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
FAX 208-364-1888

CERTIFIED MAIL: 7012 1010 0002 0836 4117

September 4, 2014

Joseph Rudd, Administrator
Apex Center
8211 Ustick Road
Boise, ID 83704-5756

Provider #: 135079

Dear Mr. Rudd:

On **August 20, 2014**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **May 12, 2014**. However, based on our on-site follow-up revisit conducted **August 20, 2014**, we found that your facility is not in substantial compliance with the following participation requirements:

F0157 -- S/S: D -- 483.10(b)(11) -- Notify Of Changes (injury/decline/room, Etc)
F0281 -- S/S: D -- 483.20(k)(3)(i) -- Services Provided Meet Professional Standards
F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
F0314 -- S/S: G -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores

In addition, a Complaint Investigation survey was conducted in conjunction with the on-site follow-up.

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. WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. **Please provide ONLY ONE completion date for each federal and state tag in column X5 (Complete Date), to signify when you allege that each**

tag will be back in compliance. After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your copy of the Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 17, 2014**.

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

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;

- How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:

  a. Specify by job title who will do the monitoring.
     * It is important that the individual doing the monitoring have the appropriate experience and qualifications for the task.
     * The monitoring cannot be completed by the individual(s) whose work is under review.

  b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3.
     * A plan for "random" audits will not be accepted.
     * Initial audits must be more frequent than monthly to meet the requirement for the follow-up.

  c. Start date of the audits;

- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- 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.*

As noted in the letter of **April 11, 2014**, following the **Recertification, Complaint Investigation and State Licensure** survey of **April 11, 2014**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **October 11, 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.

STATE ACTIONS effective with the date of this letter (**September 4, 2014**):

IDAPA 16.03.02.003.05.b.v.(b) states:

d. A major deficiency is defined as:

(b) Repeat violation of any requirement of these rules, regulation and minimum standards of Idaho law.

At this survey, the facility had one (1) repeat deficiency from the **Recertification, Complaint Investigation and State Licensure** survey of **April 11, 2014**.

C0789 -- Prevention Of Decubitus

IDAPA 16.03.02.02.200.03.b.v

If you believe the 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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:

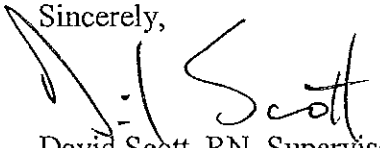
- BFS Letters (06/30/11)

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

This request must be received by **September 17, 2014**. If your request for informal dispute resolution is received after **September 17, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the on-site follow-up revisit. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



David Scott, RN, Supervisor
Long Term Care

DJS/lj

Enclosures

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

PRINTED: 09/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135079		R-C 08/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

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{F 000}	INITIAL COMMENTS The following deficiencies were cited during the onsite follow up and complaint survey of your facility. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Lorraine Hutton, RN The survey team entered the facility on August 18, 2014 and exited on August 20, 2014. Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing DNS = Director of Nursing LN = Licensed Nurse LTC = Long Term Care MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = Milligram ML = Milliliters PRN = As Needed TAR = Treatment Administration Record	{F 000}	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis Healthcare - Apex Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
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	F 157	RECEIVED SEP 19 2014 FACILITY STANDARDS **F157 – NOTIFY OF CHANGES** **RESIDENT SPECIFIC** Resident #27 discharged on 5/16/14 and no longer resides	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 91914

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 157	Continued From page 1 deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157	in this facility. Resident #3 discharged on 6/21/14 and no longer resides in this facility. **OTHER RESIDENTS** Review of current residents admitted since 8/1/14 was conducted by Nurse Managers on or before 9/22/14 to ensure bowel care orders were obtained and that MD and families notified as indicated through review with new orders obtained and noted as needed.	
	The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to notify the resident's physician when: -A resident was admitted to the facility without bowel care orders and did not have a bowel movement (BM) for 4 days; -A resident was admitted to the facility without orders or instructions on how to care for a surgical wound; -A resident's pressure sore on the coccyx worsened; and, This was true for 2 of 11 (#s 3 & 27) sampled residents. This had the potential for harm when		Review of current residents admitted since 8/1/14 was conducted by Nurse Managers on or before 9/22/14 to ensure residents with surgical incisions had treatment orders in place and that MD and families were notified as indicated through review with new orders	

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F 157	Continued From page 2 the residents' physicians were not able to make decisions based on the residents' needs. Findings included: 1. Resident #27 was admitted on 5/10/14 with multiple diagnoses including orthopedic aftercare for Lumbar 4 through Lumbar 5 (L4-L5) decompression of the lumbar spine and difficulty in walking.	F 157	obtained and noted as needed. Current residents were reviewed by Nurse Managers on or before 9/22/14 for alteration in skin integrity. MD was notified of findings at time of review with new orders obtained and care plans updated as applicable; and families were also notified by the Licensed Nurse of new findings and orders as indicated through assessments at time of review.	
	a. The resident's facility admission Interdisciplinary Progress Note (IPN) dated 5/10/14 by LN #1, documented, "Last BM 5/6/14. Hospital reported res[ident] has refused suppository, but has take [sic] PO [by mouth] bowel care." Upon review of the resident's medical record there was no documentation found of physician notification regarding the resident's lack of a BM for 4 days or the lack of bowel care orders. On 8/19/14 at 4:00 PM, the DON was interviewed with the Manager of Clinical Operations (MCO) present, regarding the lack of physician notification. When asked if the nurse notified the physician upon learning the resident had not had a BM in 4 days. The DON said the nurse did not "communicate that." When asked what the admission nurse should have done in this situation, she said the nurse should have notified the doctor. On 8/20/14 at 9:45 AM, LN #1 was interviewed, with the Administrator, DON and MCO present, regarding the physician notification issue. When asked after knowing the resident did not have a BM for 4 days and had refused a suppository, why she didn't notify the doctor, she stated, "I		FACILITY SYSTEMS Systemic Changes: Interact III SBAR- a nationally recognized communication and progress note form used for documentation of changes in condition which includes alteration in skin integrity and provides an area to prompt and document physician and family notification was implemented on or before 9/22/14 for nursing staff.	

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F 157	Continued From page 3 knew she had bowel care" in the hospital and was going to wait and see if the resident had a bowel movement. On 8/21/14, the facility faxed additional documentation which documented: "Idaho Bureau of Facility Standards alleged on 8/20/14 that the facility failed to notify MD of constipation...The facility feels they remained in substantial compliance with F157 and F309 as evidenced by the patient had no complaints of bowel issues...the patient receive [sic] the appropriate bowel care in the hospital prior to admitting and was assessed by facility nurse and MD after admission and ongoing assessments with no negative outcomes." Note: The facility failed to notify the physician regarding the resident's bowel care issues and lack of bowel care orders, not about any outcomes associated with the lack of the notification. Refer to F309 regarding the lack of bowel care. b. Resident #27's Admission Nursing Assessment dated 5/10/14 at 2:30 PM, documented a handwritten note under the Integumentary/Feet section of the form, "Surgical incision site." The human diagram on the form contained a handwritten circle in the middle back region. The resident's Admission IPN dated 5/10/14 documented, "Res. has a surgical incision down the middle of her back that is intact [with] steri-strips. Res. had spinal infusion of L4-5." Upon review of the resident's medical record there was no documentation found of physician notification regarding how to treat the surgical site	F 157	A New Admission Record Review form, a form which includes an area to validate bowel care regimen orders were obtained, notification of physician and family regarding bowel regimen and alteration in skin integrity to include surgical incisions and ensure orders are in place as applicable for new admissions was implemented on or before 9/22/14 for use by the Nurse Managers for the post-admission review of new admissions. Findings during reviews will be corrected by the Nurse Manager or designee at that time. Beginning on or before 9/22/14 the 24hr report will be read during morning clinical meeting to the clinical interdisciplinary team with record review. This process is to ensure timely family and physician notifications were made, orders were obtained as	

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F 157	Continued From page 4 or the dressing, if any, to cover the site. The resident's IPN documented the following: "5/11/14, 3:00 PM, Incision on back dsg [dressing] C/D/I [clean, dry, intact]; 5/13/14, 4:25 AM, Dsg CDI to back; 5/16/14, 2:00 PM, Wound to back clean [with no] S/SX [signs or symptoms] of infection. Steri strips in place. Dsg applied." Refer to F309 regarding the lack of physician orders for the surgical site. On 8/20/14 at 1:15 PM, the DON was interviewed with the Administrator and Manager of Clinical Operations (MCO) present, regarding the resident's surgical site. The DON reviewed the resident's medical record and was asked if the physician had an order on how to treat the site; she stated, "Not that I can see." When asked if the physician was notified regarding the lack of direction regarding the site, she said staff did not notify the physician. On 8/21/14, the facility faxed additional information which documented: "The facility feels they remained in substantial compliance with F 157...Please review the following documentation: MD note dated 8/21/14, and laminectomy after care instructions provided by the surgeon's office." Note: The after care instructions by a local surgeon's office mentioned, were not found in the resident's medical record during the survey from 8/18-8/20/14 and documented a faxed time stamp with a date of 8/21/14, a day after the survey ended, and 3 months and 11 days after the resident was admitted. Additional faxed information from the facility on	F 157	applicable, effectiveness of intervention, and potential modifications to the care plan for those residents. Findings will be corrected by the Nurse Manager or designee at that time. Nurse Managers and IDT members were educated on the SBAR tool by the Director of Nursing or designee on or before 9/22/14 Nursing staff were educated on or before 9/22/14 by the Director of Nursing or designee on the facility's new admission checklist and communication system process including use of the 24 hour shift report to communicate changes and assessment to support prompt and consistent notifications of MD and family or responsible party regarding, but not limited to, obtaining orders for bowel care regimen at time of admission, missed bowel movements per orders and	

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F 157	Continued From page 5 8/21/14, documented: "The standard of care for Steri-Strips to a surgical site or wound is to monitor the area for signs and symptoms or infection and to keep the strips in place until they fall off on their own. The application of a clean, dry dressing over the top of the strips, as long as the wound is monitored for signs and symptoms of infection, is inconsequential in the healing and treatment process, does not require a physician order, and in no way jeopardizes the healing process or otherwise place the patient at risk." Note: Perry and Potter Clinical Nursing Skills [and] Techniques 7th Edition, documented on page 979, "Do not remove an initial surgical dressing...until a physician writes an medical order for the removal." The additional documentation did not resolve the concerns regarding the lack of physician notification related to bowel care and a surgical wound site. 2. Resident #3 was admitted to the facility on 11/19/13 with diagnoses including encephalopathy, Alzheimers disease, dementia with behavioral disturbances, muscular wasting and disuse, and difficulty in walking. The resident's admission Nursing Assessment, dated 11/19/13, documented the resident had a dime sized blister/pressure ulcer on her coccyx. The resident's admission MDS assessment, dated 11/26/13, documented the resident was at risk for skin breakdown and had a Stage I and a Stage II pressure ulcer present on admission. The resident was triggered for skin and ulcer treatments including a pressure reducing device for the bed, turning/repositioning program, and	F 157	policy, obtaining orders/instruction on surgical wounds, changes of condition, and changes in alteration of skin integrity. **MONITORS** Beginning the week of 9/22/14, Director of Nurses or designee will conduct an audit of five new admissions and or change of condition records and compile the findings weekly for 4 weeks then monthly x 2 months, to ensure that timely physician and family notifications were made and orders obtained as required for new admissions and or residents with changes in condition to include but not limited to, bowel care orders and treatment orders for surgical incisions obtained on admission and administered as ordered, and to ensure that documented findings of the skin inspections including timely physician and family notification with orders as required are noted in the medical record as indicated.	

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F 157	Continued From page 6 ulcer care. Subsequent quarterly MDS assessments, dated 1/13/14 and 5/3/14, documented the resident no longer had unhealed pressure ulcers but continued to be at risk for skin breakdown. The resident's nursing notes (NNs) found on the Interdisciplinary Progress Note forms, and the resident's care plans, assessments, and physician orders, for 5/1/13 through 5/16/14, documented no issues with skin breakdown or pressure ulcers until 5/17/14. On 5/17/14, LN #2 made a late entry on the resident's NNs that documented she had observed signs of skin breakdown on the resident's coccyx 5/9, 5/10, and 5/12. LN #2 documented, "This RN [#2] saw resident skin on 5/9/14 and noted a sluggishly blanching spot on her upper coccyx [with a] 0.1 x 1 cm [centimeter] open area that appeared over scar tissue. Staff continued to utilize barrier cream. On 5/10/14 resident also re-assessed and [continued] to be sluggishly blanching... Initiated encouraging resident to lay down between meals, documented on TAR, also initiated resident to be only side to side while in bed. Checked on 5/12/14 by this RN and DNS, remained sluggishly blanching and a macerated center and hard tissue underneath thought to be scar tissue." The 5/17/14 nursing note further documented, "Area assessed today and noted area measuring 1.5 cm X 1.8 cm edges macerated health skin surrounding center non-blanching discoloration [with] hard tissue felt underneath..." There was no evidence in the resident's medical record that the resident's primary care provider was notified of the skin breakdown on 5/9: the record documented that the resident's primary care provider was not	F 157	Findings will be corrected with re-education and performance evaluations as indicated. The Administrator will review audits and education weekly to ensure follow up, to correct potential findings and root cause to ascertain trends in staff performance or need for process changes as required. The compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Committee Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance. **Date of Compliance** **9/23/2014**	

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F 157	Continued From page 7 notified of the skin breakdown until 5/17/14. On 8/19/14 at 3:25 PM, the DON was interviewed and she agreed that the resident's primary care provider had not been notified of the skin breakdown until 5/17/14.	F 157		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure licensed nurses (LNs) monitored and documented the skin conditions of residents with pressure ulcers. This was true for 2 of 4 residents reviewed (#s 3 & 29) for pressure ulcers. The failure to document skin conditions, irregularities and changes resulted in residents not receiving immediate care and services needed to prevent further skin breakdown and pressure ulcers. Findings include: Perry & Potter's, Clinical Nursing Skills & Techniques, 7th Edition, 2010, page 387 documented, "Nurses need to indicate all assessments, interventions, instructions, and referrals in the medical record..." AHIMA (American Health Information Management Association), LTC Health Information & Practice Guidelines, Version 1.0, provides standards of health care documentation. * Section 5.1 stated the medical record provides " ... a view of the resident's health history - in other	F 281	**F281 – SERVICES PROVIDED MEET PROFESSIONAL STANDARDS** **RESIDENT SPECIFIC** Resident #3 discharged on 6/21/14 and no longer resides in this facility. Resident #29 received a head to toe skin inspection by a licensed nurse on 8/27/14 with findings documented in the medical record to include MD and family notification of findings at time of assessment. New physician orders received and implemented by licensed nurse at the time of the assessment. **OTHER RESIDENTS** Current residents were reviewed by Nurse Managers on or before 9/22/14 for risk areas, changes or alteration in skin integrity. The MD was notified of findings at the time of review with new	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 8 words, it provides, a record of the resident's health status including observations, measurements, history and prognosis, and serves as the legal document describing the health care services provided to the patient," and "the record should describe the services provided the resident, document the resident's response to care and changes made to the plan of care," and provide provide a method of clinical communication and care planning among the individual health care providers serving the client. * Section 5.2.3.1 Timeliness of Entries documented, "Entries should be made as soon as possible after an event or observation is made." * Section 5.2.3.2 Pre-dating and back-dating documented, "It is both unethical and illegal to pre-date or back-date an entry. Entries must be dated for the date and time the entry is made...If pre-dating or back-dating occurs it is critical that the underlying reason be identified to determine whether there are system failures. The cause must be evaluated and appropriate corrective action implemented." 1. Resident #3 was admitted to the facility on 11/19/13 with diagnoses including including encephalopathy, Alzheimer's disease, dementia with behavioral disturbances, muscular wasting and disuse, and difficulty in walking. The resident's admission Nursing Assessment, dated 11/19/13, documented the resident had a dime sized blister/pressure ulcer on her coccyx. The resident's admission MDS assessment, dated 11/26/13, documented the resident was at risk for skin breakdown and had a Stage I and a Stage II pressure ulcer present on admission. Subsequent quarterly MDS assessments, dated	F 281	orders obtained as indicated and documented in medical records by the Licensed Nurse. Families were notified of findings and new orders received at the time of review by the licensed nurse. MD orders were implemented as indicated by the licensed nurse. **FACILITY SYSTEMS** Systemic Changes: Interact III SBAR- a nationally recognized communication and progress note used for documentation of changes in condition which includes alteration in skin integrity and provides an area to prompt and document physician and family notification was implemented on or before 9/22/14 for nursing staff. A New Admission Record Review form, a form which includes an area to validate bowel care regimen orders were obtained, notification of physician and family	

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	135079		R-C 08/20/2014

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F 281	Continued From page 9 1/13/14 and 5/3/14, documented the resident no longer had unhealed pressure ulcers but continued to be at risk for skin breakdown. The resident's nursing notes (NNs) found on the Interdisciplinary Progress Note forms, and the resident's care plans, assessments, and physician orders, for 5/1/13 through 5/16/14, documented no issues with skin breakdown or pressure ulcers until 5/17/14. On 5/17/14, LN #2 made a late entry on the resident's NNs that documented she had observed signs of skin breakdown on the resident's coccyx 5/9, 5/10, and 5/12. LN #2 documented, "This RN [#2] saw resident skin on 5/9/14 and noted a sluggishly blanching spot on her upper coccyx [with a] 0.1 x 1 cm [centimeter] open area that appeared over scar tissue. Staff continued to utilize barrier cream. On 5/10/14 resident also re-assessed and [continued] to be sluggishly blanching...Initiated encouraging resident to lay [sic] down between meals, documented on TAR, also initiated resident to be only side to side while in bed. Checked on 5/12/14 by this RN and DNS, remained sluggishly blanching and a macerated center and hard tissue underneath thought to be scar tissue." The 5/17/14 nursing note further documented, "Area assessed today and noted area measuring 1.5 cm X 1.8 cm edges macerated healthy skin surrounding center non-blanching discoloration [with] hard tissue felt underneath..." The nursing entry ended by documenting the resident's daughter and nurse practitioner were notified. The resident's medical record for the 8 days between 5/8/14 and 5/16/14, did not meet standards of practice for documenting resident's	F 281	regarding bowel regimen and alteration in skin integrity to include surgical incisions and ensure orders are in place as applicable was implemented on or before 9/22/14 for use by the Nurse Managers for post-admission reviews of new admissions. Findings will be corrected by the Nurse Manager or designee at that time. Beginning on or before 9/22/14 the 24hr report will be read during morning clinical meeting to the clinical interdisciplinary team with record review to ensure timely family and physician notifications were made, orders obtained as applicable, effectiveness of intervention, and potential modifications to the care plan. Findings will be corrected by the Nurse Manager or designee at that time. Nurse Managers and IDT members were educated on	

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F 281	Continued From page 10 health status and reporting health changes to the physician. The record did not contain: * NNs documenting LN #2's observations of the resident's coccyx on 5/9, 5/10, or 5/12 or instructions given to staff to safeguard against further breakdown. Any other LN documentation regarding monitoring the coccyx wound for the 8 days between 5/9/14 and 5/16/14. * Evidence that the resident's medical care provider was notified of skin breakdown prior to 5/17/14. * DNS documentation that the resident's skin was observed by her on 5/12/14 and any care directions provided to staff. On 8/19/14 at 3:25 PM, the DNS was interviewed. During the interview the DNS agreed LN #2 had not documented the resident's observed skin condition on 5/9, 5/10, or 5/12 and there were no other NNs indicating observation and monitoring of the coccygeal wound by facility LNs between 5/9/14 and 5/16/14. During this interview, the DNS was also asked if she documented her observation of the resident and any instructions given to staff on 5/12/14 and she stated, "No." When asked if she had checked the resident's care plan or ensured the information had been passed on to other shifts, the DNS said, "No." 2. Resident #29 was admitted to the facility on 6/16/14 with diagnoses including encephalopathy, malignant neoplasm of brain and spinal cord, malignant neoplasm of the breast, shortness of breath, anxiety, and depression. The resident's admission nursing assessment, dated 6/16/14, documented the resident was alert	F 281	the system changes by the Director of Nursing or designee on or before 9/22/14. Licensed nurses have been educated on or before 9/22/14 by the Director of Nursing or designee regarding documentation and scope of practice standards including necessity of timely documentation and physician notification; including, but not limited to, skin inspection findings and changes of condition. Licensed Nurses will also be educated on facility policies regarding documentation errors and omissions, as well as completion of the SBAR as part of the assessment and physician notification, monitoring and communication processes. **MONITORS** Beginning the week of 9/22/14, Nurse Managers will complete a follow-up skin inspection, after the weekly skin inspection is	

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F 281	Continued From page 11 and oriented to person place and time and situation, had poor decision making skills and required supervision, used a wheelchair independently, and her skin was intact. Resident #29's admission assessment, dated 6/22/14, documented the resident was at risk for skin breakdown though she had no unhealed pressure ulcers at the time of admission.	F 281	completed by the licensed nurse to validate the competency of the licensed staff. These observations will include at least five residents and an audit of documentation of their scheduled skin inspections weekly for 4 weeks then monthly x 2 months, to ensure accurate evaluation, timely physician and family notifications, treatment orders obtained as required and monitoring to include description and measurements if applicable are documented in medical record at time of identification and with changes or alterations. Findings will be corrected and reported to the Director of Nurses. The Administrator will review audit results and education weekly to ensure follow up, to correct findings and root cause as well as to ascertain trends in staff performance, or need for	
	The resident's CAA worksheet for pressure ulcers, completed on 6/27/14, documented the resident was at risk for skin breakdown due to the following conditions: * The resident was ordered medications that could increase the risk for pressure ulcers, including antipsychotic's, antidepressants, antianxiety medications, steroids and narcotics. * The resident had diagnoses and conditions which presented complications or increased risk for pressure ulcers, including cancer, depression, terminal illness, pain, and edema. A 5/12/14 late entry NN by the DNS, documented a 3 cm x 3 cm clear fluid pocket was found on Resident #29's left heel on 5/11/14. The NN documented the resident's daughter reported on 5/10/14 that the resident had removed a hard layer of dry skin from her left heel. The daughter stated the blister was not there the night of 5/10/14 after the resident removed the dry skin. An Event Investigation Interview Record, signed by LN #5 on 8/12/14, documented, "On Sunday (8/10/14) [at approximately 7:30 pm] Resident's daughter asked me to look at her mother's foot. When [Resident] told me that she had been picking a callous [sic] on her left lower heel. Her skin was very dry. Her skin where the callus had			

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F 281	Continued From page 12 been was intact [with no signs or symptoms] of bleeding or any drainage noted." LN #5's 8/10/14 observation of the resident's feet, observation and assessment of the skin under the removed callus, actions taken to protect the skin under the removed callus, or education with the resident and daughter were not documented in the resident's chart until 8/12/14; the 8/10/14 observations were documented by the DNS for LN #5 on 8/12/14. In addition, there was no indication either by NNs, Physician's Orders, or Faxes to/from the physician, that LN #5 notified the resident's primary care physician or hospice agency of the incident on 8/10/14.	F 281	process changes as required. The compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Committee Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance. **Date of Compliance** **9/23/2014**	
{F 309} SS=D	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 record review and staff interview, it was determined the facility failed to ensure bowel care was ordered for a resident who had not had a bowel movement for 7 days and also failed to ensure physician's orders were in place for a dressing which covered a surgical dressing changes. This was true for 1 of 11 (#27) sample	{F 309}	**F309 – PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **RESIDENT SPECIFIC** Resident #27 discharged on 5/16/14 and no longer resides in this facility. **OTHER RESIDENTS** Review of current residents admitted since 8/1/14 was conducted by Nurse Managers on or before 9/22/14 to ensure bowel care orders were obtained and that MD and families notified as indicated	

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{F 309}	Continued From page 13 residents. These failed practices created the potential for harm if the resident did not receive appropriate treatment for their specific conditions. Findings included: Resident #27 was admitted on 5/10/14 with multiple diagnoses including orthopedic aftercare for Lumbar 4 through Lumbar 5 (L4-L5) decompression of the lumbar spine and difficulty in walking. A physician's progress note dated 5/13/14, documented the resident's care in the facility, "Apparently she has been upset since she has been here, is not getting the care that she thinks she should have and has had complaints about the nursing staff." a. Resident #27's local hospital records found in the resident's facility chart, documented physician orders for bowel care: *5/6/14- Sennosides 17 MG 2 tablets by mouth twice a day; *5/7/14- Magnesium Hydroxide (Milk of Magnesia) up to 30 ML by mouth daily for constipation; *5/8/14- Magnesium Citrate 150 ML by mouth as needed; and, *5/8/14- Bisacodyl 10 MG suppository every 12 hours until a BM (bowel movement). The resident's facility admission Interdisciplinary Progress Note (IPN) documented by LN #1 dated 5/10/14, documented, "Last BM 5/6/14. Hospital reported res[ident] has refused suppository, but has take [sic] PO [by mouth] bowel care." Upon review of the resident's medical record, the facility's admission orders did not include bowel	{F 309}	through review with orders obtained and noted as needed. Review of current residents admitted since 8/1/14 was conducted by Nurse Managers on or before 9/22/14 to ensure residents with surgical incisions had treatment orders in place and that MD and families were notified as indicated through review with orders obtained and noted as needed. Current residents were reviewed by Nurse Managers on or before 9/22/14 for alteration in skin integrity to assist in achieving the highest practicable level of well-being.-MD was notified of findings at time of review with new orders obtained and care plans updated as applicable; and families were also notified by the Licensed Nurse of new findings and orders at time of review. **FACILITY SYSTEMS** Systemic Changes: Interact III SBAR- a	

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{F 309}	Continued From page 14 care instructions or bowel medication orders. Note: The resident had four bowel care medications while in the hospital immediately prior to the resident's admission to the facility. The resident's May 2014 Recapitulation orders dated 5/10/14 documented, "Hydrocodone-Acetaminophen-by mouth...5-325 MG...Give 2 tabs PO, PRN [as needed] Q[every] 2 h[ou]rs-Severe Pain." The resident's May 2014 MAR documented the resident received 7 doses from 5/10/14 to 5/12/14. On 5/12/14 the order was changed from PRN to "every four hours everyday." Note: The 35th Edition Nursing 2015 Drug Handbook on page 705, documented one of the potential adverse reactions for Hydrocodone was constipation. The resident's May 2014 MAR documented a physician's order dated 5/13/14: "Bowel Care: If no bowel movement in 48 hours, give Milk of Magnesia, or hot liquids, or prune juice. If no bowel movement in 72 hours give Milk of Magnesia or Dulcolax Suppository. If no bowel movement in over 72 hours, MUST notify MD and obtain applicable orders." The resident's IPN dated 5/14/14 at 6:10 PM documented, "MOM [Milk of Magnesium] given this AM results pending." The resident's May 2014 ADL Record documented the resident did not have a bowel movement until 5/14/14, 4 days after the resident was admitted to the facility, 3 days after bowel care orders were implemented and 8 days after the resident's last bowel movement. On 8/19/14 at 4:00 PM, the DON was interviewed	{F 309}	nationally recognized communication and progress note form used for documentation of changes in condition which includes alteration in skin integrity and provides an area to prompt and document physician and family notification was implemented on or before 9/22/14 for nursing staff. A New Admission Record Review form, a form which includes an area to validate bowel care regimen orders were obtained, notification of physician and family regarding bowel regimen and alteration in skin integrity to assist in achieving the highest practicable level of well-being, to include surgical incisions and ensure orders are in place as applicable was implemented on or before 9/22/14 for use by the Nurse Managers in the post-admission review of new admissions. Findings will be corrected by the Nurse Manager or designee at that	

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{F 309}	Continued From page 15 with the Manager of Clinical Operations (MCO) present, regarding the bowel care issues. She was asked if there were orders for bowel care prior to 5/13/14 and she stated, "No." When asked what the admission nurse should do if a resident was on pain medications but did not have bowel care orders, she stated, "You would notify the doctor." On 8/20/14 at 9:45 AM, LN #1 was interviewed, with the Administrator, DON and MCO present, regarding the bowel care issues. When asked about bowel care, she said she knew the hospital had given the resident bowel medications by mouth prior to discharge and LN #1 had offered the resident a suppository, but the resident refused. When asked if the offer was documented, she stated, "I did not put a note in there." When asked after knowing the resident did not have a BM for 4 days and had refused a suppository, why she didn't notify the doctor, she stated, "I knew she had bowel care," in the hospital and was going to wait and see if the resident had a bowel movement. Note: There was not a physician's order for a bowel suppository or bowel care upon admission. When asked if she informed other nursing staff about the resident's bowel issues when she left for the day, she stated she had but, "I don't remember putting it on," the 24 hour report. Refer to F157 regarding the lack of doctor notification. b. Resident #27's Admission Nursing Assessment dated 5/10/14 at 2:30 PM, documented a handwritten note under the Integumentary/Feet section of the form, "Surgical incision site." The human diagram on the form contained a handwritten circle in the middle back	{F 309}	time. Beginning on or before 9/22/14 the 24hr report will be read during morning clinical meeting to the clinical interdisciplinary team with record review to ensure timely family and physician notifications were made, orders were obtained as applicable, effectiveness of intervention, and potential modifications to the care plan for those residents who have had a change or occurrence which has the potential for requiring physician intervention to ensure physician and family notification. Findings will be corrected by the Nurse Manager or designee at that time. Nurse Managers and IDT members were educated on the system changes by the Director of Nursing or designee on or before 9/22/14. Nursing staff were educated	

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{F 309}	Continued From page 16 region. The resident's Admission IPN dated 5/10/14 documented, "Res. has a surgical incision down the middle of her back that is intact [with] steri-strips. Res. had spinal infusion of L4-5." Upon review of the resident's medical record, there were no physician orders or instructions regarding the surgical site or the surgical dressing which covered the site. Refer to F157 regarding physician notification. The resident's IPN documented the following: "5/11/14, 3:00 PM, Incision on back dsg [dressing] C/D/I [clean, dry, intact]; 5/13/14, 4:25 AM, Dsg CDI to back; 5/16/14, 2:00 PM, Wound to back clean [with no] S/SX [signs or symptoms] of infection. Steri strips in place. Dsg applied." On 8/20/14 at 1:15 PM, the DON was interviewed with the Administrator and Manager of Clinical Operations (MCO) present, regarding the resident's surgical site. The DON reviewed the resident's medical record and was asked about the care of the wound and she said the progress notes indicated the site was intact with steri-strips. When asked if the physician had an order on how to treat the site, she stated, "Not that I can see." Note: On 5/16/14 the IPN documented a new dressing was applied to the site, without a physician's order. On 8/21/14, the facility faxed additional documentation which documented: "The facility feels they remained in substantial compliance with F157 and F309 as evidenced by the patient had no complaints of bowel issues or	{F 309}	on or before 9/22/14 by the Director of Nursing or designee on the facility's new admission review process, communication system process including use of the 24 hour shift report to communicate changes and assessment findings and the use of the SBAR tool from Interact III to support prompt and consistent notifications to MD and family or responsible party regarding, but not limited to, obtaining orders for bowel care regimen at time of admission, missed bowel movements per orders and policy, obtaining orders/instruction on surgical wounds, changes of condition, and changes in alteration of skin integrity. **MONITORS** Beginning the week of 9/22/14, Director of Nurses or designee will conduct an audit of five new admissions and or change of condition records and compile the findings weekly for 4 weeks then monthly x 2 months, to	

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{F 309}	Continued From page 17 incision site, the patient receive [sic] the appropriate bowel care in the hospital prior to admitting and was assessed by facility nurse and MD after admission and ongoing assessments with no negative outcomes. Please review the following documentation: MD note dated 8/21/14, and laminectomy after care instructions provided by the surgeon's office." Note: The after care instructions by a local surgeon's office mentioned, were not found in the resident's medical record during the survey from 8/18-8/20/14 and documented a faxed time stamp with a date of 8/21/14, a day after the survey ended, and 3 months and 11 days after the resident was admitted. Additional documentation also included a telephone statement from the physician documented by facility staff on 8/21/14, which documented: "On 5/13/2014 I completed a physical assessment of [Resident's Name], who was at the time a patient at [Facility's Name]. During my assessment I reviewed all body systems and interviewed [Resident's Name] relative to her health status and any concerns she may have. As reflected in my documentation she had questions about her pain meds, but no other concerns were noted and or stated. I did palpate her abdomen without tenderness and auscultated her bowel sounds and identified nothing noteworthy. She did not express concerns about her bowel care or any discomfort." Note: The original physician's note dated 5/13/14 documented the resident had expressed care concerns. Additional faxed information from the facility on 8/21/14, documented: "The standard of care for Steri-Strips to a surgical	{F 309}	ensure that timely physician and family notifications were made and orders obtained as required for new admission and or residents with changes in condition to include but not limited to, bowel care orders and treatment orders for surgical incisions obtained on admission and administered as ordered, and to ensure that documented findings of the skin inspection including timely physician and family notification with orders as required are noted in the medical record as indicated. Findings will be corrected with re-education and performance improvement plans as indicated. The Administrator will review audit results and education weekly to ensure follow up, to correct findings and root cause to ascertain trends in staff performance, or need for process changes as required. The compiled results will be presented by the Director of	

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{F 309}	Continued From page 18 site or wound is to monitor the area for signs and symptoms or infection and to keep the strips in place until they fall off on their own. The application of a clean, dry dressing over the top of the strips, as long as the wound is monitored for signs and symptoms of infection, is inconsequential in the healing and treatment process, does not require a physician order, and in no way jeopardizes the healing process or otherwise place the patient at risk." Note: Perry and Potter Clinical Nursing Skills [and] Techniques 7th Edition, documented on page 979, "Do not remove an initial surgical dressing...until a physician writes an medical order for the removal." The additional documentation did not resolve the concerns regarding the lack of implementation of bowel care for 3 days after the admission, the lack of direction regarding the care of a surgical wound site, or the application of a wound dressing without a physician order.	{F 309}	Nursing during the QAPI Clinical Excellence Committee Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance. **Date of Compliance 9/23/2014**	
{F 314} SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	{F 314}	**F314 – TREATMENT/SERVICES TO PREVENT/HEAL PRESSURE ULCERS** **RESIDENT SPECIFIC** Resident #3 discharged 6/21/14 and no longer resides in this facility. Resident #29 head to toe skin inspection, with measurements where appropriate, completed by a licensed nurse on 8/27/14. Findings were reported to MD with new orders received and family was notified. Effective treatment was implemented	

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{F 314}	Continued From page 19 Based on observation, interview, and record review the facility failed to develop and implement systems to prevent pressure ulcers, to accurately identify and document occurrence of pressure ulcers, and to ensure timely and accurate assessments of pressure ulcers. The facility did not provide timely physician notification of new or worsened pressure ulcers and failed to obtain pressure ulcer treatment orders form the physician. This was true for 2 of 4 residents, #s 3 and 29, reviewed for pressure ulcers that developed at the facility. 1. The facility failed to inform the physician about a pressure ulcer for 8 days and Resident #3 subsequently developed an unstageable pressure ulcer, which constituted actual harm; and 2. The facility failed to implement treatment and preventive measure when the facility was aware Resident #29 disturbed a callous on her heel exposing vulnerable fragile skin. Resident #29 developed a full thickness pressure ulcer on her heel, which constituted actual harm. Findings included: The State Operations Manual (SOM) Appendix P defines pressure ulcer as any lesion caused by unrelieved pressure that results in damage to the underlying tissues. Although friction and shear are not primary causes of pressure ulcers, friction and shear are important contributing factors to the development of pressure ulcers. The SOM also defines an "avoidable" pressure ulcer as the development of a pressure ulcer when the facility did not evaluate the resident's clinical condition and pressure ulcer risk factors; define and implement interventions that were consistent with	{F 314}	per MD orders and the wound has since resolved. Additional preventative measures were implemented including Heel protector boots, blanket cradle and air mattress on or before 9/5/14. Care plan was updated by director of nursing or designee to include preventative measures. OTHER RESIDENTS Current residents were reviewed by Director of Nursing or designee on or before 9/22/14 for alteration in skin integrity. The MD was notified of findings at time of review with new orders obtained as indicated. Families were also notified of findings and new orders received. Care plans were updated as indicated through review by Nurse Managers on or before 9/22/14. Preventative measures were added as indicated at time of skin inspections to include but not limited to monitoring areas found to be high risk. Care plans were updated on or	

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{F 314}	Continued From page 20 resident needs, goals and recognized standards of practice; monitor and evaluate the impact of the interventions; and/or revise the interventions as appropriate. The National Pressure Ulcer Advisory Panel (NPUAP) defined pressure ulcer stages as: * Stage I - Intact skin with nonblanchable redness * Stage II - Partial thickness pressure ulcer with partial thickness loss of skin presenting as a shallow open ulcer with a red-pink wound bed, without slough (dead tissue). May also present as an intact or open/ruptured serum-filled blister * Stage III - Full thickness tissue loss * Stage IV - Full thickness loss with exposed bone, tendon, or muscle. * Unstageable - Full thickness loss in which depth of the ulcer is completely obscured by slough and/or eschar (dead tissue). Until enough slough and/or eschar are removed to expose the base of the wound, the true depth of the wound cannot be determined, but it will be either a Stage III or IV. A suspected deep tissue injury is characterized by purple or maroon localized area of discolored, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. 1. Resident #3 was admitted to the facility on 11/19/13 with diagnoses including Alzheimer's disease, dementia with behavioral disturbances, muscular wasting and disuse, and difficulty in walking. The admission Nursing Assessment, dated 11/19/13, documented the resident had a dime sized blister/pressure ulcer on her coccyx. The resident's admission MDS assessment, dated 11/26/13, documented the resident	{F 314}	before 9/22/14 by nurse managers to reflect additional preventative measures for identified residents. **FACILITY SYSTEMS** Systemic Changes: The Skin Integrity and Wound Management program was implemented by the Director of Nursing on or before 9/22/14, including; weekly skin inspections for residents by licensed nurses; the use of the Wound Management Tool to provide a tool to the nursing staff for comparative purposes of each residents' skin condition between skin inspections; the use of skin audit tools used by the C.N.A.'s to notify licensed nurses of skin conditions identified during cares. Additional preventative measures were implemented as appropriate for residents at risk for skin breakdown. Additionally implemented were the Interact III Stop and Watch tool to inform licensed nurses of condition changes identified during routine cares	

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{F 314}	Continued From page 21 required extensive assistance of one to two people for bed mobility and transferring; was at risk for skin breakdown and had a Stage I and a Stage II pressure ulcer present on admission. The resident was triggered for skin and ulcer treatments including a pressure reducing device for the bed, turning/repositioning program, and ulcer care. The corresponding care plan, dated 11/21/13, indicated Potential for Skin Breakdown related to, "decreased independent mobility, B&B [bowel and bladder] incontinence and Alteration in Skin Integrity related to, blister to coccyx X[times] 2 along with redness, bruises, and scratches." Interventions included: * Turn every 2 hours as resident allows, document on TAR, * Keep skin clean and dry, * Pressure relieving devices as ordered, * Provide pericare after each incontinent episode, * Report new open areas to LN, * Document if skin is intact on flow sheet, and * Weekly skin assessments. Although Resident #3 was admitted with a pressure ulcer to the coccyx, his care plan was not updated to include a "LAL [Air] mattress... to provide pressure relief" and to "lay down between meals as resident allows" until 3/27/14. On 4/24/14 the care plan re-enforced, "Monitor for skin breakdown to peri-area with peri-cares - notify floor nurse of any areas of concern." The quarterly MDS assessments, dated 1/13/14 and 5/3/14, documented the resident was at risk for skin breakdown but had no, "stage I or greater [pressure ulcers], [no] scar over bony prominences."	{F 314}	and the Interact III SBAR tool for improved patient assessment and communication with the physician. Nurse Managers were educated by the Manager of Clinical operations on or before 9/22/14 on the Skin Integrity and Wound Management program, including but not limited to prevention, identification of risk factors with timely notification of MD and family, implementation of measures, wound descriptions, measurement technique and documentation of monitoring and plan of care revisions. Nursing staff were educated, on or before 9/22/14 by Director of Nursing or designee, identifying risk factors for skin integrity impairment, preventative measures, how to complete a skin inspection, to document skin inspections in the medical record to include use of SBAR form for alteration in skin integrity or change in	

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{F 314}	Continued From page 22 Review of Nursing Notes (NN), Care Plan (CP), Physician Orders, contained no further documentation of concerns with pressure ulcers between 5/3/14 and 5/16/14. On 5/17/14, LN #2 documented a 0.1 cm x 1.0 cm coccyx wound that she observed on 5/9 that was consistent with the NPUAP definition of a Stage II pressure ulcer. The 5/17/14 documentation included descriptions of the wound as LN #2 observed it on 5/10/14 and 5/12/14. The 5/17/14 nursing note further documented, "Area assessed today and noted area measuring 1.5 cm X 1.8 cm edges macerated health skin surrounding center non-blanching discoloration [with] hard tissue felt underneath..." The facility documented weekly skin checks on 5/8, 5/12, and 5/15, which showed the resident's skin was intact. This skin check information did not indicate the Stage II pressure ulcer observed by LN #2 on 5/9, 5/10, and 5/12. On 5/17/19, LN #2 documented the resident's primary care physician's office was notified and staff were instructed to refer the resident to the wound clinic and to start treatment with a debriding agent. A faxed order, dated 5/19/14, instructed staff to obtain an OT (Occupational Therapy) evaluation and treatment if appropriate. On 5/20/14 an OT documented, "[Resident] evaluated in w/c [wheel chair]... continues to sit [with] pelvis posturing tilted. A cushion [with] a	{F 314}	condition including assessment, physician and family notification, obtaining orders, revising and implementing treatment and/or preventative interventions, and updating plans of care with identified interventions. Competency validation will be completed by the Director of Nursing or designee for licensed nurses pertaining to skin inspections and knowledge of the newly implemented Skin Integrity and Wound Management Program inclusive of preventative measures for at risk residents via a written examination. MONITORS Beginning the week of 9/22/14, Nurse Managers will complete a follow-up skin inspection, after the weekly skin inspection is completed by the licensed nurse to validate the competency of the licensed staff. These observations will include at	

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{F 314}	Continued From page 23 coccyx cut out will be trailed." Five days later, the OT documented the cushion was modified with a cutout to decrease pressure to the coccyx area. Resident #3 was visited by the Wound Clinic Nurse Practitioner (NP-C) on 5/21/14, four days after the referral. The 5/21/14 wound clinic notes documented the wound now measured 1.5 X 1.4 X 0.1 cm and was "unstageable" with 100% slough in the bed. The NP-C documented, "I believe this was likely a deep tissue injury, it is now evolving into a pressure ulcer. The patient has had excellent preventative measures in place since she was first admitted back in November... such as 2 hour turning, air mattress, 2 hours turning not involving the supine position, barrier cream and frequent skin assessments. Despite all these implementations the patient developed likely a deep tissue injury and this has now progressed to an unstageable pressure ulcer. Due to the patient's history as well as current circumstances I believe this wound is unavoidable." A 5/28/14 Wound Clinic NP-C note documented, "Unfortunately, with poor protein intake coupled with dementia, this will be very difficult to heal. This may very well worsen. We will continue to follow and try to keep this stable. I will follow-up with this patient in 2 weeks." On 6/11/14, the Wound Clinic NC-P documented, "[Resident's] wound quality is improved. She has no slough in the wound bed...measures 1.5 x 1.6 x 0.5 cm Wound bed is 100% granulation tissue." On 6/19/14 the Wound Clinic NC-P documented, "[Resident's] wound is still present. In fact, the wound bed is mostly granulation tissue now. She	{F 314}	least five residents and an audit of documentation of their scheduled skin inspections weekly for 4 weeks then monthly x 2 months, to ensure accurate evaluation, timely physician and family notifications, treatment orders obtained as required and monitoring to include description and measurements if applicable are documented in medical record at time of identification and with changes or alterations. Findings will be corrected and reported to the Director of Nurses. Director of Nursing or designee will observe five staff nurses performing skin inspections weekly for 4 weeks then monthly x 2 months, to ensure accuracy of inspection and knowledge and implementation of timely physician and family notification, obtaining orders and accurate documentation and monitoring	

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{F 314}	Continued From page 24 has progressed to a Stage 3 pressure ulcer...that measures 2.2 X 0.6, 90% granulation tissue and 10% slough." The resident expired on 6/21/14. The DNS, Corporate Nurse, and facility Administrator were interviewed on 8/19/14 at 3:25 PM. During the interview the DNS acknowledged that LN #2 had not documented the resident's skin condition as observed on 5/9, 5/10, and 5/12 until 5/17/14, eight days after the initial observation of an open area on the resident's coccyx. The DNS stated that LN #2 had texted her on 5/9 and 5/10 regarding Resident #3's skin issues. The DNS stated that although she assessed the resident's coccyx wound on 5/12/14, she did not document the observation, notify the resident's physician of the new pressure ulcer, or provide direction to staff concerning the wound. When asked if she had checked the resident's care plan or ensured the information had been passed on to other shifts, the DNS said "No." The DNS later returned with a treatment sheet for May 2014 that documented Resident #2 was turned every 2 hours, positioned off her back beginning on 5/9/14, and encouraged to lay down between meals, starting 5/10/14. NOTE: The resident's physician was not contacted, nor were physician treatment orders procured and implemented for eight days after initial discovery of the resident's coccyx pressure ulcer. When asked if nursing staff had monitored the resident's coccyx between 5/12/14 and 5/17/14,	{F 314}	The Administrator will review audit and education weekly to ensure follow up, to correct findings-and root cause, to ascertain trends in staff performance, or need for process changes as required. The compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Committee Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance. **Date of Compliance** **9/23/2014**	

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{F 314}	Continued From page 25 the DNS stated the normal semi-weekly skin checks would have been conducted. The discrepancies between the weekly skin checks and LN #2's findings were then discussed. The DNS indicated she was not aware of the discrepancies. On 8/22/14 the facility faxed additional documentation, however the information did not resolve the concerns. Resident #3, who had a history of pressure ulcers and was at high risk for developing pressure ulcers, developed an unstageable pressure ulcer on her coccyx that was first observed on 5/9/14. The LN who made that initial observation did not document the assessment until eight days after making the observation. During this time, two other nurses performing weekly skin checks documented the resident's skin was intact. Additionally, the resident's physician was not notified of the pressure ulcer until 5/17/14. Between 5/9/14 and 5/21/14, a period of 12 days, the resident's coccyx wound deteriorated from an "open area" that measured 0.1 X 1.0 to an unstageable pressure ulcer that measured 1.5 cm X 1.4 cm with 100% slough. 2. Resident #29 was admitted to the facility on 6/16/14 with diagnoses including malignant neoplasm of brain and spinal cord, malignant neoplasm of the breast, shortness of breath, anxiety, and depression. The resident's admission nursing assessment, dated 6/16/14, and MDS admission assessment, dated 6/22/14, documented the resident was alert and oriented to person, place, time and situation, had poor decision making skills, used a	{F 314}		

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{F 314}	Continued From page 26 wheelchair independently, and was at risk for skin breakdown, although her skin was intact at that time. The resident's CAA worksheet for pressure ulcers, completed on 6/27/14, documented the resident had diagnoses and took medications that increased her risk for pressure ulcers.	{F 314}		
	The resident's 6/17/14 care plan documented staff were to complete weekly skin assessments. LN weekly skin checks for June, July, and August 2014 documented the resident's skin was intact and Braden Skin Assessments conducted in July and August documented the resident was at no risk for skin breakdown. However, there was no documentation in the NNs or other nursing records that provided a full assessment of the resident's skin condition in relationship to her diagnoses, medications, past history of chemotherapy, or recognized her mobility style. For example, there was no documented assessment of skin turgor, rashes, dryness, calluses, tender or sensitive areas or how the resident accomplished wheel chair and bed mobility or whether her mobility style could create breakdown over pressure points. Nurses Notes, dated 8/11/14, documented Resident #29 had a 3 cm X 3 cm blister on her left heel. An investigation into the blister documented the resident's daughter told LN #5 on the evening of 8/10/14 that the resident had picked off a callus from her left heel. The daughter stated there was no blister to the resident's left heel at that time. The resident's medical record did not include any documentation of the daughter's report, or that the resident's left			

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{F 314}	Continued From page 27 heel had been assessed by LN #5 or any other facility staff on 8/10/14. No interventions were implemented to protect the resident's left heel until after the physician had been notified on 8/11/14 that the callus had been removed and a blister had developed. A NN, dated 8/11/14, documented a hospice physician was contacted that day and a new orders were received for wound treatment and a consult with the wound clinic. On 8/12/14 at 2:00 pm, the DNS documented a late entry for 8/11/14 the, "... resident demonstrated that she pushed self propels [wheel chair] with ... feet by first touching ground with heel ... she demonstrated how she moves herself up in bed ... used both upper extremities, while pushing [with] left leg and left heel into bed ... Raised clear fluid filled blister appears to be [related to] friction/trauma of resident self-propelling [wheelchair], pushing self-up in bed, [Care plan] updated for heel protectors, assist [with] repositioning [and] moving up in bed [every 2 hours] and lotion to [bilateral lower extremities]/feet BID [Twice per day]... Hospice and MD aware of [left] heel." On 8/13/14 the Wound Care Clinic visited the resident. The NC-P documented, "The patient has an intact blister...left heel blister 3 X 3 cm. She has 1 - 2 + pitting edema of her lower extremities bilaterally...Due to large amount of fluid in this blister, I do not believe it will reabsorb. This does need to be removed today. We will go ahead and cover this up with foam dressing. She has been off loaded with padded heel protectors, will continue to do so. I have asked her to increase her protein in her diet and this should	{F 314}		

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{F 314}	Continued From page 28 likely heal nicely..." Skin Integrity reports dated 8/13/14 and 8/20/14 did not stage the wound on the foot, documented there was pain, and measured it as 3 x 3 cm on 8/13/14 and 1.9 by 2.5 cm on 8/20/14. There was no mention of the condition of the resident's right foot in NNs or skin check documents between 8/10/14 and 8/20/14.	{F 314}		
	Resident #29 was observed on 8/20/14 at 1:45 and 1:55 pm. RN #6 was present during the observation and removed a dressing from the resident's left heel. The foam dressing contained a moderate amount of serous fluid with no odor. A large wound was observed on the resident's left heel with a full thickness of skin missing. The wound measured approximately 4.5 cm by 4.5 cm with irregular, thickened, macerated edges. There was a dime sized puffy, dusky colored spot on the outer aspect of the upper right heel. Resident #29 was alert and oriented to person and place and time of day during the observation. She explained she had picked skin off of her heel and used her heels to push her wheel chair and to help move herself up in bed. Note: A Federal Surveyor, who accompanied the state team, was asked by the state surveyor to do a joint observation of the wound. The Federal Surveyor commented that the wound looked "much larger" than 3 cm x 3 cm. LN #6 was interviewed on 8/20/14 at 2:00 pm. When asked to describe the wound, LN #6 stated she did not have a lot of experience with this type of wound and didn't really know how to describe it as far as staging and condition. When asked to use regular, everyday terms, LN #6 the heel was			

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{F 314}	Continued From page 29 open and had yellowish white skin around it. On 8/20/14 at 2:35 pm, the DON and the facility's wound nurse (LN #1) were interviewed. The wound care nurse was asked when she first saw Resident #29's heel wound. She stated she saw it with the wound care team on 8/13/14. When asked if it was unusual for her not to see a new wound for 3 days, LN #1 stated it can take three or four days for her to see a wound, depending on what day of the week it was discovered and other issues. The DNS was asked why the wound was called self-inflicted. She stated because the resident had picked off her own callus which led to the blister and subsequent deterioration. When asked if the resident's skin had been assessed, prior to the discovery of the pressure ulcer, (for dryness, calluses, self-propelling in her wheel chair and repositioning in bed using her heels), the DNS stated assessments other than the weekly skin checks and the Braden scale were not conducted. When asked if the LN who had talked to the resident after she removed the callus on the evening of 8/10/14 had assessed the skin under the callus or taken any specific measures to protect the newly uncovered skin. The DNS stated, "No." On 8/21/14 the facility faxed additional documentation, however the information did not resolve the concerns. The facility failed to complete full and accurate assessments of Resident #29's risk for developing skin breakdown and her overall skin condition based on medications, diagnoses, dry	{F 314}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135079		R-C 08/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 314}	Continued From page 30 and callused skin condition, and using her heels to self-propel her wheel chair and reposition while in bed. In addition, on 8/10/14, a facility LN was told the resident had picked off a callus from her left heel. The LN did not assess the skin after the callus was removed, nor implement preventative interventions to protect the fragile skin. Subsequently, a blister developed and progressively worsened on the resident's heel. Although aware of the risks for skin breakdown that occurred to the resident's left heel, the facility failed to assess or implement preventative/protective measures for the resident's right heel.	{F 314}		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MDS001320		R 08/20/2014

NAME OF PROVIDER OR SUPPLIER: APEX CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 8211 USTICK ROAD BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 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 onsite follow up and complaint survey of your facility. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Lorraine Hutton, RN	{C 000}	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Genesis HealthCare - Apex Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
C 745	02.200,01,c Develop/Maintain Goals/Objectives c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Please refer to F281 as it relates to standards of nursing practice.	C 745		
{C 789}	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please refer to F 314 as it relates to pressure ulcers.	{C 789}	Please Refer to F281 RECEIVED SEP 19 2014 FACILITY STANDARDS Please Refer to F314	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 9/19/14

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
FAX 208-364-1888

September 11, 2014

Joseph Rudd, Administrator
Apex Center
8211 Ustick Road
Boise, ID 83704-5756

Provider #: 135079

Dear Mr. Rudd:

On **August 20, 2014**, a Complaint Investigation survey was conducted at Apex Center. Bradley Perry, LSW, and Lorraine Hutton, RN, conducted the complaint investigation.

This complaint was investigated in conjunction with a follow-up survey on August 18, 2014 through August 20, 2014. During the investigation the identity of the resident listed in the complaint was determined and the resident's medical records were reviewed for May 12, 2014 through August 20, 2014; grievance files and incident reports were reviewed for the same period of time. Other residents were also identified and investigated who had developed pressure ulcers in the facility between May 2014 and August 2014. In addition, staff and residents were interviewed, and observations of wounds and wound care were made.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006493

ALLEGATION #1:

The complainant stated the Director of Nursing and another identified nurse were talking about finding a wound. The wound, located on the identified resident's buttocks, turned black and was the size of a silver dollar. The nurses were acting and talking like they were going to get in a lot of trouble. The nurses did not know what they were going to do because it was not reported before.

FINDINGS:

Based on the observations, interviews, and medical record reviews, it was determined the facility failed to

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develop and implement systems to prevent pressure ulcers, to accurately identify and document occurrence of pressure ulcers, and to ensure timely and accurate assessments of pressure ulcers. In addition, the facility did not provide timely physician notification of new or worsened pressure ulcers and failed to obtain pressure ulcer treatment orders from the physician. The facility was cited at F157, for failure to notify physicians, and at F314 for pressure ulcers.

CONCLUSIONS:

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

ALLEGATION #2:

The complainant stated the identified nurses stated they wanted to, "Fix it so the State did not know about it."

FINDINGS:

During the complaint investigation, it was determined the facility failed to ensure licensed nurses monitored and documented the skin conditions of residents with pressure ulcers. The failure to document skin conditions, irregularities, and changes resulted in residents not receiving immediate care and services needed to prevent further skin breakdown and pressure ulcers. The facility was cited at F281 for failure to ensure nurses documented to nursing and medical record standards of practice.

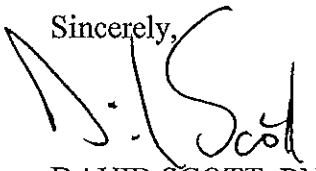
CONCLUSIONS:

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, comments or concerns regarding our investigation, please contact Lorene Kayser, LSW, QMRP, or David Scott, RN, Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



DAVID SCOTT, RN, Supervisor
Long Term Care

DS/lj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

September 11, 2014

Joseph Rudd, Administrator
Apex Center
8211 Ustick Road
Boise, ID 83704-5756

Provider #: 135079

Dear Mr. Rudd:

On **August 20, 2014**, a Complaint Investigation survey was conducted at Apex Center. Bradley Perry, LSW, and Lorraine Hutton, RN, conducted the complaint investigation.

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure follow-up survey conducted on August 18-August 20, 2014.

The following documents were reviewed:

The entire medical record of the identified resident;
The facility's Grievance file from May-August 2014;
Resident Council minutes from May-August 2014;
The facility's Incident and Accident reports from May-August 2014; and,
The facility's Allegation of Abuse reports from May-August 2014.

The following interviews were completed:

The identified resident was interviewed regarding safety concerns;
The Director of Nursing was interviewed regarding abuse allegations; and,
A nurse and a CNA were interviewed regarding abuse reporting protocols.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006539

ALLEGATION:

The complainant stated an identified resident was sexually abused by a male staff member on June 30, 2014.

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FINDINGS:

The facility's grievance file and Resident Council minutes from May-August 2014 were reviewed and no abuse concerns were identified.

The facility's Incident and Accident Reports and the facility's Allegation of Abuse Reports from May-August 2014 were reviewed. An allegation of sexual abuse was found in the file for the identified resident and was determined abuse could not be substantiated.

The entire medical record of the identified resident was reviewed, which included a local emergency room examination, an alleged sexual abuse report regarding the identified incident completed by the facility and sent to the facility standards bureau and the local police department. The investigation included staff interviews, the identified resident interview and family interviews, and other resident interviews regarding the allegations.

The identified resident was interviewed about her safety and she stated she always feels safe in the facility.

A nurse and a CNA were interviewed regarding suspected abuse and they stated they would make sure the resident was safe and then immediately report suspicions to the appropriate staff member.

The DON was interviewed regarding the alleged abuse incident and she stated they could not substantiate the alleged abuse. She stated since the incident, only female caregivers were to provide care. She also said care would be completed by two staff members at a time, because the resident falsely accuses staff due to cognitive deficits.

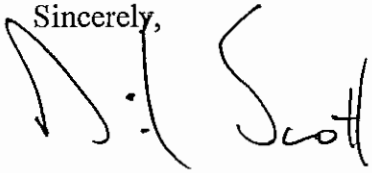
Based on the record review, resident and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,



DAVID SCOTT, RN, Supervisor
Long Term Care

DS/lj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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September 11, 2014

Joseph Rudd, Administrator
Apex Center
8211 Ustick Road
Boise, ID 83704-5756

Provider #: 135079

Dear Mr. Rudd:

On **August 20, 2014**, a Complaint Investigation survey was conducted at Apex Center. Bradley Perry, LSW, and Lorraine Hutton, RN, conducted the complaint investigation.

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure follow-up survey conducted on August 18-20, 2014.

The following observations were completed:

Call lights were observed throughout the survey.

The following documents were reviewed:

The entire medical record of the identified resident;
10 other residents' records were reviewed for Quality of Care concerns;
The facility's Grievance file from May-August 2014;
Resident Council minutes from May-August 2014;
The facility's Incident and Accident reports from May-August 2014; and,
The facility's Allegation of Abuse reports from May-August 2014.

The following interviews were completed:

Several residents were interviewed regarding Quality of Care concerns;
The Director of Nursing and the Administrator were interviewed regarding various Quality of Care concerns;

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The Director of Rehabilitation was interviewed regarding therapy concerns;
Two nurses were interviewed regarding call lights and Quality of Care concerns;
A Social Worker was interviewed regarding the procedure for resident transfers to other facilities; and,
The Receptionist was interviewed regarding phone calls coming into the facility.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006616

ALLEGATION #1:

The complainant stated an identified resident did not receive adequate rehabilitation in a timely manner.

FINDINGS:

The identified resident was no longer residing in the facility at the time the complaint was investigated.

The closed medical record for the identified resident and three other residents were reviewed for adequate therapy received in a timely manner.

The identified resident's therapy record documented the resident was admitted to the facility on the afternoon of Saturday May 10, 2014 and was evaluated by Physical and Occupational Therapy on Monday May 12, 2014 and began therapy on May 12, 2014. No issues were found for the three other residents residing in the facility regarding therapy.

The Director of Therapy was interviewed regarding timing of therapy evaluations and appropriate therapy and she said evaluations were done within a day of admissions Monday through Saturday and individual therapy goals and needs were resident specific. She also said the identified resident received appropriate therapy services based on the evaluations.

Based on the record review and staff interview it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated an identified resident did not receive pain medications when the resident

requested them.

FINDINGS:

The closed record of the identified resident and 10 other residents' records were reviewed for Quality of Care concerns, including medications given in a timely manner. The identified resident's medical record did not document medications were given late and as needed (PRN) medications were given per physician's orders.

The Director of Nursing (DON) was interviewed regarding the resident's pain needs and she stated the resident received the appropriate pain medications. She said due to frequency of the PRN pain medications the resident requested, the staff alerted the physician and the physician changed the pain medication from PRN to scheduled.

Based on the record review and staff interview it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated call lights were not answered in a timely manner for an identified resident.

FINDINGS: Call lights were observed throughout the entire survey and no concerns were observed.

The facility's grievance file and Resident Council minutes were reviewed for May-August 2014 and no call light issues were identified.

Several residents were interviewed regarding call lights and they said call lights were answered in a timely manner. Two nurses were interviewed regarding call light response times and they said they or an aide responds within a few minutes of when a call light turns on. The DON was interviewed and she said call lights are answered in a timely manner.
Although the incident may have happened as described, based on observations, record review, resident and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated an identified resident did not receive appropriate care for a surgical incision site.

FINDINGS:

The closed record of the identified resident was reviewed. Progress notes dated May 10, 2014 through May 16, 2014, revealed the incision site dressing was viewed by nursing staff for signs and symptoms of infection. However, staff never received physician's orders for treatment of the area and changed the dressing over the site, without physician's orders on May 16, 2014.

The DON said she could not find where the staff notified the physician about the lack of orders and could not find the direction by the physician regarding the dressing site.

The facility was cited at F157 and F309 for non-compliance.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

The complainant stated an identified resident did not have vital signs taken until after being at the facility for almost a week.

FINDINGS:

The entire medical record of the identified resident was reviewed and vital signs were documented for five of the six days the resident resided in the facility.

The DON was interviewed regarding how often vital signs are taken and she stated the staff take them daily unless physician orders direct otherwise.

Based on the record review and staff interview it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated facility staff delayed to arrange the transfer of an identified resident to another care facility.

FINDINGS:

The entire medical record of the identified resident was reviewed. Progress notes documented during a care conference on May 13, 2014, the resident wanted to be sent to another care facility for treatment. That same day, progress notes documented the other facility was contacted and staff at the other facility stated they could not send a staff member to evaluate the resident until May 14, 2014 and would probably not have a bed available until May 16, 2014. The identified resident was transferred on May 16, 2014 to the new facility, when a bed became available.

The Social Worker was interviewed regarding the transfer of the resident and she stated the receiving facility was notified the same day of the resident's wish to be moved. She also stated, she was in contact with the other facility, but the other facility decides when they have a bed available and when they could evaluate the resident.

Based on the record review and staff interview it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The complainant stated facility staff would not returned calls to an identified resident's family member.

FINDINGS:

The facility's Grievance file and Resident Council minutes were reviewed for May-August 2014 and no issues were identified.

The entire record of the identified resident was reviewed and progress notes documented staff spoke the family member seven times in the seven days the resident was in the facility.

The facility's receptionist was interviewed and she stated messages were taken when a resident or staff was not available and given to the appropriate party.

Based on the record review and staff interview it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

The complainant stated when family and a physician called the facility, they were told an identified resident was not a resident of the facility.

FINDINGS:

The entire record of the identified resident was reviewed and progress notes documented staff spoke to the identified family member seven times in the seven days the resident was in the facility.

The facility's receptionist was interviewed and she stated when family or a physician calls the facility she looks on a daily computer generated list of all residents in the facility on that day. She also said when there may be a concern or question she can view the computer census list by searching her computer program on her desk computer. A nurse was interviewed on how she handles calls regarding residents and she said if there is ever a doubt, she can look in the computer system at the census list. Both staff stated if the resident is not available when a call comes in for them, they will take messages for the resident.

Although the incident may have happened as described, based on record review and staff interview it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #9:

The complainant stated an identified resident's constipation was not addressed or handled correctly.

FINDINGS:

The entire medical record of the identified resident was reviewed and no bowel orders were found on admission and staff did not notify the physician on admission when it was determined the resident had not had a bowel movement in four days prior to admission.

The nurse who conducted the admission assessment was interviewed and she stated she did not notify the doctor about the resident's bowel issue. The DON was interviewed and she stated the resident did not have bowel treatment orders upon admission.

The facility was cited at F157 and F309 for non-compliance.

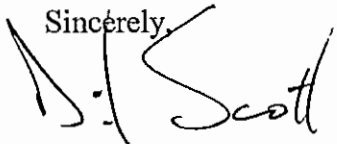
CONCLUSIONS:

Substantiated. Federal 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, comments or concerns regarding our investigation, please contact Lorene Kayser, LSW, QMRP or David Scott, RN, Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



DAVID SCOTT, RN, Supervisor
Long Term Care

DS/lj