



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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CERTIFIED MAIL: 7012 1010 0002 0836 2281

August 29, 2013

Todd A. Russell, Administrator
Clearwater Health & Rehabilitation
1204 Shriver Road
Orofino, ID 83544-9033

Provider #: 135048

RE: **RECERTIFICATION, COMPLAINT INVESTIGATION AND STATE
LICENSURE SURVEY REPORT COVER LETTER**

Dear Mr. Russell:

On **August 16, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Clearwater Health & Rehabilitation by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back**

in compliance. WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 11, 2013**. Failure to submit an acceptable PoC by **September 11, 2013**, may result in the imposition of civil monetary penalties by **October 1, 2013**.

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

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

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effective date of the remedy when determining your target date for achieving compliance.

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **September 20, 2013 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **September 20, 2013**. A change in the seriousness of the deficiencies on **September 20, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 20, 2013** includes the following:

Denial of payment for new admissions effective **November 16, 2013**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 16, 2014**, if substantial compliance is not achieved by that time.

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

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

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If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **August 16, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **September 11, 2013**. If your request for informal dispute resolution is received after **September 11, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

LKK/dmj
Enclosures

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

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/16/2013
NAME OF PROVIDER OR SUPPLIER CLEARWATER HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification and complaint survey of your facility. The survey team included: Nina Sanderson, BSW LSW - Team Coordinator Linda Kelly, RN Lauren Hoard, BSN RN Definitions: ADLs - Activities of Daily Living AIMS -A tool for measuring involuntary movement in response to medication AIT - Administrator in Training APPN - Advanced Practice Nurse BIMS - Brief Interview for Mental Status CAA - Care Area Assessment CM - Centimeter COPD - Chronic Obstructive Pulmonary Disease CVA- Cerebrovascular accident DON/DNS - Director of Nursing DPA/DPAHC - Durable Power of Attorney for Health Care GDR - Gradual Dose Reduction H & P - History and Physical IV - Intravenous LN - Licensed Nurse MDS - Minimum Data Set MG - Milligram PA - Physician's Assistant PO - Oral PT - Physical Therapy RD - Registered Dietician SSD - Social Services Director F 155 SS=E	F 000	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under State and Federal law. This Plan of Correction will serve as the Facility's allegation of substantial compliance. RECEIVED SEP 13 2013 FACILITY STANDARDS	
F 155 SS=E	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES	F 155		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Tom Russen

Administrator

9/10/13

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>The resident has the right to refuse treatment, to 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 observation, medical record review, and staff interview, it was determined the facility did not ensure residents were able to formulate complete and accurate advanced directives. This was true for 9 of 11 (R #s 1, 3, 4, 5, 7, 8, 9, 10, and 11) residents sampled for advanced directives. The deficient practice had the potential to cause more than minimal harm if the residents were to have treatment either withheld or provided, when their exact wishes were not clearly known, and if the resident legal representative for decision making was not correctly identified. Findings included:</p>	F 155	<p>F- 155 E</p> <ol style="list-style-type: none"> 1. Resident # 11 no longer resides at the facility. The Idaho Physician Orders for Scope of Treatment (POST) for residents # 1, 3, 4, 5, 7, 8, 9, and 10 have been reviewed and completed by the primary care physician. 2. The POST form for current residents have been reviewed and completed as indicated. 3. The interdisciplinary team was in-serviced by the Regional Director of Clinical Services (RDCS) regarding the policy and procedure for advance care planning and completing the POST form. 4. Social Services will review the POST form on admission and quarterly to ensure the information is accurately and completely documented in the medical record. The Executive Director (ED) / designee will complete random audits to ensure Advance Directive documentation including the POST form is complete and accurate per the resident's request weekly x 4 weeks, then monthly thereafter x 3 months. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance. 5. AOC <u>September 20, 2013</u> 		

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F 155	<p>Continued From page 2</p> <p>Idaho's Medical Consent and Natural Death Act documents: 39-4512A. Physician orders for scope of treatment (POST). (1) A physician orders for scope of treatment (POST) form is a health care provider order signed by a physician or by a PA or by an APPN. The POST form must also be signed by the person, or it must be signed by the person's surrogate decision maker provided that the POST form is not contrary to the person's last known expressed wishes or directions. (2) The POST form shall be effective from the date of execution unless suspended or revoked. (3) The attending physician, APPN or PA shall, upon request of the person or the person's surrogate decision maker, provide the person or the person's surrogate decision maker with a copy of the POST form, discuss with the person or the person's surrogate decision maker the form's content and ramifications and treatment options, and assist the person or the person's surrogate decision maker in the completion of the form.</p> <p>1. Resident #4 was admitted to the facility on 12/9/09 with multiple diagnoses which included dementia, dysphagia, and lymphoma.</p> <p>Resident #4's most recent quarterly MDS assessment, dated 6/24/13, documented severely impaired decision making skills, total dependence on staff for most ADLs, and 1 person physical assistance for eating.</p> <p>Resident #4's Durable Power of Attorney and Durable Power of Attorney for Health Care (DPA/DPAHC), dated 1/5/2004, documented *"...I hereby grant to my agent full power and authority to make health care decisions for</p>	F 155			

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F 155	<p>Continued From page 3</p> <p>me...in exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent...including...my desires concerning obtaining or refusing or withdrawing life-prolonging care..." Resident #4 further selected the option, "If at any time I should become unable to communicate my instructions and where the application of artificial life-sustaining procedures shall serve only to prolong artificially my life, I direct such procedures be withheld or withdrawn except for the administration of nutrition and hydration." The document provided the name of the designated health care agent for Resident #4. The name, address, and telephone number for Resident #4's DPA/DPAHC were listed on this form.</p> <p>Resident #4's POST documented: -Section A, "Do Not Resuscitate." -Section B, "Comfort Measures...reasonable measures are to be made to offer food and fluids by mouth..." -Section C, "Artificial Fluids and Nutrition." The box for, "IV fluid" appeared to have both a check mark and an "X" in it. Next to the box was the word "error" and initials. [NOTE: The initials on this part of the form were not the same initials as the name of the DPAHC.] The boxes for, "No feeding tube" and "No IV" both had a checkmark in them. -Section D, "Advanced Directives: The following documents also exist:" The boxes for "Living Will" and "DPAHC" were blank. The box for "DPA" had a check mark. -Section E, Resident #4's DPAHC had signed the "Patient/Surrogate Signature" space, and dated</p>	F 155			

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F 155	<p>Continued From page 4</p> <p>the form 2/13/09. Resident #4's physician signed and dated the form 4/29/09. There were boxes in this area of the form to indicate whether the physician had discussed this form with the Patient, Spouse, DPA, DPAHC, or other. Those boxes were all blank. There were boxes in this area of the form to document whether the basis for the information on the form was, "Patient's request" or "Patient's known preference." These boxes were also blank.</p> <p>Resident #4's POST indicated the resident did not have a living will, even though there was a living will document in the resident's record. There was no explanation regarding the differences in those directives regarding nutrition and hydration. There were several areas of the POST form which were blank. 75 days elapsed between the time Resident #4's DPA/DPAHC and the physician signed the POST document. Resident #4's POST was dated 5 years after her living will, which indicates her past wishes were known.</p> <p>Resident #4's History and Physical (H&P), dated 12/6/09, documented the resident had family members to help her with medical decisions. The name and telephone number for Resident #4's DPA/DPAHC were listed.</p> <p>Resident #4's physician's progress notes documented: 5/15/13, "weight loss...she is not a candidate for a feeding tube and has already written that into her POST." 7/17/13, "weight loss unavoidable, not candidate for feeding tube, not really responding to interventions."</p> <p>On 8/13/13 at 1:40 PM, the DNS and RD were</p>	F 155		

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F 155	<p>Continued From page 5</p> <p>interviewed regarding Resident #4's weight loss and her advanced directives. The RD reported the facility was monitoring Resident #4's weight loss trend, and had implemented a number of interventions in an effort to alter that trend. The DNS and RD were asked about the contents of Resident #4's living will regarding nutrition and hydration. The RD stated she did not know about that information, but Resident #4 had a POST and the physician had indicated the resident was not a candidate for a feeding tube. The RD and the DNS did not know why the living will and the POST differed in direction regarding nutrition and hydration. The RD and the DNS did not know if Resident #4's physician was aware of the contents of the resident's living will, or if the physician was aware that Resident #4's power of attorney document prohibited her DPA from making health care choices inconsistent with her living will. The RD and the DNS were asked if the facility or the physician had spoken with Resident #4's DPA regarding the weight loss, in terms of how either her POST or her living will applied. The DNS stated Resident #4's DPA rarely visited, so the facility had not initiated conversation. The DNS stated she was not sure the facility had contact information for Resident #4's POA.</p> <p>Please see F157 as it pertains to family notification.</p> <p>2. Resident #8 was admitted to the facility on 11/26/04 and re-admitted on 7/25/12 with multiple diagnoses including type 2 diabetes, chronic obstructive pulmonary disease, and schizophrenia.</p> <p>Resident #8's POST documented the following in Section E:</p>	F 155			

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F 155	<p>Continued From page 6</p> <p>*Resident #8 signed the document on 7/25/12. *Resident #8's physician signed the document on 8/7/12. NOTE: 13 days elapsed between the time Resident #8 signed the POST, and the time the physician signed the POST. *The boxes indicating whether the physician discussed this document with the patient, spouse, DPA, DPAHC, or "other", were all blank. *The boxes indicating whether this directive was based on "Patient's request" or "Patient's known preference," were blank.</p> <p>On 8/15/13 at 9:00 AM, the SSD was asked about the dates on Resident #8's POST indicating the resident and physician had signed on different dates, and about the incomplete areas of Resident #8's POST. The SSD indicated she had only started working at the facility a short time before the survey started, and was not aware of these issues for Resident #8's POST. The SSD stated, "I'll have to work on that."</p> <p>3. Resident #11 was admitted to the facility on 10/31/12 with multiple diagnoses including a pelvic fracture, chronic kidney failure, and congestive heart failure.</p> <p>Resident # 11's POST was incomplete in Section E, as follows: *The areas for the physician's license number and date the physician signed the form were blank. *The area indicating who the POST had been discussed with was blank. *The area indicating the basis for the orders was blank.</p> <p>On 8/15/13 at 4:00 PM, the DNS was asked</p>	F 155		

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F 155	<p>Continued From page 7</p> <p>about Resident #11's POST. The DNS was not aware the POST was incomplete.</p> <p>4. Similar results were noted for Resident #s 1, 3, 7, 9, and 10.</p> <p>5. Resident #5 was admitted to the facility on 11/16/2011 with a diagnosis of dementia with paranoia and delusional disorder.</p> <p>Resident #5's most recent quarterly MDS, dated 7/3/13, coded a BIMS of 13 (mildly impaired cognition), no depressive symptoms, and delusions present.</p> <p>Resident #5's medical record contained a document from the District Court indicating a temporary guardian had been appointed for the resident on 11/4/11, extending for 90 days after that date.</p> <p>On 8/14/13 at 2:45 PM, the DNS was asked about the guardianship status for Resident #5. The DNS stated, "We'll get updated papers."</p> <p>On 8/15/13 at 9:00 AM, the SSD was asked about the guardianship status for Resident #5. The SSD stated she had only been working in the facility for a short time, and did not know Resident #5 ever had a guardian. The surveyor showed the SSD the guardianship document in Resident #5's chart. The SSD stated she would have to look into it further.</p> <p>On 8/15/13 at 5:00 PM, the Administrator, AIT, and DNS were informed of the surveyor's findings. The facility offered no further information.</p>	F 155			

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F 156 F 156 SS=D	Continued From page 8 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of	F 156 F 156	F- 156 D 1. Resident # 11 no longer resides at the facility 2. Admission paperwork for current residents has been reviewed to ensure completeness. 3. The Director of Admissions and Social Services were in-serviced by the ED regarding the completion of admission paperwork. 4. The ED / designee will complete random audits of admission paperwork to ensure completeness weekly x 4 weeks, then monthly thereafter x 3 months. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance. 5. AOC <u>September 20, 2013</u>		

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F 156	<p>Continued From page 9</p> <p>legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to</p>	F 156			

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F 156	<p>Continued From page 10</p> <p>receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not ensure residents were informed of their rights prior to admission to the facility. This was true for 1 of 11 residents (R #11) sampled for resident rights. The deficient practice had the potential to cause more than minimal harm when a resident did not have information regarding exercising his rights within the facility. Findings included:</p> <p>Resident #11 was admitted to the facility on 10/31/12 with multiple diagnoses including a pelvic fracture, chronic kidney failure, and congestive heart failure.</p> <p>On 8/15/13 at 10:00 AM, the surveyor requested documentation indicating Resident #11 had been informed of his rights prior to admission. At 11:00 AM, the facility provided information regarding Resident #11. The surveyor reviewed the information, but did not find evidence the resident had been informed of his rights. At 12:55 PM, the surveyor again asked the Administrator for that documentation. The Administrator stated, "You already have everything we've got for [Resident #11]."</p> <p>On 8/15/13 at 4:00 PM, the DNS was asked about the process of informing residents of their rights prior to admission. The DNS stated that process should take place with social services at the time of admission. The DNS stated the facility</p>	F 156			

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F 156	Continued From page 11 had recognized there were "problems", and had recently hired a new social worker, and the facility had a new administrator within the past week. The DNS was unsure if the problem had been completely corrected, and stated, "It'll get better." On 8/15/13 at 5:00 PM, the Administrator, the AIT, and the DNS were informed of these concerns. The facility offered no further information.	F 156			
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). 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	F 157			

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F 157	<p>Continued From page 12 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 staff interview and record review, it was determined the facility did not ensure a resident's legal representative was informed of a significant change in their status. This was true for 1 of 7 (R #4) residents sampled for family notification. The deficient practice had the potential for more than minimal harm when Resident #4's legal representative was not given information to make an informed decision regarding a change in her status and treatment options. Findings included:</p> <p>Resident #4 was admitted to the facility on 12/9/09 with multiple diagnoses which included dementia, dysphagia, and lymphoma.</p> <p>Resident #4's most recent quarterly MDS assessment, dated 6/24/13, documented severely impaired decision making skills, total dependence on staff for most ADLs, 1 person physical assistance for eating.</p> <p>Resident #4's Durable Power of Attorney and Durable Power of Attorney for Health Care (DPA/DPAHC), dated 1/5/2004, provided the name of a designated health care agent for Resident #4, along with an address and telephone number for that person.</p> <p>Resident #4's History and Physical (H&P), dated</p>	F 157	<p>F-157 D</p> <ol style="list-style-type: none"> 1. Resident # 4's family has been notified of the resident's unavoidable weight loss. Interventions as indicated on resident's current POST form have also been reviewed and discussed with the resident's DPOA for health care. 2. An audit of the 24-hour report for current residents in the past 30 days was completed to ensure responsible parties have been notified of changes in condition as indicated. 3. The interdisciplinary team and licensed nurses have been in-serviced regarding the policy related to notification of resident's change in condition. Notification will include discussion related to the resident's current POST form as indicated. 4. The DCS / designee will review the 24-hour report at the clinical meeting 5x/week to ensure RP's are notified of the resident's change in condition. The ED / designee will conduct a random audit of the 24-report to ensure proper notification of changes in condition weekly x 4 weeks, then monthly thereafter x 3 months. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance. 5. AOC <u>September 20, 2013</u> 		

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F 157	<p>Continued From page 13</p> <p>12/6/09, documented the resident had family members to help her with medical decisions. The name and telephone number for Resident #4's DPA/DPAHC were listed.</p> <p>Resident #4's physician's progress notes documented: * 5/15/13, "weight loss...she is not a candidate for a feeding tube and has already written that into her POST." 7/17/13, "weight loss unavoidable, not candidate for feeding tube, not really responding to interventions."</p> <p>On 8/13/13 at 1:40 PM, the DNS and RD were interviewed regarding Resident #4's weight loss and family notification. The RD reported the facility was monitoring Resident #4's weight loss trend, and had implemented a number of interventions in an effort to alter that trend. The RD and the DNS were asked if the facility or the physician had spoken with Resident #4's DPA regarding the resident's weight loss. The DNS stated Resident #4's DPA rarely visited, so the facility had not initiated conversation regarding this topic. The DNS stated she was not sure the facility had contact information for Resident #4's POA. The surveyor asked whether or not the facility had attempted to use the information in Resident #4's DPAHC or H&P in an effort to contact Resident #4's family. The DNS stated she was unaware that information was in those documents, so did not think any attempts had been made to use it.</p> <p>On 8/15/13 at 5:00 PM, the Administrator, AIT, and DNS were informed of these concerns. The facility offered no further information.</p>	F 157			

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F 246 F 246 SS=D	Continued From page 14 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that: * Furniture and fixtures in common areas frequented by residents were accommodating of physical limitations of residents in regards to handrail usage and availability; and, * Resident's call lights were accessible. This was true for 1 of 11 sample residents (#1), 1 random resident (#12), and any resident needing to use the handrails in the hallway outside the back dining room. The failed practices created the potential for decreased independent functioning and well-being, and physical, and possibly emotional harm for residents whose call light was not available when assistance was needed or wanted. Findings included: 1. On 8/13/13 at 7:50 a.m., 8:45 a.m., 9:30 a.m., 10:35 a.m., 2:10 p.m., 3 to 4 mechanical lifts were observed near the back dining room up against the handrail on the west side of the hall. On the wall above the handrail there was a sign stating, "Please Keep Hallway Clear." On 8/14/13 at 9:40 a.m. and 4:00 p.m., 3 to 4	F 246 F 246	F-246 D 1. The call light for resident # 12 was immediately moved within the resident's reach when staff became aware it was not accessible. Hoyer lifts were removed from the back hallway to allow resident access to handrails. 2. An audit has been completed to ensure call lights are accessible to residents. Hoyer lifts have been relocated to allow residents access to hand rails. 3. The facility staff were in-serviced regarding call light placement to ensure accessibility to the resident and proper storage of hoyer lifts when not in use. 4. The facility management team will audit accessibility of call lights and location of hoyer lifts during daily mock survey rounds. The ED / designee will complete a random audit of call light accessibility and location of hoyer lifts weekly x 4 weeks, then monthly thereafter x 3 months. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance. 5. AOC <u>September 20, 2013</u>	

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F 246	<p>Continued From page 15</p> <p>mechanical lifts were observed near the back dining room up against the handrail on the west side of the hallway blocking 15 feet of the 24 foot handrail.</p> <p>On 8/15/13 at 11:35 a.m., during the environment tour, the Plant Operations Manager (POM) was asked where equipment is stored such as mechanical lifts. The surveyor followed the POM to the hallway near the back dining room where the mechanical lifts had been observed, and identified it as the equipment storage area.</p> <p>On 8/15/13 at 4:45 p.m., the Administrator, DON, and Administrative Assistant were notified of the equipment storage issue. No other information or documentation was received that resolved the issue.</p> <p>2. On 8/13/13 at 10:30 a.m., groaning sounds were heard coming from Resident #12's room. When the resident did not respond to repeated knocks on the partially opened door, the surveyor stepped into the room. The resident was observed in a geri-chair with a tray across the front of the chair. The chair was parked near the head of the resident's bed and on the right side of the bed (as one would look from the end toward the head of the bed). The call light was in the middle of the bed about 1 foot from the end of the bed and about 4 feet away from the resident. The resident's call light was not accessible.</p> <p>At about 10:32 a.m., from a room across the hallway from Resident #12's room, the Plant Operations Manager stated, "He won't respond. He can't talk."</p> <p>At 10:40 a.m., CNA #5 walked down the hallway</p>	F 246			

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F 246	Continued From page 16 without looking into Resident #12's room. At 10:50 a.m., CNA #5 and CNA #2 accompanied the surveyor to Resident #12's room. When asked if the resident's call light was accessible, both of the CNAs said, "No." CNA #5 moved the call light to the tray on the resident's geri-chair and stated, "It should be." Review of Resident #12's care plan revealed the problems included: * "At risk for contractures due to lack of mobility" and "[Resident's name] needs assistance with all ADLs." Approaches to the ADL problem included, "[Resident's name] needs 1 person assistance with dressing...needs assistance grooming and personal hygiene...2 person assist [with] transfers...2 person assist [with] toileting..."	F 246			
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine;	F 272			

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F 272	Continued From page 17 Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not ensure the CAA areas of residents' comprehensive assessments included input from residents or their legal representatives as part of the care planning decision process. This was true for 7 of 7 residents (#s 1-7) sampled for CAA completion. The deficient practice had the potential to cause more than minimal harm when care plans were developed without recognition of residents' perceptions of their situation and care. Findings	F 272	F-272 E 1. Comprehensive assessments (CAA) for resident's # 1, 2, 3, 4, 5, 6, and 7 were reviewed and updated to include resident / responsible party (RP) input to the care planning process as well as facility analysis of the findings. 2. An audit of current resident comprehensive assessment completed in the past three months was conducted to ensure the CAA section is complete and accurate. 3. The MDS coordinator and IDT have been in-serviced by the Regional MDS Coordinator regarding completion of the comprehensive assessment and care planning process to include resident / RP input and facility analysis. 4. The DCS / designee will complete a random audit of comprehensive assessments to ensure proper completion weekly x4 weeks, then monthly thereafter x 3 months. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance. 5. AOC <u>September 20, 2013</u>		

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F 272	<p>Continued From page 18 included:</p> <p>1. Resident #4 was admitted to the facility on 12/9/09 with multiple diagnoses which included dementia, dysphagia, and lymphoma.</p> <p>Resident #4's most recent annual MDS assessment, dated 10/13/12, documented difficulty understanding and making self understood, severely impaired decision making skills, minimal depression, always incontinent of bladder and bowel, total dependence on staff for most ADLs, 1 person physical assistance for eating, and requires a mechanically altered therapeutic diet.</p> <p>Resident #4's most recent CAAs, dated 10/23/12, triggered Cognitive Loss, Communication, Urinary Incontinence, Mood State, Activities, Falls, Nutritional Status, and Pressure Ulcer. In each of these triggered areas, there was a space for notes regarding input from the resident or family as part of the care plan consideration. Each of these areas for Resident #4 documented, "Blank." There was also a space for notes regarding an analysis of the facility findings. The triggered areas of Cognitive Loss, Mood State, and Activities also documented, "Blank."</p> <p>2. Resident #5 was admitted to the facility on 11/16/2011 with a diagnosis of dementia with paranoia and delusional disorder.</p> <p>Resident #5's most recent annual MDS, dated 10/23/12, coded supervision from staff or 1 person assist for ADLs, swallow disorder, and an anti-psychotic medication administered each of the past 7 days.</p>	F 272			

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F 272	<p>Continued From page 19</p> <p>Resident #5's most recent CAAs, dated 10/29/12, triggered Communication, ADL Function, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use. In each of these triggered areas, there was a space for notes regarding input from the resident or family. Each of these areas for Resident #5 documented, "Blank." There was space for notes regarding an analysis of the facility findings. This space for the triggered area of Psychotropic Drug Use also documented, "Blank."</p> <p>3. Resident #7 was admitted to the facility on 11/29/11 and re-admitted on 12/23/11 with multiple diagnoses which included left above the knee amputation and wound infection.</p> <p>Resident #7's most recent annual MDS, dated 11/13/12, coded severely impaired cognitive skills with fluctuation, total dependence for most ADLs, incontinent of bowel and bladder, required a mechanically altered therapeutic diet, and received an anti-psychotic medication each of the past 7 days.</p> <p>Resident #7's most recent CAAs, dated 11/23/12, triggered Delirium, Cognitive Loss, Visual Function, Communication, ADL Function, Urinary Incontinence, Mood State, Falls, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use. In each of these triggered areas, there was a space for notes regarding input from the resident or family. Each of these spaces documented, "Blank." Each of these triggered areas also had a space for an analysis of the facility findings. These spaces for the triggered areas of Mood State and Nutritional Status documented, "Blank."</p>	F 272			

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F 272	<p>Continued From page 20</p> <p>4. Resident #1 was admitted to the facility on 7/25/12 with multiple diagnoses which included depression, psychotic disorder, hypertension, hyperlipidemia, COPD, stroke, and anxiety disorder.</p> <p>The Resident #1's most recent annual MDS assessment, dated 7/4/13, coded in part:</p> <ul style="list-style-type: none"> * Moderately impaired cognition with a BIMS score of 9; * Total assistance of 2 or more persons for bed mobility; * Total assistance of 1 person for dressing and personal hygiene; * Always incontinent of bladder and bowel; * Risk of pressure ulcers; and, * Anti-psychotic and antidepressant medication administered each of the past 7 days. <p>Resident #1's most recent CAAs, dated, 7/17/13, triggered Delirium, Cognitive Loss, Communication, ADL functioning, Urinary Incontinence, Falls, Nutritional Status, Pressure Ulcer, Psychotropic Drug Use, and Pain. In each of these triggered areas, there was a space for notes regarding input from the resident or family. Each of these areas for Resident #1 documented, "Blank." There was also a space for notes regarding an analysis of the facility findings. The triggered areas of Delirium, Cognitive Loss, and Nutritional Status also documented, "Blank."</p> <p>5. Similar results were noted for Resident #s 2, 3, and 6.</p> <p>On 8/14/13 at 2:45 PM, the DNS and the Admissions Nurse were asked about the blank spaces in the CAAs. The DNS reviewed the CAAs and stated, "I see."</p>	F 272			

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F 272	Continued From page 21 On 8/15/13 at 9:00 AM, the SSD was interviewed regarding the MDS and care planning process. The SSD stated she had only been working in the facility a short time, but as a rule she would like to be able to include more input from the resident in the MDS and care planning process. The SSD was asked if she utilized the space in the CAAs for resident input. The SSD stated she was not sure where that was. When shown this area by the surveyor, the SSD stated, "Oh, I see. I will definitely use that in the future." On 8/15/13 at 5:00 PM, the Administrator, AIT, and DNS were informed of the surveyor's findings. The facility offered no further information.	F 272			
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 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.	F 280			

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F 280	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not ensure resident care plans were periodically reviewed and revised. This was true for 7 of 10 (#s 1, 2, 4, 5, 7, 8, and 9) residents sampled for care plan revisions. The deficient practice had the potential to cause more than minimal harm when care plans did not reflect the resident's current status to ensure appropriate provision of care, and/or it could not be determined when new interventions had been implemented. Findings included: 1. Resident #1 was admitted on 7/25/12 with multiple diagnoses which included diabetes, hypertension, stroke, COPD, hemiplegia, depression, and psychotic disorder. On the date of admission, 7/25/12, Resident #1 identified on the Idaho Physician Orders for Scope of Treatment (POST) form, via the Power of Attorney (POA) the following: * Resuscitate (Full Code); * Aggressive Interventions: In addition to the care described above, you may include endotracheal intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. Receiving hospital may admit to Intensive Care if indicated; * Artificial Fluids and Nutrition: Feeding tube and intravenous (IV) fluid; and, * Antibiotics and Blood Products. Resident #1's July 2013 Physician's Orders	F 280	F -- 280 (E) 1. Resident # 1's care plan was immediately corrected to reflect the resident's Advance Directive care plan in accordance with the resident's POST form. Resident # 2, 4, 5, 7, 8, and 9 care plans were reviewed and updated to reflect their current condition. 2. Care plans of current residents will be transitioned to the new format allowing space to add individualized approaches; starting with the most current comprehensive assessment coming due. 3. The IDT was in-serviced to update the resident's plan of care during weekly clinical meetings as changes in condition occur. 4. The IDT will update the resident's plan of care during weekly clinical meetings to reflect changes in condition and new orders. The DCS / designee will conduct random audits of the resident's care plans to ensure accuracy weekly x 4 weeks, then monthly thereafter x 3 months. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance. 5. AOC <u>September 20, 2013</u>		

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F 280	<p>Continued From page 23</p> <p>included an order for Code Status: Full code (FC), with a start date of 7/25/12.</p> <p>Resident #1's Advanced Directive Care Plan , dated 9/25/12, documented the following:</p> <ul style="list-style-type: none"> * Problem - Resident has Advanced Directives of: POST form; * Goal - Resident will have Advanced Directives followed as evidenced by: Do Not Resuscitate (DNR) through next review date; * Implementation Date: 9/25/12; and, * Approaches and Interventions - Discuss Advanced Directives with resident and/or responsible party/family, and Physician order for DNR. <p>Resident #1's Advanced Directive Care Plan identified the resident as a DNR per the resident's POST form and Physician's order. However, the Physician's order and the POST form indicated the resident to be a full code.</p> <p>On 8/14/13 at 11:30 a.m., the DON was informed of the code status issue related to the care plan. However, no further information or documentation was received that resolved the issue.</p> <p>Note: Please see F155 as it pertains to advanced directives.</p> <p>2. Resident #4 was admitted to the facility on 6/5/08 and re-admitted on 12/9/09 with multiple diagnoses which included dementia, history of chronic pain, and hypertension.</p> <p>Resident #4's DPA and DPAHC, dated 4/5/04, documented the name, address, and telephone number for the resident's surrogate decision maker.</p>	F 280		

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F 280	<p>Continued From page 24</p> <p>Resident #4's H&P, dated 12/6/09, documented the resident had family members to assist with medical decisions, along with the DPA's name and a telephone number.</p> <p>Note: Please see F 155 as it pertains to advanced directives, and F 157 as it pertains to family notification.</p> <p>Resident #4's most recent MDS assessment, dated 6/24/13, coded the resident sometimes understands when communicating with others, was dependent on staff for most ADLs, had severely impaired decision making skills, and no resident or family participation in the assessment.</p> <p>Resident #4's Quarterly Social Services Progress Notes documented: -3/25/13, "...Family does not visit, or attend quarterly care meetings." -6/24/13, "...Her family does not visit but do send flowers, cards, and orders a birthday cake each year..."</p> <p>On 8/12/13 at 2:45 PM, during the initial tour of the facility, the DNS stated Resident #4 did not have much family support, and the facility's only knowledge of contact between the family and the resident was a yearly birthday cake which was sent to the resident at the facility.</p> <p>Resident #4's care plan documented: a) Problem/need, onset date 6/7/13, "Family rarely visit [Resident #4]." Goal, "[Resident #4] will express no discomfort in lack of family contact," dated 9/8/13. Approaches, "Encourage [Resident #4] to attend activities of choice. Encourage [Resident #4] to socialize with others who match</p>	F 280		

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F 280	<p>Continued From page 25</p> <p>her cognitive abilities. Encourage [Resident #4] to spend time outside her room daily. If family does visit [Resident #4] and family will be provided with space to spend time together."</p> <p>The "problem" was identified on 6/7/13, but there was social services documentation on 3/25/13 of family not visiting. There was no explanation in the care plan to identify what had happened which was limiting family visits, so staff could be sensitive to that aspect of Resident #4's care. There was no documentation in the care plan as to how the staff should respond to Resident #4 if she verbalized an awareness of the lack of family visits. There was no documentation as to what attempts had been made to contact family and attempt to facilitate the resumption of family visits.</p> <p>b) The following updates were hand-written on Resident #4's care plan, without dates or signatures indicating when the care plan had been updated or by whom [Note: A change which had been crossed out indicated the item had been discontinued from the resident's care plan. A hand-written item indicated it had been added to the resident's care plan]:</p> <ul style="list-style-type: none"> -Problem area of, "Difficulty in making decisions...", the approaches, "Repeat and rephrase residents request to clarify if ensure understanding", and, "Assist resident to make appropriate decision", were crossed out. The approach, "anticipate resident's needs," was added. -Problem area, "[Resident #4] has frequent worried expressions" had the words, "and is withdrawn from socialization and group facility activities. [Resident #4's] moods are not easily redirected," were crossed out. The approach "If in 	F 280		

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F 280	<p>Continued From page 26</p> <p>room [Resident #4] prefers to sit in front of window and look outside." was added.</p> <p>-Problem area of, "DNR", the approach of, "Alert noted on front of chart per facility policy", was crossed out. The words, "if family available," were added to the approach of, "Review quarterly with resident and family during care conferences."</p> <p>-Similar results were found throughout Resident #4's care plan.</p> <p>On 8/14/13 at 2:45 PM, the DNS was asked about care plan updates for Resident #4, regarding her family involvement. The DNS stated she was not aware of the contents of that portion of Resident #4's care plan, but the facility had recently hired a new social worker who would be reviewing and updating care plans in that regard.</p> <p>3. Resident #5 was admitted to the facility on 11/16/11 with multiple diagnoses including dementia with paranoia and delusional disorder.</p> <p>Resident #5's most recent quarterly MDS, dated 7/3/13, coded mild cognitive impairment and delusional symptoms noted.</p> <p>a) Resident #5 pre-admission H&P, dated 11/16/11, documented, "...presented with his wife with noted increased confusion, agitation, aggression with a history of dementia. He became very paranoid over the past several months despite his medication regime...the patient suspected that his 'son and wife were sexing' upwards of 'three times a day.' He was initially said to have wanted to 'buy a gun and kill us.'...has all sorts of paranoid thoughts and agitation. He has even hit his wife once and today he got violent and they had to call the police who</p>	F 280		

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F 280	<p>Continued From page 27 brought him in..."</p> <p>Resident #5's Physician's Orders for July 2013 included, for a diagnosis of dementia with behavioral disturbance, Seroquel 12.5 mg at bedtime daily, Depakote 1000 mg at bedtime daily, and Aricept 10 mg at bedtime daily.</p> <p>Review of Resident #5's care plan revealed no care plan present for behaviors, or history of behaviors. There was no information contained in his care plan regarding his history of aggression, how his delusions presented historically, how caregivers should interact with him to reduce the likelihood of delusions presenting, or how they should respond should delusional thoughts or aggression occur.</p> <p>b) Resident #5's care plan also documented updates or changes, without indication of when the updates were completed or by whom, as follows:</p> <p>-Under the problem area of "[Resident #5] is experiencing the presence of occasional pain in legs/knees.", an added approach of, "Non-pharmalogical intervention: Biofreeze to [left] lower side [twice daily as needed.]"</p> <p>Throughout this problem area, goals, and approaches, the care plan had listed the wrong name for Resident #5. These errors were crossed out with his correct name hand-written in, without listing the initials or signature of the person who had made these changes.</p> <p>-Under the problem area of, "[Resident #5] is at risk for side effects from antipsychotic drug use,", an added approach of, "AIMS assessment</p>	F 280			

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F 280	<p>Continued From page 28 quarterly. Ortho [blood pressure] monthly."</p> <p>See staff interview regarding Resident #5 in example #4 below.</p> <p>4. Resident #8 was admitted to the facility on 7/25/12 with multiple diagnoses including schizophrenia.</p> <p>Resident #8's most recent annual MDS assessment, dated 7/8/13, coded moderately impaired cognitive skills, minimal depression, and no current hallucinations or delusions.</p> <p>Resident #8's most recent care plan for Anti-psychotic Medication use, Impaired Cognition, and Behavior Management, were all pre-printed pages with a column of pre-printed problems, goals, target dates, implementation dates, and interventions. Next to each pre-printed items in these columns were boxes which could be checked if it was felt the item pertained to the resident. There was no space provided for problems, goals, or approaches to be individualized for a specific resident.</p> <p>On 8/14/13 at 2:45 PM, the DNS and the Admission's nurse were interviewed about the resident care plans. The DNS stated she was aware of the inconsistencies in dating and signing care plan updates. The DNS stated she had been working with her staff to correct the problem, and would continue to work on it. The DNS was asked about the development of behavioral care plans for residents with psychiatric diagnoses or behavioral issues. The DNS stated she was unaware of the behavioral history for Resident #5 or Resident #8, so did not know if that history was included in the care plans. The DNS stated the</p>	F 280			

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F 280	<p>Continued From page 29</p> <p>facility had recently hired a new social worker, and the new social worker would be working on developing behavioral care plans.</p> <p>On 8/15/13 at 9:00 AM, the SSD was interviewed regarding the development of behavioral care plans. The SSD stated she had not worked in the facility for very long, and would be working on reviewing and updating those care plans. Regarding Resident #5, the SSD stated her understanding was his behaviors had improved significantly during his time in the facility, now that he was receiving his medications regularly. The SSD was unsure of the exact nature of Resident #5's behavioral history, but stated she would be investigating it.</p> <p>The SSD was then asked about the pre-printed care plans for Resident #8. The SSD said the pre-printed form was one the facility had recently been directed to use, and that all resident's care plans would be transitioned to a pre-printed form. The SSD was asked how the direct care staff for Resident #8 would be made aware of important aspects of her schizophrenia, i.e., what is normal and safe behavior for that resident, what behavior should be concerning, any history of self-harm or harm to others, what interventions were historically beneficial to this resident, and what coping mechanisms the resident had developed over time. The SSD stated, "I wish it was a better form. I try to squeeze at least one sentence on each one that is specific to the resident, but it is hard. There isn't much room for that."</p> <p>5. Resident #9 was admitted to the facility on 11/27/12, and readmitted on 4/12/13, with multiple diagnoses including mental disorder (not</p>	F 280			

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F 280	<p>Continued From page 30 elsewhere classified), depressive disorder, and dementia.</p> <p>The resident's recapitulation of Physician's Orders for August 2013 included the following medications for depression, Depakote 250 milligrams (mg) by mouth (PO) 2 times a day and Celexa 20 mg PO daily. Both were ordered on 4/12/13.</p> <p>A Telephone Order (TO), dated 8/3/13, documented, "Depakote 250 mg P.O. [by mouth] [at] PM one time dose.</p> <p>Another TO, dated 8/5/13, included an order for Haldol 5 mg PO every 6 hours as needed for psychosis.</p> <p>The resident's "Anti-psychotic Medication Care Plan," dated 8/5/13, contained pre-printed problems, goals, target dates, implementation dates, and interventions. Next to each pre-printed item in these columns were boxes which could be checked if it was felt the item pertained to the resident. There was no space provided for problems, goals, or approaches to be individualized for a specific resident. This care plan documented psychosis as a problem. Checked approaches/interventions included, "Observe for signs and symptoms, increase or decrease in behavior...Redirect as needed...Remove resident from situations causing anxiety..." The behavior signs and symptoms to observe for were not identified. Refer to F329 regarding unnecessary medications</p> <p>The resident's "Mood Care Plan," also dated 8/5/13, documented the problem, "Sad,</p>	F 280			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/16/2013
NAME OF PROVIDER OR SUPPLIER CLEARWATER HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
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F 280	<p>Continued From page 31</p> <p>Apathetic, Anxious appearance[,] As Evidenced By: crying, paranoid delusions..." The goal was, "[Resident's name] will demonstrate an improved mood as evidenced by: [decrease] in crying [and] paranoid delusions." The approaches did not include to monitor for crying or paranoid delusions.</p> <p>The resident's "Behavior Management Care Plan," dated 8/12/13, documented the problem, "Other Behaviors[:] Picks at objects [and] Reaches for other residents chairs." Only 1 intervention/approach was documented. It was, "Help keep [resident's name] engaged in social activities, conversation, and interactions with staff and residents." he care plan did not direct how staff were to monitor/track if/when the resident picked at things or reached for other residents chairs.</p> <p>On 8/15/13 at 5:00 PM, the Administrator, and DON were informed of these issue. No other documentation or information was received from the facility.</p> <p>6. Resident #2 was admitted to the facility on 5/24/13 with multiple diagnoses including aspiration pneumonitis, dysphagia, and multiple skin injuries.</p> <p>Resident #2's care plan, dated 5/24/13, documented multiple problem areas and check marks in many of the pre-typed approaches/interventions. However, several undated handwritten entries were also in the "Approaches/Interventions" sections as follows: * At risk for aspiration - "Res[ident] ref[used] [thickened liquids as ordered]"; "Res request [no] H2O [water] other in room"; "[I]ce cream ok"; and,</p>	F 280			

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F 280	Continued From page 32 "[R]es ref [swallow study as indicated and ordered]." * Self care deficit ambulation - "PT [physical therapy] for muscle weakness [and] diff[iculty] walking." * Self care deficit eating - "[An R with a circle around it which typically indicates refusal] to eat in dining rm [room]." * At risk for falls - "[B]olsters on bed." Without the date, it would be impossible to know when an approach/intervention was supposed to be implemented. On 8/15/13 at 4:45 p.m., the Administrator and DON were informed of the care plan issue. No other information or documentation was received from the facility which resolved the issue.	F 280		
F 309 SS=D	7. Similar findings of undated and unsigned care plan changes were noted for Resident #7. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to provide the necessary care and services to meet	F 309		

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F 309	<p>Continued From page 33</p> <p>the needs for 2 of 11 sample residents (#1 and #8). Failure to consistently apply Ted hose and Zero-G boot to left leg, as ordered, placed Resident #1 at risk for skin breakdown and edema, and failure to arrange a psychological evaluation as ordered delayed treatment for Resident #8. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 7/25/12 with multiple diagnoses which included CVA, hypertension, hyperlipidemia, COPD, and diabetes.</p> <p>Resident #1's most recent annual MDS assessment, dated 7/4/13, coded in part: * 7/4/13 - Moderately impaired cognition with a BIMS score of 9; and, * Total assistance of 1 person for dressing.</p> <p>Resident #1's July 2013 Physician's Orders and Treatment Record included in part: * Knee high TED hose (anti-embolism stocking) to left leg, on in the morning, off at night; and, * Zero-G boot (special boot to alleviate pressure) on at all times.</p> <p>On 8/14/13 at 10:55 a.m., Resident #1 was observed in bed. LN #1, CNA #2, and CNA #5 were present to transfer resident into a wheelchair. The resident had socks on both feet with no TED hose, no Zero-G boot, and no heel elevation. When asked about the Zero-G boot and heel elevation, LN #1 stated, "[We] usually keep the boot on. Usually there's a pillow under her heels in bed." The resident's heels were observed to have no areas of skin breakdown noted. LN #1 was asked if Resident #1 had a pressure relieving or pressure reducing mattress. The LN stated, "Its a pressure relief mattress,</p>	F 309	<p>F-309 D</p> <ol style="list-style-type: none"> 1. Resident #1's adaptive devices (zero G boot and Ted Hose) are applied as ordered. Resident # 8 had a Telepsych consult on September 5, 2013. 2. Current residents with orders for adaptive devices were audited to ensure devices are in place per physician order. Current residents with orders for psychological evaluation were audited to ensure consults are scheduled timely. 3. Nursing staff were in-serviced on application of adaptive devices according to physician orders. The IDT has been in-serviced by the RDCS on scheduling psychiatric consults in a timely manner. 4. Social Service will schedule psychological consults as indicated in a timely manner. The Mock Survey team will conduct audits 5 x/week to ensure adaptive devices are in place per physician order. The DCS / designee will conduct random weekly audits weekly x 4 weeks, then monthly thereafter x 3 months to ensure adaptive devices are in place per order and psychological consults are scheduled timely. Result of the audits will be reported to the monthly QAPI committee to ensure substantial compliance. 5. AOC <u>September 20, 2013</u> 		

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F 309	<p>Continued From page 34 same for all the beds here."</p> <p>On 8/15/13 at 4:45 p.m., the Administrator, DON, and AIT were informed of the failure to follow physician orders. No further information was received that resolved the issue.</p> <p>The facility failed to consistently place the physician ordered Zero-G boot on Resident #1's foot for pressure redistribution, and failed to ensure the resident's TED hose were in place to the left lower extremity.</p> <p>2. Resident #8 was admitted to the facility on 7/25/12 with multiple diagnoses including schizophrenia.</p> <p>Resident #8's annual MDS assessment, dated 7/8/13, coded moderately impaired cognitive skills, minimal depression, and no hallucinations or delusions.</p> <p>Resident #8's physician progress notes, dated 7/17/13, documented the resident received Seroquel 50 mg per day for schizophrenia and Haloperidol Lactate 120 mg injection every 7 days for psychosis.</p> <p>On 4/22/13, Resident #8's Physician's Order Sheet documented, "Please have consult with [psychiatrist's name] regarding potential for simplification of psychotropic meds [medications]."</p> <p>On 8/14/13 at 9:10 AM, a Social Services Progress Note documented, "Met with resident and completed tele-psych paperwork with her to return to [clinic name] for appt [appointment]."</p>	F 309		

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F 309	Continued From page 35 More than 3 months had elapsed between the time the physician wrote the order for the psychiatric consultation, and the time the facility followed up to arrange the appointment. On 8/15/13 at 9:00 AM, the SSD was interviewed about the delay in the psychiatric consultation for Resident #8. The SSD stated she had only worked at the facility a short time, and had discovered only a few days before that the consultation had never taken place. The SSD stated she had begun working on it as soon as the DNS informed her about the order, and was working with the clinic to arrange the appointment as soon as an opening was available.	F 309			
F 315 SS=D	On 8/15/13 at 5:00 PM, the Administrator, AIT, and DNS were informed of these findings. The facility offered no further information. 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 record review and staff interview, the facility failed to ensure residents who were	F 315			

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F 315	<p>Continued From page 36</p> <p>incontinent of urine were thoroughly assessed to determine if a toilet training program may be beneficial and assist to restore continence. This was true for 1 of 10 sample residents (#9). Failure to assess voiding patterns placed Resident #9 at risk for skin breakdown and urinary tract infections. Findings included:</p> <p>Resident #9 was admitted to the facility on 11/27/12, and readmitted on 4/12/13, with multiple diagnoses including mental disorder (not elsewhere classified), depressive disorder, dementia, after care for a traumatic hip fracture, and type 2 diabetes.</p> <p>The resident's most recent quarterly MDS assessment, dated 5/22/13, coding included: * Severely impaired cognition, with a BIMS score of 6; * Understood by others; * Usually able to understand others; * Extensive assistance of 1 person for transfers and toileting; * Frequent urinary incontinence and no toileting program; and, * Occasional bowel incontinence and no toileting program.</p> <p>Resident #9's Urinary Incontinence Care Plan, dated 12/18/12, documented the urinary incontinence was related to, "Not aware of toileting needs [with "occasionally" in handwriting]." Goals were, "Resident will transfer to toilet with assist thru next review" and "Will have [no] skin breakdown thru next review." Other pre-printed goal choices, such as "...will not experience further decline in urinary incontinence (frequency)" and "...will maintain current level of urinary function (frequency)," were not checked.</p>	F 315	<p>F-315 D</p> <ol style="list-style-type: none"> 1. Resident 9 was reassessed for a toileting program and the care plan was updated to reflect the resident's toileting needs. 2. Current residents who are incontinent were reassessed to determine if a toileting program may be beneficial to restore continence. 3. The IDT was in-serviced by the RDSC regarding assessment of incontinent residents to determine if a personalized toileting program is indicated. 4. The DCS / designee will audit admission and quarterly assessments to ensure incontinent residents are assessed for personalized toileting programs weekly x 4 weeks, then monthly thereafter x 3 months. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance. 5. AOC <u>September 20, 2013</u> 		

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F 315	<p>Continued From page 37</p> <p>The approaches and interventions included, "Complete Incontinence Data Collection tool[;] Assistance needed to access toilet 1 person[;] Absorbent Products[;] and, Provide assistance as needed with transfers and toileting."</p> <p>A Skin Prevention Care Plan, also dated 12/18/12, documented Resident #9 was at risk for skin breakdown related to occasional bowel and bladder incontinence, among other reasons. Interventions/Approaches included, "Assure resident is free of body waste[;] Apply skin barrier after incontinent episode[;] [and] Incontinence care [every] 2 [hours]." Several other pre-printed interventions were listed but not checked. The interventions not checked included, "B&B [bowel and bladder] program."</p> <p>An Admission-Data Collection Form, dated 4/12/13, and a Quarterly Data Collection Tool, dated 5/22/13, both documented Resident #9 was a candidate for a toileting schedule, such as timed voiding.</p> <p>The resident's clinical record, however, did not include any documentation if there was a specific time when the resident was incontinent or a plan developed to assist the resident to achieve a higher level of continence. In addition, the record did not include a thorough assessment of factors that may predispose the resident's urinary incontinence, such as the type of incontinence, prior history of urinary incontinence, voiding patterns, review of medications that might affect continence, patterns of fluid intake, environmental factors & assistive devices that may restrict or facilitate a resident's ability to access the toilet.</p> <p>On 8/15/13 at 1:30 p.m., the DON was</p>	F 315			

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F 315	Continued From page 38 interviewed about Resident #9's incontinence. After a brief review of the resident's clinical record, the DON acknowledged the resident's incontinence was not thoroughly assessed and a toileting schedule was not developed for the resident. On 8/15/13 at 5:00 p.m., the Administrator and AIT were also informed of the issue. No other information or documentation was received from the facility.	F 315			
F 329 SS=D	483.25(i) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329			

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F 329	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not ensure adequate monitoring for the use of psychotropic medications, or ensure gradual dosage reductions (GDR) of those medications were consistently considered. This was true for 3 of 5 residents (#s 1, 5, and 9) sampled for psychotropic medication use. The deficient practice had the potential to cause more than minimal harm if residents received medication for which there was no clinical indication. Findings included: 1. Resident #5 was admitted to the facility on 11/16/11 with multiple diagnoses including dementia with paranoia and delusional disorder. Resident #5's most recent quarterly MDS, dated 7/3/13, coded mild cognitive impairment and delusional symptoms noted. Resident #5 pre-admission H&P, dated 11/16/11, documented, "...presented with his wife with noted increased confusion, agitation, aggression with a history of dementia. He became very paranoid over the past several months despite his medication regime...the patient suspected that his 'son and wife were sexing' upwards of 'three times a day.' He was initially said to have wanted to 'buy a gun and kill us.'...has all sorts of paranoid thoughts and agitation. He has even hit his wife once and today he got violent and they had to call the police who brought him in..." Resident #5's Physician's Orders for July 2013	F 329	F-329 D 1. Resident's # 1, 5, and 9 Behavior Modification Flow Records (BMFR) for behavior tracking were updated to reflect target behaviors specific to psychoactive medications in use. Psychoactive medications requiring gradual dose reduction (GDR) were reviewed by the IDT to determine the appropriate therapeutic dose. 2. Current residents with orders for psychoactive medications were audited to ensure BMFRs reflect target behaviors and GDRs are addressed quarterly by the IDT. 3. The IDT was in-serviced by the RDCS regarding use of the BMFR to track target behaviors and GDR for residents receiving psychoactive medications. Licensed nurses were in-serviced on behavior documentation. 4. Social Services will conduct weekly audits of BMFRs to ensure target behaviors are addressed for residents receiving psychoactive medications. The DCS / designee will conduct random audits weekly x 4 weeks, then monthly thereafter x 3 months to ensure BMFRs and GDRs are completed for residents receiving psychoactive medications. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance. 5. AOC <u>September 20,2013</u>	

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F 329	<p>Continued From page 40</p> <p>included, for a diagnosis of dementia with behavioral disturbance, Seroquel 12.5 mg at bedtime daily, Depakote 1000 mg at bedtime daily, and Aricept 10 mg at bedtime daily.</p> <p>Resident #5's Behavior/Intervention Monthly Flow Record for June, July, and August 2013 documented Resident #5 was being monitored for, "Focus on ex-employee" and, "Tearful crying." However, there was no documentation of monitoring for any of the behaviors described in the resident's H&P.</p> <p>On 8/14/13 at 2:45 PM, the DNS and Admissions Nurse were asked about the target behaviors for Resident #5, as they pertained to anti-psychotic use. The DNS stated she was aware of Resident #5's behavioral history prior to his admission, but was unsure why those target behaviors were not being tracked in the facility. The DNS identified the Behavior/Intervention Monthly Flow sheets were generated by social services, and the facility had recognized problems within that department. The DNS stated a new social worker had recently been hired, and was planning on implementing some new forms which would be more thorough.</p> <p>On 8/15/13 at 9:00 AM, the SSD was asked about Resident #5's behavior tracking. The SSD stated her understanding was the resident's behaviors had improved significantly during his time in the facility, now that he was receiving his medications regularly. The SSD was unsure of the exact nature of Resident #5's behavioral history, but stated she would be investigating it, and would update his behavior tracking to reflect the target behaviors specific to the anti-psychotic use.</p>	F 329			

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F 329	<p>Continued From page 41</p> <p>On 8/15/13 at 5:00 PM, the Administrator, AIT, and DNS were informed of these findings. The facility offered no further information.</p> <p>2. Resident #1 was admitted on 7/25/12 with multiple diagnoses which included depression, and psychotic disorder.</p> <p>Resident #1's most recent quarterly MDS assessment, dated 4/9/13, coded in part: * Moderately impaired cognition with a BIMS score of 10; * Delusions (misconceptions or beliefs that are firmly held, contrary to reality).</p> <p>Resident #1's Anti-Psychotic Medication Care Plan, dated 9/25/12, documented in part: * Problem - Anti-psychotic medication, diagnosis of hallucinations; * Goal - Resident will maintain lowest effective dose of anti-psychotic medication with therapeutic effect while minimizing risk for side effects through next review date; and, * Approaches and Interventions - Anti-psychotic medication as ordered, observe for signs and symptoms, increase or decrease in behavior, and assess for dose reduction quarterly.</p> <p>Resident #1's July 2013 Physician's Orders included the following for hallucinations: * Risperdal 1 mg tablet PO every morning; and, * Risperdal 2 mg tablet PO every night.</p> <p>Resident #1's Antidepressant Medication Care Plan, dated 9/25/12, documented in part: * Problem - Antidepressant medication; * Goal - Resident will maintain lowest effective dose of antidepressant medication with therapeutic effect while minimizing risk for side</p>	F 329			

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F 329	<p>Continued From page 42</p> <p>effects through next review date; and,</p> <ul style="list-style-type: none"> * Approaches and Interventions - Antidepressant medication as ordered, observe for signs and symptoms or complaints of depression, and assess for dose reduction quarterly. <p>Resident #1's July 2013 Physician's Orders included the following for depression:</p> <ul style="list-style-type: none"> * Depakote 500 mg tablet PO three times a day; and, * Zoloff 100 mg tablet PO every morning. <p>Resident #1's July 2013 Behavior/Intervention Monthly Flow Record included the following behaviors:</p> <ul style="list-style-type: none"> * Verbal outburst; * Refusal of cares; and, * Obsessing about returning home. <p>On 8/14/13 at 11:35 a.m., the DON was interviewed about the lack of hallucination tracking on the Behavior/Intervention Monthly Flow Record. The DON stated, "Nope you're right, its not on there." The DON was also asked about documentation for GDRs for Depakote and Risperdal. She indicated she would look into it.</p> <p>On 8/15/13 at 9:20 a.m., The DON was interviewed again regarding the GDR documentation for Depakote and Risperdal at which she replied, "I can't find them. I know its been done." The DON presented to the surveyors a Physician's Progress Notes sheet that stated the following in regards to the GDR:</p> <ul style="list-style-type: none"> * Psych history, marginally stable on current meds; and, * Not currently candidate for taper, expect deterioration if we did. 	F 329		

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NAME OF PROVIDER OR SUPPLIER CLEARWATER HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
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F 329	<p>Continued From page 43</p> <p>Resident #1 was admitted on 7/25/12 and there was no documentation that showed evidence a GDR had been attempted, nor was there a rational documented for not attempting a GDR until over a year later on 8/15/13.</p> <p>Resident #1's Care Conference Record documented in part: * 6/21/13 - Reason for assessment: GDR anti-psychotic; * 6/27/13 - Reason for assessment: GDR antidepressant; * 7/25/13 - Reason for assessment: GDR anti-psychotic and antidepressant; and, * 8/8/13 - Reason for assessment: GDR anti-psychotic.</p> <p>The Care Conference Record shows that GDR assessments were discussed. However, no further documentation was provided that indicated a GDR was attempted for the anti-psychotics or antidepressants.</p> <p>On 8/15/13 at 4:45 p.m., the Administrator, DON, and Administrative Assistant were informed of the GDR and behavior tracking issues. However, no further information or documentation was provided that resolved the issue.</p> <p>3. Resident #9 was admitted to the facility on 11/27/12, and readmitted on 4/12/13, with multiple diagnoses including mental disorder (not elsewhere classified), depressive disorder, and dementia.</p> <p>Resident #9's most recent quarterly MDS assessment, dated 5/22/13, coding included: * Severe cognitive impairment, with a BIMS score of 6;</p>	F 329			

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F 329	<p>Continued From page 44</p> <ul style="list-style-type: none"> * Usually understood by others and usually able to understand others; * Feeling tired/little energy for 2-6 days in the previous 2 weeks; * Trouble concentrating on things like reading/watching television for 2-6 days in the previous 2 weeks; and, * No delirium/hallucinations/delusions/behavioral symptoms. <p>The resident's recapitulation of Physician's Orders for August 2013 included the following medications for depression, Depakote 250 milligrams (mg) by mouth (PO) 2 times a day and Celexa 20 mg PO daily. The order date for both medications was 4/12/13.</p> <p>A Telephone Order (TO), dated 8/3/13, documented, "Depakote 250 mg P.O. [by mouth] [at] PM one time dose.</p> <p>Another TO, dated 8/5/13, included an order for Haldol 5 mg PO every 6 hours as needed for psychosis.</p> <p>The resident's "Anti-psychotic Medication Care Plan," dated 8/5/13, documented psychosis as a problem. Approaches/interventions included, "Observe for signs and symptoms, increase or decrease in behavior...Redirect as needed...Remove resident from situations causing anxiety..." The behavior signs and symptoms to observe for were not identified.</p> <p>The resident's "Mood Care Plan," also dated 8/5/13, documented the problem, "Sad, Apathetic, Anxious appearance[.] As Evidenced By: crying, paranoid delusions..." The goal was, "[Resident's name] will demonstrate an improved</p>	F 329		

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F 329	<p>Continued From page 45</p> <p>mood as evidenced by: [decrease] in crying [and] paranoid delusions." The approaches did not include to monitor for crying or paranoid delusions.</p> <p>The resident's "Behavior Management Care Plan," dated 8/12/13, documented the problem, "Other Behaviors[:] Picks at objects [and] Reaches for other residents chairs." Only 1 intervention/approach was documented. It was, "Help keep [resident's name] engaged in social activities, conversation, and interactions with staff and residents." Monitoring for "picks at objects" and "reaches for other residents chairs" was not included in the care plan.</p> <p>Resident #9's Behavior/Intervention Monthly Flow Records (B/IMFR) for June, July, and August 2013 documented the following behaviors were monitored and the number of episodes each behavior occurred: * June - self isolation (once), tearful crying (16 times on 5 different days), and delusional statements (none); * July - self isolation (none) and tearful crying (none); and, * August - self isolation (none) and confusion (17 times on 5 different days). Note: No other behavior monitor documentation was found in the resident's clinical record.</p> <p>On 8/15/13 at 1:00 p.m., when asked about behavior monitoring, including Haldol for psychosis, for Resident #9, the DON stated, "Haldol was recently started and the behavior should have been added to the behavior monitor." The DON stated she would get the current behavior monitor record.</p>	F 329			

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F 329	Continued From page 46 At 1:05 p.m., the DON returned with Resident #9's B/IMFR for August and stated, "The behavior was not on the current form." The DON added paranoid delusions to the resident's August B/IMFR. When asked why delusional statements were monitored in June but not in July or August, the DON stated, "I don't know why." The clinical record documentation revealed Resident #9 was not consistently monitored for delusional statements before or after Haldol was ordered on 8/5/13. In addition, there was no documented evidence that other behaviors, "picks at objects" and "reaches for other residents chairs" was monitored at all. On 8/15/13 at 4:45 p.m., the Administrator was also informed of the issue. However, no other information or documentation was received from the facility which resolved the issue.	F 329			
F 431 SS=E	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.	F 431			

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F 431	Continued From page 47 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 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed ensure medications were stored in locked areas and not accessible to residents. This was true for 1 of 2 medication carts which was left unlocked and unattended in a hallway. This created the potential for a negative affect for any cognitively impaired and independently mobile residents if they ingested the accessible medications. Findings included: On 8/13/13 from 8:40 a.m. to 8:45 a.m., 2 surveyors observed medication (med) cart B was unlocked and unattended while it was parked in the hallway near room 14. One surveyor easily opened 2 drawers on the left side and 2 drawers on the right side of the med cart before LN #1 returned to the med cart. Hundreds of	F 431	F-431 E 1. The medication cart was immediately locked when the licensed nurse became aware it was unlocked. The DCS immediately in-serviced the licensed nurse to lock the medication cart when not in direct contact with the cart. The licensed nurse is no longer employed by the facility. 2. The facility has two medication carts. The other cart was observed to be consistently locked when the licensed nurse was not in direct contact with cart. 3. Licensed nurses were in-serviced to keep the medication cart locked when not in direct contact with the cart. 4. The DCS / designee will conduct random audits to ensure medication carts are locked when the licensed nurse is not in direct contact with the cart weekly x 4 weeks, then monthly thereafter x 3 months. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance. 5. AOC <u>September 20, 2013</u>	

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F 431	Continued From page 48 prescription and other-the-counter medications were in the drawers. At 8:45 a.m., when LN #1 arrived at med cart B she pushed in the lock. When asked about the med cart, the LN confirmed it had been unlocked. LN #1 stated, "I usually make sure its locked. I was pulled [away] a lot this morning." On 8/15/13 at 4:45 p.m., the Administrator and DON were informed of the unlocked and unattended med cart. No other information was received from the facility regarding the issue.	F 431			
F 441 SS=D	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	F 441			

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F 441	<p>Continued From page 49</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined the facility failed to ensure staff performed hand hygiene after glove removal following contact with residents. This was true for 1 of 4 LNs (#4) and it involved 1 of 6 residents (#8) during medication pass observations. Failure to follow standard infection control measures placed residents at risk for infections. Findings included:</p> <p>On 8/13/13 at 9:50 a.m., LN #4 was observed as she poured, then administered, 8 oral medications and Humulin 70/30 insulin 24 units per subcutaneous injection for Resident #8. Before the insulin injection, the LN sanitized her hands and applied gloves. After the injection, the LN removed her gloves. However, the LN did not wash or sanitize her hands before she left the resident's room and returned to the medication cart.</p> <p>At about 9:55 a.m., LN #4 removed 1 fentanyl 25</p>	F 441	<p>F-441 D</p> <ol style="list-style-type: none"> 1. Resident # 8 has not sustained an adverse outcome related to the licensed nurse not performing hand hygiene between tasks. The licensed nurse was in-serviced by the DCS regarding hand hygiene during medication administration. The licensed nurse is no longer employed by the facility. 2. Other licensed nurses observed during medication administration performed proper hand hygiene. 3. Nursing staff were in-serviced on proper hand hygiene before and after resident contact and after glove removal. 4. The mock survey team will conduct random audits of staff performing proper hand hygiene during resident care 5x/week on Mock Survey rounds. The DCS/designee will conduct random weekly audit 4 x/week, then monthly thereafter to ensure staff perform proper hand hygiene during resident care. Results of the audit will be reported to the QAPI committee to ensure substantial compliance. 5. AOC <u>September 20, 2013</u> 	

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F 441	<p>Continued From page 50</p> <p>microgram patch from the medication cart for Resident #8. In the resident's room, the LN sanitized her hands and applied gloves before she administered the fentanyl patch to the resident's left upper back. After that, the LN removed the gloves. However, again the LN did not wash or sanitize her hands before she left the resident's room and returned to the medication cart.</p> <p>At 9:45 a.m., when asked about no hand hygiene after glove removal following the insulin injection and fentanyl patch administration for Resident #8, LN #4 nodded "Yes" and confirmed she had not performed hand hygiene either time.</p> <p>On 8/15/13 at 3:00 p.m., the DON was informed of the aforementioned observations regarding no hand hygiene after glove removal. The facility's policy regarding hand hygiene was requested at that time.</p> <p>On 8/15/13 at 4:45 p.m., the Administrator was also informed of the infection control issue.</p> <p>On 8/16/13 at 10:30 a.m., the DON provided a Hand Washing Technique policy and procedure which documented, in part, "Hands must be washed: ...After removal of gloves..."</p> <p>No other information was received from the facility which resolved the issue.</p>	F 441			

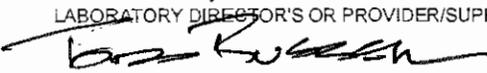
Bureau of Facility Standards

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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 cited during the annual state licensure survey of your facility. The survey team included: Nina Sanderson BSW LSW Linda Kelly RN Lauren Hoard BSN RN	C 000			
C 118	02.100,03,c,ii Available Services and Charges ii. Is fully informed, prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services not covered under Titles XVIII or XIX of the Social Security Act, or not covered by the facility's basic per diem rate; This Rule is not met as evidenced by: Please see F 156 as it pertains to notification of rights upon admission.	C 118	<p>RECEIVED</p> <p>SEP 13 2013</p> <p>FACILITY STANDARDS</p> <p>Refer to F156</p>		
C 119	02.100,03,c,iii Informed of Medical Condition by Physician iii. Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and	C 119			

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9/10/13
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C 119	Continued From page 1 to refuse to participate in experimental research; This Rule is not met as evidenced by: Please see F 155 as it pertains to advanced directives and surrogate decision making.	C 119	Refer to F155	
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: Please see F 329 as it pertains to psychotropic medication use.	C 147	Refer to F329	
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: Please see F 157 as it pertains to family notification.	C 155	Refer to F157	
C 644	02.150,01,a,i Handwashing Techniques	C 644		

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C 644	Continued From page 2 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 as an infection control measure.	C 644	Refer to F441	
C 779	02.200,03,a,i Developed from Nursing Assessment i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Please see F 272 as it pertains to completion of assessments.	C 779	Refer to F272	
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 care plan revisions.	C 782	Refer to F280	
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:	C 784	Refer to F246	

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C 784	Continued From page 3 Refer to F246 as it relates to equipment storage.	C 784		
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F309 as it relates to following physician's orders.	C 788	Refer to F309	
C 795	02.200,03,b,xi Bowel/Bladder Evacuation/Retraining xi. Bowel and bladder evacuation and bowel and bladder retraining programs as indicated; This Rule is not met as evidenced by: Refer to F315 as it related to incontinence.	C 795	Refer to F315	
C 838	02.201,02,I Secure Storage of Medications i. All medications in the facility shall be maintained in a locked cabinet located at, or convenient to, the nurses' station. Such cabinet shall be of adequate size, and locked when not in use. The key for the lock of this cabinet shall be carried only by licensed nursing personnel and/or the pharmacist. This Rule is not met as evidenced by: Refer to F431 as it related to medication storage.	C 838	Refer to F431	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001140	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/16/2013
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NAME OF PROVIDER OR SUPPLIER CLEARWATER HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544
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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) COMPLETE DATE
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C 856	Continued From page 4	C 856		
C 856	02.201,04,c Documentation of Use and Results	C 856		
	<p>c. Reasons for administration of a PRN medication and the patient's/resident's response to the medication shall be documented in the nurse's notes.</p>		Refer to F329	
	<p>This Rule is not met as evidenced by: Refer to F329 as it relates to monitoring medication effects.</p>			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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September 25, 2013

Todd A. Russell, Administrator
Clearwater Health & Rehabilitation
1204 Shriver Road
Orofino, ID 83544-9033

Provider #: 135048

**RE: COMPLAINT FINDINGS FOR CLEARWATER HEALTH &
REHABILITATION**

Dear Mr. Russell:

On **August 16, 2013**, a Complaint Investigation survey was conducted at Clearwater Health & Rehabilitation. Nina Sanderson, L.S.W., Linda Kelly, R.N. and Lauren Hoard, R.N. conducted the complaint investigation.

Information reviewed included: hospital physician's progress notes from September 21, 2012 through October 4, 2012, October 31, 2012 and November 4, 2012; physician's orders when the resident was admitted to the facility on October 31, 2012; laboratory results from the aforementioned hospital stays, as well as labs drawn while the resident was in the facility; facility nurse's notes, Medication Administration Records and Treatment Administration Records and the resident's admission agreement documentation.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005852

ALLEGATION #1:

The complainant stated an identified resident was not assessed as having an acute change in his

condition. The facility refused to call emergency services for the resident, leaving the resident's family to summon emergency transport for the resident. The resident died later that day, at the hospital.

FINDINGS:

The facility documented an assessment of the resident at the time he experienced a change in condition; however, documentation indicated that before the assessment could be completed and the physician notified of the results, the resident's family called emergency services to transport the resident to the acute care hospital. The resident had several significant underlying chronic health conditions. Labs drawn in the facility on November 2, 2012, and labs drawn at the hospital on November 4, 2012, indicated deterioration in the resident's renal function in that timeframe. However, by later that evening, the resident was in acute renal failure, which was listed as his cause of death.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated an identified resident received the medication Norco, which would have been contraindicated given the identified resident's history with alcohol use.

FINDINGS:

The physician's orders admitting the identified resident to the facility included orders for Norco as needed for pain, stemming from an acute pelvic fracture. The resident was noted to receive the Norco per his request, approximately twice per day from October 31, 2012, through November 3, 2012.

There was one mention in the resident's physicians progress notes of remote alcohol use on the part of the resident, but no indication that this was a current problem or that the resident's past alcohol use was contraindicated for the use of Norco for pain control after an acute fracture.

After the resident was admitted to the acute care hospital, there was documentation the physician onsite had a dialogue with the identified resident's family members regarding the need for adequate pain control for the resident's acute fracture, even if the resident was more confused or groggy as a result. The resident was documented to have received Norco approximately 14 hours prior to his change in condition.

Todd A. Russell, Administrator
September 25, 2013
Page 3 of 3

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated an identified resident did not complete admission paperwork prior to receiving services in the facility, or at any point after the resident was admitted.

The complainant stated after the identified resident passed away in the hospital, the admission paperwork for the facility was sent to a family member to complete and sign.

FINDINGS:

This allegation was substantiated and the facility was cited at F156 and C118.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

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

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

Sincerely,

A handwritten signature in cursive script that reads "Loretta Todd".

LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj