen cart between resident room #s 304 and 306, another mechanical lift between room 304 and the fire door, and a bath chair parked in front of the fire door. The placement of equipment at this time blocked access to any handrail located on the entirety of the even-numbered side of the hallway. *On 8/5/14 at 7:45 AM and 8:50 AM, all equipment remained as previously described, except for the bath chair. *On 8/5/14 at 12:55 PM, a resident wheelchair was observed along the handrail between resident room #s 310 and 312, and a four-wheeled walker between rooms 308 and 310. At 1:40 PM, the equipment was in the same position, with the addition of another wheelchair between rooms 306 and 308. *On 8/6/14 at 6:15 PM, a wheelchair was observed between rooms 310 and 312, a four wheeled walker between rooms 308 and 310, and a wheelchair between rooms 306 and 308. On 8/6/14 at 6:15 PM, LN #6 was asked about the equipment in the 300 hallway. LN #6 stated the four-wheeled walker and one of the wheelchairs were stored in the hallway whenever they were not in use by the residents, as the residents were in semi-private rooms which did not allow for equipment storage. LN #6 stated the	F 323	Education was provided by the DETD regarding maintaining hallways free of clutter and equipment. How the corrective action will be monitored to ensure the deficient practice does not recur Caring Partners will monitor hallways daily Monday through Friday X 30 days and then monthly X 4 to ensure hallways are free of clutter and equipment. These audits will be reviewed by the Administrator and presented to QAPI monthly X 3 for further education and training opportunities. Individual to ensure compliance and date of compliance The Administrator will ensure compliance. Date of compliance <u>9-17-14</u>	

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F 323	Continued From page 48 other wheelchair in the hallway at the time was used for a resident in a room across the hall from that wheelchair, who rarely got out of bed but had been out, "a few days ago for a blood transfusion." LN #6 stated, "Honestly, I don't know why it's still there." On 8/7/14 at 9:15 AM, the DNS was asked about the equipment in the 300 hallway. The DNS left to go look at the equipment. Approximately one-half hour later, the DNS returned to the surveyor and reported the facility had found alternate storage for all the resident equipment observed. On 8/7/14 at 6:15 PM, the Administrator, DNS, and RDO were informed of the surveyor's findings. The facility offered no further information.	F 323	F-329 What corrective action will be accomplished for those residents found to have been affected by the deficient practice Residents #1, 4, 5, 7, 8 and 9 have had their medication regime reviewed by the IDT and the Pharmacy. Recommendations were sent to the MD for review and changes. Care plans and care delivery guides have been updated as indicated.	
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	F 329	How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents receiving psychotropic medication have the potential to be effected by the practice. Residents receiving psychotropic medications have had their medication regimes reviewed by	

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F 329	<p>Continued From page 49</p> <p>drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</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: * A resident did not receive duplicate therapy for antidepressant medications without clinical justification; * A resident's antidepressant medication was increased per increased signs and symptoms of depression and not per family request; * Residents receiving antipsychotic medication and other psychotropic medications had appropriate indications for use, treated a clinical symptom, were monitored, had GDR's (gradual dose reductions), and were evaluated for possible underlying medical causes. This affected 6 of 15 (#s 1, 4, 5, 7, 8 & 9) sampled residents. This created the potential for harm to the residents as unnecessary drugs can lead to adverse reactions and health decline. Findings included:</p> <p>1. Resident #5 was admitted to the facility on 11/18/13 with multiple diagnoses which included paraplegia and chronic pain.</p> <p>The most recent quarterly MDS assessment for Resident #5, dated 5/20/14, documented he received an antidepressant medication 7 days out</p>	F 329	<p>the IDT and Pharmacy with recommendations sent to the MD and appropriate follow-up. Care plans and care delivery guides have been updated.</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur</p> <p>Education was provided by the DETD/designee to the interdisciplinary team regarding psychotropic medication use including, assessment, non-pharmacological approaches related to behaviors, GDR and required documentation for Residents receiving psychotropic medication.</p> <p>How the corrective action will be monitored to ensure deficient practice does not recur</p> <p>Facility IDT will review residents receiving psychotropic medications</p>	
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F 329	<p>Continued From page 50 of the past 7 days, was severely impaired in cognition with a BIMS of 4, had a PHQ9 severity score of 4 and did not have behaviors.</p> <p>Resident #5's Mood and Behavior Symptom Assessment/Plan of Care documented: * Assessment - At risk for depression as evidenced by: PHQ9 Severity Score of 0-4, feeling down, depressed or hopeless in February 2014 and May 2014, trouble falling asleep in November 2013 and May 2014, and feeling tired or having little energy in February 2014 and May 2014; * Interventions - Depression Treatment Plan: Monitor for increased signs and symptoms, encourage resident to express feelings and concerns, report any changes in mood to LN or SS (Social Services); Medication: Zoloft; and Side effect monitoring.</p> <p>July 2014 recapitulated Physician's Orders for Resident #5 documented, 6/9/13 "SERTRALINE HCL 25 MG [Milligrams] TABLET...GIVE 3 TABLETS (75MG) ORALLY ONCE A DAY (DEPRESSION)."</p> <p>Resident #5's Compressed Mood and Behavior Report for July and August 2014 documented 1 episode of physical abuse and 4 episodes of resistance to care. The boxes for verbal expressions of distress, sleep-cycle issues, sad, apathetic, anxious appearance, loss of interest and mood were all left blank.</p> <p>A Progress Note for Resident #5, dated 6/3/14, documented, "Dtr [Daughter]/Guardian called with concerns about res[ident] saying he was depressed [and] not sleeping. Spoke to res: denied depression, staff [illegible word] never saw</p>	F 329	<p>daily using the 24 hour report, behavior tracking report and MD orders Monday through Friday X 30 days then weekly for 8 weeks. Facility IDT will also review residents receiving psychotropic medications in conjunction with their MDS for care plan changes and monitoring effectiveness. Audits will be presented to QAPI monthly X 3 for education and training opportunities.</p> <p>Individual to ensure compliance and date of compliance</p> <p>Director of Nursing/Social Services Director will ensure compliance.</p> <p>Date of compliance <u>9-12-14</u></p>	

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F 329	<p>Continued From page 51</p> <p>him crying. Res sleeping 3x [times] I tried to see him. Denies any issues with sleeping..."</p> <p>On 6/9/14 a fax was sent to Resident #5's Physician which documented, "...When talking [with] guardian, she feels he may need an increase in his Zoloft 50 mg daily. Please advice." The Physician responded on the form, "Increase Zoloft to 75 mg PO q d [by mouth every day] dx [diagnosis] depression."</p> <p>On 8/7/14 at 10:35 a.m., Social Worker (SW) #8 was interviewed about Resident #5 and his antidepressant medication. She said the resident showed signs and symptoms of depression such as crying and statements of wanting to die, but had not seen him expressing symptoms of depression for the last few months. When asked if antidepressant medications were increased per family request, she stated, "No," and added they take the family's suggestions into consideration. When asked if signs and symptoms of depression were being monitored, she stated, "Yes" The SW continued to say the staff, "Everybody" charted mood and behavior in the care tracker system.</p> <p>Documented evidence of the resident making statements of wanting to die and crying was requested. However, the documentation provided did not provide evidence the resident was making statements of wanting to die or crying.</p> <p>On 8/7/14 at 10:45 a.m., LN #7 was interviewed about Resident #5 and his antidepressant medication. She said the last increase in the medication was due to the daughter suggesting it and the doctor agreed. The LN added increasing antidepressant medication wasn't usually done</p>	F 329		

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F 329	<p>Continued From page 52 that way.</p> <p>On 8/7/14 at 6:10 p.m., the Administrator and DON were informed of the issues with the antidepressant medication. No further information or documentation was provided.</p> <p>2. Resident #7 was admitted to the facility on 7/22/13 with multiple diagnoses which included dementia with behavioral disturbance and anxiety.</p> <p>The most recent annual MDS assessment for Resident #7, dated 7/29/14, documented severely impaired cognition with a BIMS of 3, a PHQ9 score of 5, verbally abusive towards others 1-3 days, and received an antidepressant medication 7 days out of the past 7 days.</p> <p>Resident #7's Mood and Behavior Symptom Assessment Care Plan, dated 7/21/14, documented:</p> <ul style="list-style-type: none"> * Assessment - Psychotropic drug use: Lexapro, Diagnosis: Depression, Behavioral symptoms drug is intended to treat: decreased mood; * Interventions - Monitor for side effects of repetitive physical movement, hypotension, unsteady gate and swallowing problem; Monitor for drug-related Cognitive/Behavioral impairment: Periods of altered perception or awareness of surroundings, episodes of disorganized speech and periods of lethargy, deterioration in communication, mood and behavioral symptoms; and Monitor for drug-related discomfort of constipation, fecal impaction and lung aspiration; * Assessment - Medical condition(s): Depression (Insomnia was also written in this area but had a line through it); * Interventions - Medication: Trazodone, side 	F 329		

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F 329	<p>Continued From page 53 effect monitoring.</p> <p>July 2014 recapitulated Physician's Orders for Resident #7 documented, 4/18/14 "TRAZODONE 50 MG TABLET: GIVE 1 TABLET ORALLY DAILY AT BEDTIME(BPSD) [Behavioral and psychological symptoms of dementia]," and 4/29/14, "ESCITALOPRAM 20 MG TABLET- Generic for - LEXAPRO 20 MG TABLET: GIVE 1 TABLET ORALLY ONCE A DAY (DEPRESSION)."</p> <p>Resident #7's Compressed Mood and Behavior Report for July and August 2014 documented 3 episodes of physical abuse, 2 episodes of wandering, 7 episodes of verbal abuse, 1 episode of social inappropriateness and 1 episode of resistance to care. The boxes for verbal expressions of distress, sleep-cycle issues, sad, apathetic, anxious appearance, loss of interest and mood were all left blank.</p> <p>A Consultation Report for Resident #7 from the pharmacist on 3/26/14 documented, "[Resident's name] receives two antidepressants: Trazodone 50 mg PO QHS and was recently started on Escitalopram [Zoloft] 10 mg PO once daily for depression. She currently sleeps about 6-7 hours a night. Recommendation: Please re-evaluate the need for both agents, perhaps giving consideration to discontinuing use of trazodone..." The Physician marked a box with documented, "I decline the recommendation(s) above and do not wish to implement any changes due to the reasons below. Rational: Trazodone used for sleep aid." The Physician dated it 4/4/14.</p> <p>Physician's Telephone Orders for Resident #7, dated 7/30/14, documented, "DC [discontinue]</p>	F 329			

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F 329	<p>Continued From page 54</p> <p>Trazodone 50 mg, Trazodone 25 mg [one tablet] PO QHS" for the diagnosis of, "depression."</p> <p>On 8/7/14 at 10:30 a.m., SW #8 was asked why Resident #7 was receiving 2 antidepressant medications. She stated, "Because one doesn't work." The SW said the resident was receiving Trazodone for BPSD, insomnia and anxiety.</p> <p>On 8/7/14 at 6:10 p.m., the Administrator and DON were informed of the duplicate therapy issues. No further information or documentation was provided.</p> <p>3. Resident #8 was admitted to the facility on 12/6/13 with multiple diagnoses which included advanced dementia, anemia, chronic kidney disease, and hypertension.</p> <p>Resident #8's most recent quarterly MDS assessment, dated 6/9/14, coded: *Moderately impaired cognitive skills; *Behavioral symptoms 1 to 3 days out of the past 7 days; *Extensive assistance of 1 for transfers and toilet use; and *Frequently incontinent of bowel and bladder.</p> <p>Resident #8's care plan documented, for "Mood and Behavior Symptom Assessment/Plan of Care," **"Resident frequently yells out," under the assessment column. The corresponding "Interventions" column documented, "Ask resident to please be quiet." * "Calling out, yelling for staff/not using call light," and "May smear feces on self/bedding," under</p>	F 329			

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F 329	<p>Continued From page 55</p> <p>the assessment column. The corresponding "interventions" column documented, "...offer toileting or to go lay down, frequent checks for needs."</p> <p>**"Verbally abusive [with] staff during cares; easily annoyed," and, "short-tempered [with] staff during cares," under the assessment column. The corresponding interventions column documented, "...reorient to time and place..."</p> <p>These updates were hand-written on Resident #8's care plan, but not signed or dated, so it was not possible to tell when they had been implemented. Please see F 280 as it pertains to care plan revisions.</p> <p>Resident #8's Physician's orders documented the resident received Seroquel 25 mg 1/2 tablet in the morning and 1 tablet in the evening, beginning 2/18/14 for a diagnosis of BPSD.</p> <p>On 5/57/14, Resident #8's social services progress notes documented, "Res [resident] due for review of Seroquel. Res continues to show a lot of behaviors, such as calling out, confusion, dementia, smearing feces. Interventions are difficult and [moderately] successful. Pain reviewed. Recommend trial of Depakote and review next month."</p> <p>There was no documentation as to how persistent the identified behaviors were, how confusion was identified as a target behavior, if a toileting plan had been implemented to address the availability of feces to the resident, how the behaviors presented a danger to the resident or others, which non-pharmacological interventions had been attempted and ruled out as effective, and whether or not environmental factors, such as</p>	F 329			

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F 329	<p>Continued From page 56</p> <p>noise, had been considered as a precipitating factor to the resident's behaviors.</p> <p>Resident #8's physician's orders documented: *6/23/14, Depakote 125 mg twice daily, for a diagnosis of BPSD. *7/4/14, Keflex 500 mg for 7 days, for a UTI. *7/7/14, Depakote discontinued due to increased lethargy. *7/9/14, chest x-ray ordered due to a "cough."</p> <p>On 7/9/14, a physician's progress note for Resident #8 documented, "Recently [discontinued] Depakote due to behavior change on 7/7/14. Was very animated and agitated, Tried to kick staff and kick at doorway...ST working with her now due to possible swallow dysfunction noted [with] behavior change above...She was seen by GI for consult found hemorrhoids..." There was no documentation as to whether or not discomfort from hemorrhoids had been a contributing factor in the resident's agitation, or whether or not more frequent attention to her bowel-related toileting needs would potentially reduce those behaviors.</p> <p>On 7/26/14, Resident #8's physician's orders documented Lexapro 10 mg daily started due to depression and restlessness, and a urinalysis and culture and sensitivity ordered to rule out a UTI.</p> <p>When asked for behavior tracking for Resident #8, in terms of target behaviors identified for the use of Seroquel, and the addition of Depakote and Lexapro, the facility provided a, "Behavior Symptoms Detail Report." The reports were generated by the CNA caring for the resident at the end of each shift. The CNA was presented</p>	F 329		

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F 329	<p>Continued From page 57</p> <p>with a list of pre-determined generic resident behaviors, and the CNA would document whether or not the behavior had occurred for their shift. There were no specific target behaviors related to Resident #8 and the use of psychotropic medications, and no documentation of persistence or frequency. There was no documentation as to whether specific individualized interventions had been attempted, nor the effectiveness of those interventions.</p> <p>On 8/5/14 at 1:40 PM, Resident #8 was lying in bed her room. As the surveyor approached the room, Resident #8 was heard yelling, "Please help me here. Help me. Please come and clean me up. Pretty please. I need to go so bad." The resident repeated this several times. The resident was unable to be heard by staff due to the noise levels in the hallway, and did not receive staff intervention until 1:53 PM. The resident's calling out became louder, with increased intensity and urgency, during this time.</p> <p>On 8/5/14 at 2:00 PM, LN #6 was asked about Resident #8's behaviors, and medications used. LN #6 stated Resident #8 received psychotropic medications due to her calling out. The LN was asked how she could determine the resident was calling out as a result of her dementia, versus a purposeful request for assistance. LN #6 stated, "Sometimes she just calls out, 'Mama, mama, mama, but does not tell us what she needs.'" When asked about delays in responding to the resident's requests related to the noise levels, LN #6 stated, "That's a good question. I know we go in there as soon as we hear her, but when do we hear her? I don't know."</p> <p>On 8/7/14 at 9:00 AM, the DNS was asked about</p>	F 329		

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F 329	<p>Continued From page 58</p> <p>the use of anti-psychotics for Resident #8. The DNS stated:</p> <p>*Prior to June 2014, the facility did not have a full-time social worker, and relied solely on the recommendations of the pharmacist to manage and monitor the appropriateness of psychotropic medication use.</p> <p>*Since the facility social worker started full-time in July 2014, the facility had worked on improving systems for psychotropic medication use.</p> <p>*Regarding Resident #8 specifically, the DNS stated:</p> <p>-Some of the interventions in the resident's care plan, such as re-orientation and telling her to be quiet, were not generally considered as appropriate. The DNS stated, "I will look into that and fix it right away."</p> <p>-When informed of the surveyor's observation of the resident calling out for help for toileting assistance, along with the documented target behaviors of calling out and smearing feces to justify Seroquel use for the resident, the DNS stated, "That's terrible. I understand."</p> <p>-The DNS was asked about the addition of Depakote and Lexapro while the physician was conducting testing to rule out acute respiratory and urinary disease. The DNS stated, "Usually people in a nursing homes have reason to be depressed, and they are entitled to all forms of physical and emotional support." The DNS stated she would have to investigate the timing of the new medication orders in terms of the potential development of acute illnesses.</p> <p>-Regarding the care plan for Resident #8's incontinence, in terms of her target behavior of smearing feces, the DNS stated, "That's not even specific. We don't even say we're going to take her to the toilet. We'll fix it right away."</p>	F 329			

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F 329	<p>Continued From page 59</p> <p>On 8/7/14 at 6:15 PM the Administrator, DNS, and RDO were informed of the surveyor's findings. The facility offered no further information.</p> <p>4. Resident #1 was admitted to the facility on 6/30/12. Her multiple diagnoses included dementia, osteoporosis, and history of CVA.</p> <p>Resident # 1's most recent quarterly MDS assessment, dated 7/28/14, coded: *Long- and short-term memory deficits with severely impaired decision making; *Levels of consciousness vary over time; *No physical or verbal behavioral symptoms; *No rejection of care; *Extensive assistance of one person for bed mobility, transfers, locomotion on and off the unit, and eating; and *Extensive assistance of two persons for toileting and dressing.</p> <p>Resident #1's care plan for Mood and Behavioral symptoms, initially dated November 2013 and reviewed in February 2014 and May 2014 documented: NOTE: The front of each page of this care plan was marked as, "Revised/Rewritten." However, there was no date documented as to when this occurred. The items in each column for Assessment, Goal, and Interventions were not dated, so it was impossible to discern when each item was identified or added to the care plan. *The Assessment column documented the resident had a medical condition of anxiety, with advanced dementia and chronic pain in various locations due to osteoporosis. The column also documented the resident was physically abusive with staff at times, with vocal symptoms such as</p>	F 329			

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F 329	<p>Continued From page 60</p> <p>screaming and disruptive sounds. The resident was documented as receiving Ativan for agitation. *The Goal column documented, "Will exhibit socially appropriate behaviors [as evidenced by] CareTracker." There was no documentation as to what constituted "socially appropriate" behavior.</p> <p>On 4/27/14, a physician's progress note for Resident #1 documented, "...still doing well...I do see a slow decline physically, but very stable per staff..." The note documented no medication changes would be made at that time.</p> <p>On 4/30/14, a physician's order for Resident #1 documented the resident was to begin receiving Ativan 0.25 mg twice per day.</p> <p>Resident #1 was observed in bed on her left side, sleeping, on the following occasions: 8/4/14 at 1:40 PM; 8/5/14 between 8:30 AM and 11:00 am, with observations approximately every 10-15 minutes; 8/5/14 between 1:00 and 4:00 PM, with observations every 10-15 minutes; 8/7/14 between 1:00 and 5:00 PM, with observations every 10-15 minutes.</p> <p>On 8/7/14 at 11:45 AM, the SSA was interviewed about Resident #1. The SSA stated Resident #1 had behaviors of calling out and being resistive to cares. The SSA stated these behaviors were not tracked for this resident specifically, but only through the facility's generalized CareTracker program. The SSA stated the data retrieved from this program would not give details regarding the persistence of the resident's behavior, nor if individualized interventions for Resident #1 had been attempted or effective. The SSA could not state if the resident's pain had been considered</p>	F 329			

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F 329	<p>Continued From page 61</p> <p>as a contributing factor to her identified behaviors, or how pain had been ruled out as a potential cause.</p> <p>On 8/7/14 at 6:15 PM, the Administrator, DNS, and RDO were informed of the surveyor's concerns. The facility offered no further information.</p> <p>5. Resident #9 was admitted to the facility on 9/13/12 with a primary diagnosis of lack of normal physiological development unspecified, diabetes type II, and obsessive compulsive disorder.</p> <p>The resident's annual MDS assessment, dated 9/11/13, included:</p> <ul style="list-style-type: none"> - Intellectual Disability ("mental retardation" in federal regulation); - BIMS = 00 (severely cognitively impaired); - Did not exhibit hallucinations or delusions; - Did not exhibit behavioral symptoms directed toward others; and - Did not exhibit behavioral symptoms not directed toward others. <p>Resident #9's record included a physician note, dated 6/23/14, which documented "trial of Abilify low dose. this [sic] is leading to picking that leads to infections." The resident's MAR documented Abilify 5 mg was started 6/24/14 and discontinued on 7/3/14.</p> <p>Resident #9's-nursing Progress Notes documented:</p> <ul style="list-style-type: none"> - 6/5/14 - "multiple scabs/open areas to back of neck, midback, arms due to increased picking." - 6/25/14 at 2:25 p.m. - "Alert, started abilify last 	F 329		

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F 329	<p>Continued From page 62</p> <p>eve[ning], sleeping more today, blank facial expression, not smiling per her usual."</p> <p>- 6/25/14 at 9:45 p.m. - "Alert, cooperative. Sleepy [after] taking Abilify...but now lying in bed smiling."</p> <p>- 6/26/14 at 2:50 p.m. - "Alert, pleasant, [no side effects] to start of abilily [sic], continues to self pick skin."</p> <p>- 7/3/14 untimed - "Received order to [discontinue] Abilify."</p> <p>- 7/4/14 untimed - documented there were no adverse side effects to discontinuing the Abilify and no behaviors were noted.</p> <p>No additional documentation related to picking, including frequency or duration, could be found in the record.</p> <p>On 8/7/14 at 3:33 p.m., RCM #1 was interviewed and stated Resident #9's Abilify was started due to picking behavior related to OCD, but was discontinued due to the drug causing a flat affect. Data related to Resident #9's picking behavior was requested for June and July of 2014.</p> <p>On 8/7/14 at 4:03 p.m., RCM #1 stated the only documentation related to Resident #9's picking was in the nursing Progress Notes and the facility was not tracking frequency or duration of the behavior.</p> <p>On 8/7/14 at 4:57 p.m., the DNS was interviewed and stated she would look for additional information, but stated Resident #9's Abilify should not have been started.</p>	F 329	

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F 329	<p>Continued From page 63</p> <p>No additional information was provided related to Resident #9's Ability.</p> <p>6. Resident #4 was admitted to the facility on 10/28/08 and readmitted on 5/24/11. The resident had diagnoses including dementia unspecified with behavioral disturbance.</p> <p>Resident #4's quarterly MDS assessment, dated 8/4/14, documented:</p> <ul style="list-style-type: none"> - BIMS = 04 (severely cognitively impaired); - Bed mobility required 2+ person physical assist; - Total dependence for bathing; - Required 2+ person physical assist for locomotion; - Impaired range of motion to both lower extremities; and - Physical behavioral symptoms exhibited 1 - 3 days. <p>Resident #4's 7/1/14 Recap Physician's Orders documented an order for Zyprexa, dated 5/16/13, 2.5 mg twice daily for Behavioral and Psychological Symptoms of Dementia (BPSD).</p> <p>An IDT note, dated 6/7/13, documented "Res currently taking Zyprexa for Dem[entia] illness w/behavior. Mood [and] behaviors were reviewed...Res is at baseline for mood/behaviors. Continues to resist care at times but is manageable."</p> <p>IDT notes documented:</p> <ul style="list-style-type: none"> - 9/6/13 - "Res[ident] is due for review of Zyprexa. Behaviors, mood [and] interventions were reviewed. She continues to display some behaviors however is at baseline [and] behaviors 	F 329		

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F 329	<p>Continued From page 64 manageable at this time."</p> <p>- 1/22/14 - "Res due for review of Zyprexa. Mood, behaviors, pain [and] interventions were reviewed. Res continues to exhibit behaviors but is mostly managed at this time. Res is at baseline for mood [and] behaviors. Recommend do not taper."</p> <p>- 4/21/14 - "Res due for review of Zyprexa. Mood [and] behaviors were reviewed. Res continues to display physical/verbal abuse to staff. Res is at baseline mood/behavior [and] at lowest possible dose."</p> <p>A Progress Note, dated 7/20/14, documented "I Will [not decrease] Zyprexa due to Verbal [and] Phys[ical] Abuse w/staff. She cannot do a dose reduction."</p> <p>However, Resident #4's behavioral tracking data for 5/8/14 - 8/5/14 was reviewed and documented:</p> <p>Refused care: - 2 out of 68 times in May; - 1 out of 89 times in June; - 1 out of 92 times in July; and - 2 out of 15 times in August.</p> <p>Physically abusive towards staff during cares: - 5 out of 59 times in May; - 3 out of 88 times in June; - 1 out of 92 times in July; and - 1 out of 14 times in August.</p> <p>Easily annoyed or short tempered with staff (included swearing and yelling at staff and shouting to get her meal in the dinning room):</p>	F 329			

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F 329	Continued From page 65 - 13 out of 68 times in May; - 11 out of 90 times in June; - 6 out of 92 times in July; and - 1 out of 16 times in August. Resident #4's most frequent exhibited behavior was being easily annoyed or short tempered with staff. It was not clear how the severity of the behavior justified continued use of the drug without reduction attempts. On 8/7/14 at 8:50 a.m., RCM #2 was interviewed and stated Resident #4's Zyprexa was for BPSD exhibited by yelling and cursing at staff, and sometimes trying to scratch or hit staff. When asked about drug reductions, RCM #2 stated that was a question for Social Services. On 8/7/14 at 9:50 a.m., the Social Worker was interviewed and stated reduction of Resident #4's Zyprexa had been attempted over a year ago and the resident became anxious and agitated and lost focus on eating. The Social Worker stated the resident's behaviors were directed at staff and not other residents.	F 329	F-353 C-111 What corrective action will be accomplished for those residents found to have been affected by the deficient practice Residents #1, 2, 3, 4, 5, 7, 8, 9, 10, 13, 14 and 15 were assessed related to identified issues, care plan/care delivery guides were reviewed and changes were made as indicated. Resident #6 no longer resides in the center How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents residing in the facility have the potential to be effected by this practice. Caring Partners interviewed residents related to staffing level concerns. Concern forms were generated for those		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing	F 353			

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F 353	<p>Continued From page 66</p> <p>care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident group interview, individual and family interviews, staff interviews, record review, and reports from other resident advocacy groups, it was determined the facility failed to ensure adequate staffing to meet the residents' needs. This was true for 14 of 15 sampled residents (Resident #s 1-10 and 12-15), and 9 of 9 residents in attendance at the resident group. The deficient practice had the potential to cause harm when residents were not provided care and treatment per physician's orders; did not have enough assistance at meals, for toileting, or bathing; and received psychotropic medications for calling out for assistance without first assuring assistance was actually available. Findings included:</p> <p>1. Resident Group.</p> <p>On 8/5/14 at 10:00 AM, during the resident group interview, the nine residents present unanimously reported concerns with staff availability. Specifically: *The residents reported the facility was frequently</p>	F 353	<p>residents identified. The Concern reporting process was followed for satisfaction</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur</p> <p>Facility leadership evaluated staffing patterns, break times and resident acuity and implemented needed changes related to staffing. The DETD provided education on meeting resident needs.</p> <p>Se POC for 311</p> <p>See POC for 368</p> <p>As they pertain to bathing and HS snacks</p> <p>How the corrective action will be monitored to ensure the deficient practice does not recur</p> <p>Caring Partners will conduct questionnaires weekly X 12 with</p>		

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F 353	<p>Continued From page 67</p> <p>"short staffed," particularly from the end of the evening meal until most of the residents had gone to bed.</p> <p>*There had been an ongoing concern in the facility regarding the frequency with which showers were offered, which the resident group felt was related to lack of available staff.</p> <p>*Only diabetic residents were offered a snack at bedtime. Otherwise, snacks were available, but residents had to request them.</p> <p>Please see F 311 as it pertains to assistance with bathing, and F 368 as it pertains to bedtime snacks.</p> <p>2. Family Interviews.</p> <p>An undisclosed number of resident family members, interviewed between 8/4/14 and 8/7/14, who wished to remain anonymous, reported:</p> <p>*The staff present in the facility worked hard, but there were not enough of them to meet residents' needs.</p> <p>*Call light response times were slow during meals, particularly the evening meal.</p> <p>*On some units, only one staff member was stationed on the hall during the evening meal. That person's responsibilities included passing meal trays to residents who wished to dine in their rooms, assisting residents to eat who required assistance, and answering call lights. As a result, either call lights did not get answered or residents did not receive assistance to eat.</p> <p>*Resident family members had attempted to help their loved ones identify needs in advance so as to not further burden the staff. One example was a family member who asked for ice for their loved one's beverage an hour and a half before the</p>	F 353	<p>residents related to their personal satisfaction with care and any staffing level concerns. IDT will conduct call light audits daily on varying shifts for 30 days then weekly X 8 weeks to residents needs are met in a timely manner.</p> <p>Findings of both the Caring Partners and call light audits will be reviewed daily Monday through Friday at the daily management meeting. Negative findings will be corrected immediately. Audits will be presented at QAPI monthly X 3 for further intervention needs related to staffing</p> <p>Individual to ensure compliance and date of compliance</p> <p>Administrator will ensure compliance</p> <p>Date of compliance <u>9-12-14</u></p>	

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F 353	<p>Continued From page 68</p> <p>beverage was to be consumed, to avoid disrupting staff at a busy time.</p> <p>*On a recent evening during the dinner meal, a resident was overheard calling for help for over 45 minutes, but the staff assigned to care for that resident was feeding a different resident and was unable to respond.</p> <p>3. The Ombudsman.</p> <p>On 8/6/14 at 2:10 PM, the Ombudsman's office reported multiple visits to the facility since the last survey, with ongoing resident concerns regarding call light response times, frequency of bathing, and assistance for toileting. The Ombudsman's office reported the facility generally seemed to not have enough help for the residents' needs.</p> <p>4. Resident Interviews.</p> <p>Resident #10 reported she spilled coffee on herself, sustained a burn, and had to wait over an hour for assistance on 8/1/14. The resident ultimately administered first aid on herself by accessing her ice water pitcher and a washcloth. Please see F 309 as it pertains to the facility's response to Resident #10's burn.</p> <p>Resident # 14 had reported to the facility an instance where he was left in a soiled incontinence brief for an extended period of time, on the evening of 7/14/14. When interviewed by the survey team, the resident reported the facility had investigated his concern as an allegation of neglect. The resident emphasized to the survey team his concern was not that the staff had ignored him, but he felt there were consistently too few staff to provide cares to all of the residents, including himself. Please see F 315 as</p>	F 353			

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F 353	<p>Continued From page 69 it pertains to incontinence management.</p> <p>5. Surveyor Observations and Record Review:</p> <p>a. Resident #6 had bilateral heel wounds with wounds for twice daily dressing changes, beginning 6/2/14. There were multiple occasions for June, July, and August 2014 where the dressings were not changed as ordered.</p> <p>b. Resident #10 was scheduled to have a 24 hour urine test on 8/3/14 which was delayed after the staff failed to collect her urine sample and the resident dumped it out. As of 8/7/14, the test had not yet been completed.</p> <p>c. Resident #10 failed to have her blood glucose checked and insulin administered as ordered on the morning of 8/5/14.</p> <p>d. On 8/6/14, Resident #9 left the dining room before her meal was served. Staff did not notice this, and the resident returned to her room. Once in her room, the resident was assisted to bed without being set up or offered her meal.</p> <p>Please see F 309 as it pertains to the details of the above identified concerns.</p> <p>e. On 8/5/14, Resident #8 was observed to call out for approximately 13 minutes for assistance to use the toilet, before staff responded. Please see F 315 as it pertains to incontinence management.</p> <p>g. Resident #8 received an anti-psychotic medication for target behaviors of calling out and smearing her feces. The resident was documented to have hemorrhoids and was</p>	F 353			

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F 353	<p>Continued From page 70</p> <p>documented, to be frequently incontinent of bowel, with no toileting plan in place. Please see F 329 for details.</p> <p>h. On 8/6/14 at 6:32 p.m., Resident #25's dinner tray was set up on her bedside table which was next to her bed and had not yet been completed. The resident was asked if she needed assistance to finish her meal and she stated, "She'll be right back."</p> <p>On 8/6/14 at 6:33 p.m., CNA #13 was asked if she was helping Resident #25 with the dinner meal and she said yes. When asked if she was the only staff on the 100 hall, she stated, "Yes," and said she would poke her head out of the resident's room to see if any call lights were on. The CNA added she had to multitask because the other CNA scheduled on the 100 hall was in the restorative dining room. CNA #13 went into Resident #25's room and continued to assist with the meal.</p> <p>On 8/6/14 at 7:19 p.m., while the surveyor stood near room 204 at the front end of the 200 hall, Resident #7 was heard yelling from the back end of the hallway, "Help, help." CNA #11 and CNA #12 were observed standing at a computer and did not respond to the resident. The CNA's each entered a resident's room and closed the doors. While the surveyor stood at the nurse's station on the corner of the 300 and 200 hall, Resident #7 was again heard calling out, "Help, help, help." There were no staff observed in the 300 and 200 hallways. The resident continued to yell, "Help, help, help, help." The resident was observed to be in the Oasis room near rooms 215 and 217, and had self-propelled herself half-way out of the Oasis room and continued to call out, "Please,</p>	F 353		

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F 353	Continued From page 71 help me. Somebody please help me. Help, help, help me. Somebody help, help." Again there were no staff observed to be in the 300 and 200 hallways. Resident #7 continued to call out for help until 7:25 p.m. at which time the Administrator was observed walking towards the resident from the front end of the 200 hall and stated to the resident, "I heard your voice, let's get you fixed up." On 8/7/14 at 8:45 AM, the DNS was asked about overall staffing in the facility. The DNS stated she had been trying to hire additional staff to be available to cover unanticipated staffing shortages, but had encountered some barriers in implementing that plan. The DNS reported her long-term goal was to "hire ahead" to ensure fully trained staff were available to cover call-ins, vacations, and unexpected staff turnover. The DNS stated, "It's gotten better in the last month. We have looked at assignments and reasons for disruption in any type of care, from call lights to RNA to showers, but we still have a ways to go and we know that." On 8/7/14 the Administrator, DNS, and RDO were informed of the surveyor's concerns. However, the facility offered no further information.	F 353	F-368 What corrective action will be accomplished for those residents found to have been affected by the deficient practice No individual residents were identified How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents residing in the facility have the potential to be effected by this. The facility Administrator provided education to Resident Council on the accessibility of snacks and the snack pass time at HS. HS snacks are being offered/passed and documented by staff. What measures will be put in place or what systemic change will		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a	F 368			

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F 368	<p>Continued From page 72</p> <p>substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident group interview and staff interview, it was determined the facility did not offer a bedtime snack to all residents. This was true for 7 of 9 residents in the resident group, and had the potential to impact any resident in the facility who was not diabetic. The deficient practice had the potential to cause harm if residents experienced hunger between dinner and breakfast.</p> <p>On 8/5/14 at 10:00 AM, the surveyors asked the resident group if snacks were offered at bedtime. The residents in the group reported snacks were available at bedtime to any resident who requested one, but were offered only to the diabetic residents.</p> <p>On 8/7/14 at 9:00 AM, the DNS was asked about the facility's practice for offering bedtime snacks. The DNS stated snacks were always available, but could not state for sure if the snacks were offered to each resident at bedtime, or if the residents had to request one. The DNS was asked to provide documentation that residents</p>	F 368	<p>you make to ensure that the deficient practice does not recur</p> <p>Education was provided by the DETD to the facility staff related to the passing of HS snacks and documentation of HS snacks through Care Tracker.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not occur</p> <p>Caring Partners will interview residents daily Monday-Friday for 30 days and then weekly X 8 weeks to ensure snacks were passed and/or offered. Care Tracker reports will be reviewed daily Monday through Friday X 30 days then weekly X 4 weeks to validate documentation of HS snacks. These interviews and audits will be presented to QAPI monthly X 3 for identification of further education and training opportunities.</p>	

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F 368	Continued From page 73 were offered a bedtime snack; however, no documentation was provided. On 8/7/14 at 6:15 PM, the Administrator, DNS, and RDO were informed of the surveyor's concerns. The facility offered no further information.	F 368	Individual to ensure compliance and date of compliance The Director of Nursing/designee will ensure compliance Date of compliance <u>9-12-14</u>		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431	F-431 What corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #21 has had the " Boston butt cream" discontinued Resident #22 has had the triamcinolone ointment has been discarded and replaced as needed Resident # 10 is receiving her levothyroxine as per MD order How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken		

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F 431	<p>Continued From page 74</p> <p>package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and policy review, it was determined the facility failed to ensure expired medications for 2 random residents (#s 21 and 22) were not available for use and accessory instructions for medications were included in physician orders and medication administration records and on prescription labels for 1 of 3 residents (#10) during medication pass observations. These failures created the potential for diminished efficacy of expired ointments and medication being administered at the wrong time. Findings included:</p> <p>1. On 8/7/14 at 11:25 a.m., during inspection of the Main Nurses' Station Medication room with LN #5 in attendance, the following medications were observed to be expired: * A jar of Boston Butt Cream prescribed for Resident #21 expired 6/6/13; and, * A tube of Triamcinolone 0.1% ointment for Resident #22 expired "2013/10/10."</p> <p>LN #5 said she would dispose of the outdated medications. When asked what was in Boston Butt Cream, the LN said she would call the pharmacy to request the formula.</p> <p>In the afternoon on 8/7/14, LN #5 provided the Boston Butt Cream formula, which documented: * Lidocaine 2% jelly-30 milliliters;</p>	F 431	<p>Residents residing in the facility have the potential to be effected by this practice. Medication room and medication carts have been audited and any outdated medications have been discarded. Residents receiving levothyroxine have had their records reviewed and are receiving the medication as per MD order. Residents receiving Levothyroxine have had their bubble packs reviewed and now include the accessory information as indicated by the pharmacy.</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur</p> <p>Licensed Nurses and Central Supply staff have been educated by the DETD regarding expired medication use. Licensed Nurses have been educated on the use of levothyroxine per the '<u>Nursing 2014 Drug Handbook</u>'.</p>	

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F 431	<p>Continued From page 75</p> <p>* Nystatin cream-30 grams; and, * Vitamin A & D oint[ment]-30 grams.</p> <p>2. The Nursing 2014 Drug Handbook for levothyroxine sodium documented, "ADMINISTRATION P.O....Give drug at same time each day on an empty stomach, preferably 1/2 to 1 hour before breakfast."</p> <p>Resident #10's July 2014 recapitulated Physician's Orders documented, "MEDICATION: Levothyroxine 50 mcg [micrograms] PO Q AM [by mouth every morning], DX [diagnosis] hypothyroidism."</p> <p>On 8/7/14 at 9:05 a.m., a medication pass with LN #9 was observed by the surveyor for Resident #10. The LN poured multiple medications which included levothyroxine 50 mcg; The LN entered the resident's room and administered the medications to Resident #10.</p> <p>Resident #10's MAR documented, "LEVOTHYROXINE 50 MCG TABLET...GIVE 1 TABLET ORALLY EVERY MORNING," and included the frequency of, "AM."</p> <p>The bubble pack label for Resident #10's medication included, "LEVOTHYROXINE 50 MCG TABLET, GIVE 1 TABLET ORALLY EVERY MORNING...TAKE WITH PLENTY OF WATER."</p> <p>The Physician's Orders, MAR and bubble pack label did not contain accessory information related to when the medication should be administered.</p> <p>On 8/7/14 at 3:00 p.m., the DON was interviewed about the Resident #10's medication label. She</p>	F 431	<p>How the corrective action will be monitored to ensure the deficient practice does not recur</p> <p>Audits of the medication room and medication carts will be done weekly X 12 to ensure there are not expired medications available for resident use. Residents receiving levothyroxine will be audited daily X 14 to ensure accessory information is followed through on and then weekly X 8. These audits will be reviewed by the Director of Nursing for compliance and then to QAPI monthly X 3 for further education and training opportunities.</p> <p>Individual to ensure compliance and date of compliance</p> <p>Director of Nursing will ensure compliance.</p> <p>Date of compliance <u>9-12-14</u></p>	

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F 431	Continued From page 76 stated levothyroxine should be given before meals. The DON was informed of the medication label which did not contain accessory information and immediately contacted the pharmacy to resolve the issue.	F 431	F-441		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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. (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.	F 441	What corrective action will be accomplished for those residents found to have been affected by the deficient practice Residents #4, 23 and 24 have been assessed for negative outcomes and none were noted. How you will identify other residents having the potential to be affected by the same deficient practice Residents residing at the facility have the potential to be effected by this practice. <ul style="list-style-type: none"> Residents with catheters have the proper hanging/coverings. Residents requiring dressing changes by licensed nurse have infection control standards for hand washing in place. 		

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F 441	<p>Continued From page 77</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: Based on observation, staff interviews, and record review, it was determined the facility failed to ensure staff adhered to standard infection control practices for 1 of 15 sample residents (#4), 2 of 6 random residents (#s 23, and 24), and a test tube in a Specimen Collection for Rapid Influenza A&B bag. These failures created the potential for the development and/or spread of infection when hand hygiene was not performed after wound care; a resident's urinary drainage bag was in contact with the floor; a test tube in a Specimen Collection bag was expired; and, when a sign to indicate isolation was not in place. Findings included:</p> <p>1. During the initial tour of the facility on 8/4/14 at 8:50 a.m., Resident # 23's urinary drainage bag was observed half in and half out of a privacy bag. Both the privacy bag and the exposed part of the urinary drainage were in contact with the floor by the resident's bed.</p> <p>At 8:53 a.m., LN #3 accompanied the surveyor to the resident's room. When asked about the urinary drainage bag and privacy bag on the floor, the LN stated, "It shouldn't be there." The LN picked up the bags, placed the urinary drainage bag all the way in the privacy bag, then suspended them on the bed frame.</p>	F 441	<ul style="list-style-type: none"> Residents requiring isolation have the correct signage in place. <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur</p> <p>Staff has been educated on infection control standard of care for hand-washing, isolation, and the use of catheter dignity bags by the DETD.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not recur</p> <p>Infection control audits for the use of catheter dignity bags, isolation precaution signage and hand-washing during dressing changes by LN's will be done daily Monday through Friday X 30 days then weekly X 8 for compliance. Any negative findings will be corrected immediately. Audits will be</p>	

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F 441	<p>Continued From page 78</p> <p>2. On 8/6/14 at 10:55 a.m., LN #2 was observed as she provided wound care to Resident #4's stage IV sacral pressure ulcer (PU) with LN #6's assistance. As LN #2 removed the old dressing and packing, she said she planned to measure the PU. LN #2 then cleansed the PU and began to apply new packing into the PU. When asked how she would measure the depth of the PU with the packing in place, LN #2 removed the packing and obtained the measurements. At that point, LN #2 said she needed more supplies, removed her gloves, and without any type of hand hygiene, the LN left the resident's room. LN #2 returned moments later with more supplies, washed her hands, applied new gloves and completed the wound care.</p> <p>At 11:15 a.m., LN #2 was informed of the observation and asked about the lack of hand hygiene during the wound care. The LN smiled slightly and indicated "yes" with a nod of her head.</p> <p>3. On 8/7/14 at 9:45 a.m., during inspection of the 600 Hall Medication room with LN #1 present, a green top test tube in a Specimen Collection for Rapid Influenza A&B bag was observed expired as of 11/13/13. LN #1 confirmed the expiration date on the test tube and stated, "I'll get rid of this one and get another one."</p> <p>4. During the initial tour of the facility on 8/4/14 at 8:55 AM, Resident #24's room was observed to have a isolation cart outside the door, but the signage to indicate isolation was not in place.</p> <p>At 9:30 AM, LN #1 was interviewed regarding the isolation cart and the lack of a sign to indicate for visitors and/or staff to check with the front nursing</p>	F 441	<p>presented at QAPI monthly X 3 with Infection Control report for education/training purpose.</p> <p>Individual to ensure compliance and date of compliance</p> <p>The Director/designee will ensure compliance</p> <p>Date of compliance <u>9-12-14</u></p>		

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F 441	<p>Continued From page 79</p> <p>desk before entering. LN #1 stated, "Yes, she's in isolation for MRSA [methycillin resistant staphylococcus aerous] in the nares. There should be a sign on the door to indicate that everyone must check in with the front desk."</p> <p>Resident #24's Actual/Potential for Infection Plan of Care, dated 4/2/14, included: *Monitor for signs/symptoms of infection. *Isolation as needed 7/31/14.</p> <p>The resident's Physician's Telephone Orders dated 7/31/14 documented the following: *MRSA precautions times 14 days and no roommate times 14 days.</p> <p>Resident #24's wound culture report dated 7/30/14 documented the following: "...Culture, wound, deep 1+ Staphylococcus Aureus MRSA...Critical value called...date 7-31...Source Nasal Sinus..."</p> <p>Federal Guidelines for F 441 state: "...It is essential both to communicate transmission-based precautions to all health care personnel, and for personnel to comply with requirements. Pertinent signage (ie., isolation precautions) and verbal reporting between staff can enhance compliance with transmission-based precautions to help minimize the transmission of infections within the facility...Communication (e.g., verbal reports, signage) regarding the particular type of precaution to be utilized is important..."</p> <p>On 8/7/14 at 6:15 PM, the Administrator, DNS, and RDO were informed of the issues. The facility provided no additional information to resolve the issues.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814
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(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
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F 514 SS=E	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional 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 staff interview and record review, it was determined the facility failed to maintain clinical records for each resident in accordance with accepted professional standards and practices to ensure the records were complete and accurate. This was true for 4 of 15 (#s 4, 10, 14 and 15) sampled residents. This deficient practice created the potential for medical decisions to be based on incomplete or inaccurate information which increased the risk for complications due to inappropriate care or interventions. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 10/28/08 and readmitted on 5/24/11. The resident had diagnoses that included dementia unspecified with behavioral problems and had a stage IV sacral pressure wound.</p> <p>Resident #4's MARs and TARs from 6/1/14 -</p>	F 514	<p>F-514</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice</p> <p>Resident #4 had MAR/TAR (medication and treatment administration record) reviewed for the month of June to August. Notification to the MD was made for missed items. Resident was assessed for negative outcomes and none were found.</p> <p>Resident #10 has had her MAR/TAR reviewed for the month of August, notification to MD of missed items was made. Resident was assessed for negative outcomes and none were found.</p> <p>Resident #14- 15 minute checks have been discontinued and issue is resolved</p>	
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F 514	<p>Continued From page 81</p> <p>8/6/14 were reviewed. The MAR and TAR did not contain complete documentation. Examples included, but were not limited to, the following:</p> <p>a. A 7/1/14 Recap Physician's Order documented an order, dated 10/15/12, for Resident #4 to wear a splint to her left hand for 3 hours at a time 2 times daily. Staff were to document refusals on the back of the TAR.</p> <p>Resident #4's TAR lacked complete documentation including the staff initials and/or number of hours the splint was worn 1 time in July and 3 times in August on the AM shift; and 10 times in June, 3 times in July, and 5 times in June on the PM shift.</p> <p>Additionally, staff had documented "Ref" (Refused) on the front of the TAR for the AM shift on 6/9/14 and 7/2/14; and on the PM shift 6/9/14 and 6/27/14. However, there was no documentation on the back of the TAR.</p> <p>b. A 7/1/14 Recap Physician's Order documented an order, dated 10/15/12, for Resident #4's catheter to be checked for patency every shift.</p> <p>Resident #4's TAR did not document the checks were completed 1 time in June on the AM shift; 2 times in June and 1 time in July on the PM shift; and 1 time in June and 5 times in July on the NOC shift.</p> <p>c. A 7/1/14 Recap Physician's Order documented an order, dated 12/23/11, for Resident #4's O2 saturations to be checked every shift and as needed.</p> <p>Resident #4's TAR did not document the checks</p>	F 514	<p>Resident #15 has had a bladder assessment completed. Residents care plan and care delivery guide have been updated.</p> <p>How will you identify other residents having the potential to be affected by the dame deficient practice and what corrective action will be taken</p> <p>Residents residing in the facility have the potential to be effected by this practice. Medication and treatment records were reviewed for the last 14 days and MD has been notified of missed items causing a negative outcome.</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur</p> <p>Licensed Nurses have been educated by the DETD/designee regarding the clinical record containing sufficient information</p>	

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

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F 514	<p>Continued From page 82 were completed 2 times in June and 2 times in July on the PM shift.</p> <p>d. Resident #4's MAR did not document the following medications had been given: - Lantus 14 units on the AM shift 6/25/14; - Senna Plus, 2 tablets on the AM shift 6/25/14; - Methadone HCL 5 mg on the AM shift 6/25/14; - Mirtazapine 15 mg at bedtime on 7/2/14; - Olanzapine 2.4 mg on the PM shift 7/29/14; and - Methadone HCL 5 mg on the PM shift 8/5/14.</p> <p>Additionally, the back of the MAR did not include documentation related to medication refusals, availability, etc. It was not clear from the documentation if the medications had been given or not.</p> <p>On 8/7/14 from 8:50 - 9:40 a.m., RCM #2 was interviewed and stated she believed Medical Records staff were the ones responsible for monitoring records for completion and accuracy, but stated she tries to review them the month after they are completed.</p> <p>On 8/7/14 from 4:57 - 5:30 p.m., the DON was interviewed and stated monthly reviews of the MAR and TAR were not sufficient and the RCMs should be reviewing them more frequently.</p> <p>2. Resident #14 was admitted to the facility on 5/19/14 with a primary diagnosis of C5-C7 level with complete lesion of the spinal cord.</p> <p>The resident's admission MDS assessment, dated 6/3/14, included: - BIMS = 8 (moderate cognitive impairment); - Range of motion limitations to both upper and lower extremities on both sides; and</p>	F 514	<p>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>How the corrective action will be monitored to ensure the deficient practice does not recur</p> <p>The clinical leadership and medical records department will conduct audits Monday through Friday daily X 30 then weekly X 4 weeks on the medication and treatment records for accuracy and completeness.</p> <p>Individual to insure compliance and date of compliance</p> <p>The Director of Nursing will ensure compliance.</p> <p>Date of compliance <u>9-12-14</u></p>	

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F 514	<p>Continued From page 83</p> <p>- Required 2+ persons physical assist for toileting tasks.</p> <p>A Resident Incident report, dated 7/22/14, documented Resident #14 had alleged he had been left in his own feces for one and a half to two hours on 7/14/14. Interventions implemented for Resident #14 as a result of the incident included 15 minute checks for incontinent care.</p> <p>Documentation for Resident #14's 15 minute checks was requested and reviewed. The documentation was not consistent or complete, as follows:</p> <p>a. The facility provided documentation from 7/15/14 - 7/20/14 and 7/24/14 - 7/29/14. No documentation was provided from 7/21/14 - 7/23/14, or from 7/30/14 forward.</p> <p>b. The forms from 7/15/14 - 7/20/14 were all marked as 15 minute checks. The forms were broken into 15 minute time blocks with space to document information related to the residents activity, location, and staff initials over a 24 hour period. The documentation was not completed for the following time blocks:</p> <ul style="list-style-type: none"> - 7/15/14 from 5:15 - 11:45 p.m.; - 7/16/14 from 1:00 - 1:45 p.m.; - 7/17/14 from 6:00 a.m. - 1:45 p.m.; - 7/18/14 from 2:15 a.m. - 9:45 p.m.; - 7/19/14 from 8:15 a.m. - 9:45 p.m.; and - 7/20/14 from 2:15 - 11:45 p.m. <p>Additionally, multiple sections of the forms were lined through. For example, on 7/15/14 staff had documented a "Q" on the form for "Quiet," then "Bed" and their initials at 4:00 p.m. A line was then drawn down each column from 4:15 - 10:00</p>	F 514	<p>"A" FORM 8-8-14</p> <p>F-281</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice</p> <p>There were no residents identified to be affected</p> <p>How you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <p>LN #4 and LN #1 were educated on the destruction of fentanyl patches per the standard of practice on fentanyl destruction. Residents using fentanyl patches have been reviewed and have the regulatory components of 483.20(K0(i) met.</p>	

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F 514	<p>Continued From page 84</p> <p>p.m. It was not clear if this form of documentation was to indicate the staff had actually checked Resident #14 at each 15 minute increment as required or not.</p> <p>c. The forms from 7/27/14 - 7/29/14 were all marked as hourly checks. The 7/24/14 form had a hand-written note which documented "While in Bed." None of the other sheets were marked as while in bed only. The documentation was not completed for the following time blocks: - 7/24/14 from 12:00 a.m. - 1:00 p.m.; - 7/25/14 from 6:00 a.m. - 9:00 p.m.; - 7/26/14 from 7:00 a.m. - 1:00 p.m.; - 7/27/14 from 7:00 a.m. - 9:00 p.m.; - 7/28/14 from 7:00 a.m. - 9:00 p.m.; and - 7/29/14 from 6:00 a.m. - 9:00 p.m.</p> <p>Additionally, Resident #14's Fall/Injury Assessment: Prevention and Management Care Plan, dated 5/20/14, included an undated and unsigned hand-written note which documented, "1 [hour checks] for Incont[inence]." No other information was present on the care plan related to frequency of incontinence checks.</p> <p>On 8/7/14 from 4:57 - 5:30 p.m., the DON was interviewed and stated she had initiated the 15 minute checks as a result of Resident #14 being left in feces for 2 hours. The DON stated she changed the checks to hourly, but did not have an explanation for the missing documentation or the use of a line as part of the documentation. The DON stated the charge nurses should be checking and monitoring the documentation each shift.</p> <p>3. Resident #10 was admitted to the facility on 7/31/14. The resident had diagnoses which included muscle weakness, atrial fibrillation, end</p>	F 514	<p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur</p> <p>Licensed Nurses were educated by the DETD related to the professional standard 483.20(K)(i).</p> <p>How the corrective action will be monitored to ensure the deficient practice does not recur</p> <p>The destruction of fentanyl patches will be audited weekly X 4 and then monthly X 2 for compliance and to meet the standard of practice</p> <p>Individual to ensure compliance and date of correction</p> <p>The Director of Nursing will ensure compliance</p> <p>Date of compliance <u>9-12-14</u></p>	

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F 514	<p>Continued From page 85</p> <p>stage renal disease with peritoneal dialysis (ESRD), anemia, hypertension, hypothyroidism, coronary artery disease, and diabetes.</p> <p>Review of the resident's clinical record revealed undated documents and multiple documents with erroneous dates. Resident #10's MARs and TARs were located in the current August books. The following MARs and TARs reflected medications and treatments administered on August 1st through August 6th 2014, but not dated as being for the month of August.</p> <p>*3 pages of MARs dated "July 2014" but medications documented as administered on days of 1-6.</p> <p>*3 pages of MARs dated "3/1/14" with insulin administered on days 1-5 and 1 entry on day 2 of a low blood sugar intervention.</p> <p>*1 page of a MAR dated "2/1/13" with medication documented as administered on days 1-5 and pain assessed on days 1-5.</p> <p>*1 page of a MAR with no month or year.</p> <p>*1 page of a TAR dated "3/1/14" with treatments documented on days 2-6.</p> <p>*1 page of a TAR dated "5/1/14" with oxygen saturation documented on days 1-6.</p> <p>*3 pages of TARs with no month or year.</p> <p>On 8/7/14 at 6:15 PM, the Administrator, DNS, and RDO were informed of the issues. The facility has provided no additional information to resolve the issues.</p> <p>4. Resident #15 was admitted to the facility on 11/9/07 and readmitted on 3/5/12 with multiple diagnoses which included neuroleptic malignant syndrome and cerebrovascular disease.</p>	F 514			

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F 514	<p>Continued From page 86</p> <p>Resident #15's Alteration in Urinary Continence Plan of Care, dated 5/14/14, documented in the Problem area, "Bladder and Bowel Assessment indicates resident's incontinence appears related to the following conditions:... Chronic urinary incont[inence]." The Interventions area documented, "Complete Bladder Data Collection and Assessment...Provide adult: Briefs...Provide/assist with pericare after each incontinent episode..."</p> <p>The Bladder Date Collection and Assessment for Resident #15, dated 5/14/14, documented, "In the past seven days: Resident has been incontinent of urine..." The box for, "NO" was marked.</p> <p>On 8/7/14 at 2:35 p.m., LN and Resident Care Manager #2 was interviewed about Resident #15. The RCM said the resident was incontinent, "By her choice. Will use [the] call light to be changed," and added the resident is also offered to be toileted. The RCM was referred to the Bladder Data Collection Assessment which documented the resident was not incontinent and asked if it was accurate. The RCM said it was inaccurate and added the resident was incontinent. No further information or documentation was provided.</p>	F 514			

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NAME OF PROVIDER OR SUPPLIER
LACROSSE HEALTH & REHABILITATION CENT

STREET ADDRESS, CITY, STATE, ZIP CODE
210 WEST LACROSSE AVENUE
COEUR D'ALENE, ID 83814

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C 000	16.03.02 INITIAL COMMENTS 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. The following deficiencies were conducted during the State licensure and complaint survey of your facility. The survey team entered the facility on August 4 and exited on August 8, 2014. The surveyors were: Nina Sanderson LSW BSW, Team Coordinator Linda Kelly RN Lauren Hoard RN BSN Michael Case LSW BSW QIDP Linda Hukill-Neil RN	C 000	<i>"This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not a submission of our agreement of the deficiencies or conclusions contained in the Departments inspection report."</i> RECEIVED SEP 08 2014 FACILITY STANDARDS	
C 111	02.100,02,f Provide for Sufficient/Qualified Staff f. The administrator shall be responsible for providing sufficient and qualified staff to carry out all of the basic services offered by the facility, i.e., food services, housekeeping, maintenance, nursing, laundry, etc. This REQUIREMENT is not met as evidenced by: Please see F 353 as it pertains to adequate nursing staff in the facility.	C 111	For C 111 See F353	
C 121	02.100,03,c,v Encouraged/Assisted to Exercise Rights v. Is encouraged and assisted, throughout his period of stay, to exercise his rights as a patient/resident and as a citizen, and	C 121	For C 121 See F244	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Paul M. [Signature] 9-9-14

Bureau of Facility Standards

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C 121	Continued From page 1 to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; This Rule is not met as evidenced by: Please see F 244 as it pertains to the facility's response to concerns from the resident group.	C 121		
C 147	02.100,05,g Prohibited Uses of Chemical Restraints 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. This Rule is not met as evidenced by: Refer to F329 as it relates to antipsychotic medications.	C 147	For C 147 See F 329	
C 155	02.100,08 NOTIFICATION OF CHGE PTNT/RSDNT STATUS 08. Notification of Change in Patient/Resident Status. There shall be written policies and procedures relating to notification of next of kin, or sponsor, in the event of a significant change in a patient's/resident's status. This Rule is not met as evidenced by:	C 155		

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C 155	Continued From page 2 Please see F157 as it pertains to family notification of an accident.	C 155	For C 155 See F 157	
C 173	02.100,12,d Immediate Notification of Physician of Injury d. The physician shall be immediately notified regarding any patient/resident injury or accident when there are significant changes requiring intervention or assessment. This Rule is not met as evidenced by: Please see F157 as it pertains to physician notification of an accident.	C 173	For C 173 See F 157 For C 644 See F 441 For C 653 See F 441	
C 644	02.150,01,a,i Handwashing Techniques a. Methods of maintaining sanitary conditions in the facility such as: i. Handwashing techniques. This Rule is not met as evidenced by: Refer to F441 as it related to hand hygiene.	C 644	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Pharmacist attended the August 2014 Infection Control Committee meeting.	
C 653	02.150,01,c ISOLATION PROCEDURES c. Isolation procedures. This Rule is not met as evidenced by: Refer to F441 as it related to signage regarding isolation.	C 653	How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.	
C 666	02.150,02,c Quarterly Committee Meetings c. Meet as a group no less often than quarterly with documented minutes of meetings maintained showing members present, business addressed and signed	C 666		

Bureau of Facility Standards

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C 666	<p>Continued From page 3</p> <p>and dated by the chairperson. This Rule is not met as evidenced by: Based on record review, staff interview and policy review, it was determined the facility's Infection Control Committee meetings did not include the Pharmacist at their quarterly meetings. This had the potential to impact all of the residents, staff, and visitors in the facility. The findings included:</p> <p>On 8/7/2014 at 3:25 PM, the DON was interviewed regarding the attendees at the monthly Infection Control Meetings. The DON said the facility's pharmacist had not attended the monthly or the quarterly meetings for the last 6 months. The facility held their Quality Performance Improvement (QPI) meetings on a monthly basis in which infection control was a component. These meetings were held on 2/13, 3/13, 4/17, 5/13, 6/17, and 7/15/2014.</p> <p>On 8/7/2014 at 5:15 PM, the Administrator provided copies of the participants in attendance for the last 6 monthly meetings (which would have covered the last 2 quarterly meetings). The pharmacist is not listed as being one of the participants.</p> <p>On 8/8/2014 at 11:20 AM, the DON provided the facility's QPI Policy and Procedures that documented: The Administrator will: 1. Schedule monthly QAPI (Quality Assurance Performance Improvement) Steering Committee meeting. 2. Develop a center QAPI Organizational Chart that includes the following steering committee members: *Administrator (Chairs the committee) *Department Heads *Regional Staff (Attends at least quarterly)</p>	C 666	<p>Residents residing within the facility have the potential to be effected by this practice. Pharmacist attended the August 2014 Infection Control Committee.</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur.</p> <p>Education was provided to facility Administrator, and Director of Nursing regarding regulations related to Pharmacist attendance at facility quarterly Infection Control Committee meetings.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not recur</p> <p>The facility will review Monthly x 3 months, then quarterly x 2 quarters the Pharmacists attendance at the facility monthly Infection Control Committee. Findings of these reviews will be</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001350	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/08/2014
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NAME OF PROVIDER OR SUPPLIER
LACROSSE HEALTH & REHABILITATION CEN1

STREET ADDRESS, CITY, STATE, ZIP CODE
**210 WEST LACROSSE AVENUE
COEUR D'ALENE, ID 83814**

(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) COMPLETE DATE
C 666	Continued From page 4 *Medical Director (Attends quarterly at a minimum, monthly is preferred) *Pharmacist (Attends at least quarterly) On 8/7/14 at 6:10 p.m., the Administrator and DON were informed of the issue. No further information or documentation was provided.	C 666	reviewed by the Administrator monthly. Negative trends will be sent to the QAPI meetings for 3 months for further education and training opportunities.	
C 671	02.150,03,b Handling Dressings, Linens, Food b. Proper handling of dressings, linens and food, etc., by staff. This Rule is not met as evidenced by: Refer to F441 as it related to placement of urinary drainage bags.	C 671	Individual to ensure compliance and date of compliance The Administrator or designee will ensure ongoing compliance Date of Compliance <u>9-12-14</u>	
C 745	02.200,01,c Develop/Maintain Goals/Objectives c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Refer to F281 as it related to accepted standards of practice.	C 745	For C 671 See F 441 For C 745 See F 281 For C 782 See F 280	
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: Please see F 280 as it pertains to resident participation in care planning, and to the review and revision of resident care plans.	C 782		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814
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C 784	Continued From page 5	C 784	For C 784 See F 309	
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Refer to F309 as it relates to following Physician's orders.	C 784	For C 785 See F 311 For C 790 See F 323	
C 785	02.200,03,b,i Grooming Needs i. Good grooming and cleanliness of body, skin, nails, hair, eyes, ears, and face, including the removal or shaving of hair in accordance with patient/resident wishes or as necessitated to prevent infection; This Rule is not met as evidenced by: Please see F 311 as it pertains to resident bathing and showering.	C 785		
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Please see F 323 as it pertains to hazards in the resident environment.	C 790		
C 792	02.200,03,b,viii Comfortable Environment viii. Maintenance of a comfortable environment free from soiled linens, beds or clothing, inappropriate application of restraints and any	C 792		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CEN1	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814
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C 792	Continued From page 6 other factors which interfere with the proper care of the patients/residents; This Rule is not met as evidenced by: Please see F 258 as it pertains to comfortable sound levels.	C 792	For C 792 See F 258 For C 821 See F 431 For C 832 See F 431	
C 821	02.201,01,b Removal of Expired Meds b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days. This Rule is not met as evidenced by: Refer to F431 as it related to expired medications.	C 821		
C 832	02.201,02,f Labeling of Medications/Containers f. All medications shall be labeled with the original prescription legend including the name and address of the pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.) This Rule is not met as evidenced by: Refer to F431 as it related to labeling of medications.	C 832		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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August 22, 2014

Paul McVay, Administrator
LaCrosse Health & Rehabilitation Center
210 West Lacrosse Avenue
Coeur d'Alene, ID 83814-2403

Provider #: 135042

Dear Mr. McVay:

On **August 8, 2014**, a Complaint Investigation survey was conducted at LaCrosse Health & Rehabilitation Center. Nina Sanderson, L.S.W., Linda Kelly, R.N., Lauren Hoard, R.N., Michael Case, L.S.W., Q.M.R.P. and Linda Hukill-Neil, R.N. conducted the complaint investigation. The complaint investigation was conducted in conjunction with the facility's annual Recertification and State Licensure survey.

The following was completed by the survey team:

- Review of the identified resident's record, along with the records of 17 other sample residents.
- Review of the facility's grievance file.
- Review of the facility's policies and procedures related to advanced directives, family notification and physician notification.
- Review of the facility's incident and accident reports.
- Review of information from the Ombudsman's office.
- Individual residents and family interviews.
- A resident group interview.
- Interviews with key nursing personnel, direct care staff and other facility managers.
- Observations.

The complaint allegations, findings and conclusions are as follows:

Complaint #6461

ALLEGATION #1:

A complainant stated an identified resident's Power of Attorney was not notified of changes in the resident's clinical condition or when the resident fell.

FINDINGS #1:

Review of the identified resident's record revealed an Idaho Physician's Order for Scope of Treatment (POST) form but no other advanced directives on file. However, the record included a document, from an agency providing care to the resident at the time of admission, documenting the existence of a Living Will and Durable Power of Attorney for Health Care for the resident.

The facility expressed an awareness of these documents and stated they had requested copies from the agency. When the documents were not immediately provided, the facility did not pursue the matter further and did not have the documents on file throughout the resident's stay. While the facility documented someone was notified of changes in the resident's clinical condition or when the resident had a fall, the same person was not notified each time, and it was not clear if any of the persons notified was the resident's designated surrogate decision maker.

This portion of the complaint was substantiated and cited at F155.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

A complainant stated an identified resident suffered a stroke on an identified date, but the physician was not notified.

FINDINGS #2:

On the date specified by the complainant, the identified resident's record documented a period of lethargy, and a certified nurse aide reported to the licensed nurse that the resident had difficulty grasping with his left hand. The licensed nurse assessed the resident and ruled out symptoms of a stroke. The nurse's assessment was that the resident had become slightly over-sedated from pain medications; therefore, did not give the resident his scheduled pain medication that morning. The resident's status was monitored and within a few hours the resident had returned to baseline, was ambulating with his walker and able to exit the building for leisure pursuits. Since

Paul McVay, Administrator
August 22, 2014
Page 3 of 4

there was no evidence of a stroke from the facility's clinical assessment, the physician was not notified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated an identified resident was not receiving adequate pain control and did not receive pain medications unless the resident approached staff and asked for them.

FINDINGS #3:

The identified resident experienced both chronic and acute pain.

The physician's orders documented the resident had routine morphine three times daily and could also have one to two tablets of "as needed" hydrocodone, every four to six hours.

The resident was ambulatory and cognitively able to alert nursing staff when pain was present and pain medications were needed. The resident had a diagnosis of lung cancer.

When first admitted, the resident used the "as needed" pain medication infrequently but that usage gradually increased over time. At the time the complaint was made, the resident was receiving as needed pain medication one to two times per day, as well as his routine dose. The resident's record documented some infrequent occasions when the morning dose of the resident's pain medication was not administered, with documentation that the resident was lethargic. On those occasions, it was documented a short time later the resident became more alert and would ask for pain medications if breakthrough pain was present.

The facility was documenting the resident's pain levels each shift and whether or not the resident's pain management reached an acceptable level as defined by the resident. All of these assessments were documented in the affirmative.

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.

Paul McVay, Administrator
August 22, 2014
Page 4 of 4

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care 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,

A handwritten signature in black ink that reads "Lorene Kayser". The letters are cursive and somewhat slanted to the right.

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

LKK/dmj