



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 2212

September 23, 2013

Bobette Steffler, Administrator
McCall Rehabilitation & Care Center
418 Floyde Street
Mc Call, ID 83638-4508

Provider #: 135082

RE: RECERTIFICATION AND STATE LICENSURE SURVEY REPORT COVER LETTER

Dear Ms. Steffler:

On **August 30, 2013**, a Recertification and State Licensure survey was conducted at McCall Rehabilitation & Care Center by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be **ISOLATED** deficiencies and to constitute immediate jeopardy to residents' health and safety. You were informed of the immediate jeopardy situations in writing on **August 28, 2013**.

On **August 30, 2013**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the residents had been removed. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction. The most serious deficiency now constitutes actual harm that is not immediate jeopardy and that is isolated in scope, as

evidenced by the Form CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **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 Plan of Correction (PoC) for the deficiencies must be submitted by **October 7, 2013**. Failure to submit an acceptable PoC by **October 7, 2013**, may result in the imposition of additional civil monetary penalties by **October 28, 2013**.

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

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

c. Start date of the audits;

- Include dates when corrective action will be completed in column 5.

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

Based on the immediate jeopardy cited during this survey;

F226 – S/S: J – 42 CFR §483.13(c) – Develop/Implement Abuse/Neglect, etc Policies

We are recommending to the Centers for Medicare & Medicaid Services (CMS) Regional Office that the following remedies be imposed:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

A 'per instance' civil money penalty of **\$5000.00**.

(THIS REMEDY IS GENERALLY RESERVED FOR SITUATIONS OF SERIOUS NONCOMPLIANCE AS DESCRIBED AT §7510) (§488.430)

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 1, 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Your facility's noncompliance with the following:

Bobette Steffler, Administrator
September 23, 2013
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F226 -- S/S: J -- 42 CFR §483.13(c) -- Develop/Implement Abuse/Neglect, etc Policies;
F252 -- S/S: F -- 42 CFR §483.15(h)(1) -- Safe/Clean/Comfortable/Homelike Environment

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents # **1-9, 11-13** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

STATE ACTIONS effective with the date of this letter (**September 23, 2013**): None

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:

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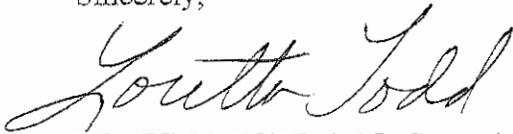
- BFS Letters (06/30/11)

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

This request must be received by **October 7, 2013**. If your request for informal dispute resolution is received after **October 7, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

LT/dmj
Enclosures

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

PRINTED: 09/23/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135082	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET MC CALL, ID 83638	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recent Federal Re-certification and State Licensure survey. An Immediate Jeopardy was identified at F 226. The facility was notified of the jeopardy in writing on 8/28/13 at 5:30 PM, and an acceptable abatement plan was presented at 8:45 AM on 8/30/13.</p> <p>The survey team included: Nina Sanderson BSW LSW, Team Coordinator Linda Kelly RN Lauren Hoard BSN RN</p> <p>Survey Definitions: MDS = Minimum Data Set CAA = Care Area Assessment cm = centimeter mg = milligram PRN = as needed PT = Physical Therapy OT = Occupational Therapy D/C = discontinued DNS/DON = Director of Nursing ADL = Activities of Daily Living MSS = Medical Social Services RN = Registered Nurse LPN = Licensed Practical Nurse MSW = Master's Social Worker</p>	F 000	<p><i>Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority. Accordingly, the facility has drafted this Plan of Correction in accordance with Federal and State Laws which mandate the submission of a Plan of Correction as a condition for participation in the Medicare and Medicaid program. This Plan of Correction shall constitute this facility's credible allegation compliance with this section.</i></p>	
F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone</p>	F 164	<p>The facility does ensure privacy is maintained when insulin subcutaneous injection is administered.</p> <p><i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i></p>	10/28/13

RECEIVED
OCT - 7 2013
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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 164	<p>Continued From page 1</p> <p>communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure privacy was maintained when a subcutaneous injection was administered into a residents' abdomen. This was true for 1 of 2 residents (#6) who received a medication by subcutaneous injection during medication pass observations. The failed practice created the potential for a negative affect on the residents' psychosocial well-being related to the need for privacy. Findings included:</p> <p>On 8/27/13 at about 11:35 a.m., LN #3 wheeled Resident #6 in her wheelchair into the Activity Room and performed a blood glucose (BG)</p>	F 164	<p>License Nurse #3 who administered insulin subcutaneous injection on Resident #6 facing toward a large, uncovered picture window between the Activity Room and the Dining Room was provided with 1:1 education on 10/4/13 by the Director of Nursing with regards to F-164, with emphasis on ensuring Residents' privacy when administering insulin subcutaneous injection.</p> <p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:</p> <p><i>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.</i></p> <p>However, to address other residents who are receiving insulin subcutaneous injection that may have the potential to be affected by this deficiency, On 10/6/13 a Window Covering (Blinds) was installed in the uncovered window at the Activity Room to accommodate Residents' privacy.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur an In-service training was completed on 10/5/2013 by Administrator and/or Director of Nursing regarding F-164 to all Licensed Nurses on the importance of ensuring Residents' privacy during an insulin subcutaneous injection.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p><i>Monitoring will be done through:</i></p> <p>The Director of Nursing or designee will do a visual observation to ensure that privacy is provided by the License Nurses on Residents who are receiving insulin subcutaneous injection.</p>	

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F 164	<p>Continued From page 2</p> <p>check. The resident was faced toward a large, uncovered picture window between the Activity Room and the Dining Room. After the BG check, the LN exposed the resident's abdomen then administered 5 units of NovoLog insulin into the resident's right upper abdomen. During this time, several residents were in the dining room and more residents arrived, including 1 male resident who was observed walking near the uncovered window between the two rooms.</p> <p>Immediately afterward, when informed of observation and asked about the resident's privacy, LN #3 acknowledged she administered the injection while Resident #6 was in front of the uncovered window and that other residents were in the dining room. The LN stated, "We talked about that."</p> <p>On 8/30/13 at 6:45 p.m., the Administrator and the DNS were informed of the observation. No other information or documentation was received from the facility regarding the privacy issue.</p>	F 164	<p>Monitoring will start on October 07, 2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Director of Nursing or designee will submit to the Administrator or designee, and the QA&A Committee during the quarterly QA&A Committee meeting her findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p>	F 225	<p>The facility does ensure that all allegations of abuse or neglect are investigated, and that residents were protected from further abuse when abuse is alleged.</p> <p><i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>10/28/13</p>

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F 225	<p>Continued From page 3</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident, Interested Party, and staff interviews; record review, abuse policy and procedure review, and review of abuse investigation reports; it was determined the facility failed to: * Investigate all allegations of abuse or neglect; and, * Ensure residents were protected from further abuse when abuse was alleged. This deficient practice created the potential for more than minimal harm when allegations of abuse were not investigated after a resident</p>	F 225	<p>Prior to the identification of the allegation by the surveyors, immediately upon notification the facility Administrator on 8/12/13 did meet with Resident #2 and her family and followed up the allegation. Resident #2 and family were asked by the Administrator if they wanted to file a formal grievance and they declined. Resident # 2 was asked by the Administrator "Did she (C.N.A.) really throw it (call light) at you?" and Resident # 2 said "No." Then Resident #2 and family were asked if they believed that abuse occurred and they stated "No."</p> <p>The facility Administrator generated the allegation of abuse report for Resident #2 on 8/28/13, and reported allegation to the State Survey and Certification Agency.</p> <p>The facility Administrator, with the DNS, and MSW present, on 8/29/13, suspended the alleged employee pending the completion of the investigation and obtained statement from the alleged employee involved in the incident.</p> <p>The facility Administrator on 8/30/13 reported the result of investigation on the allegation to the State Survey and Certification Agency.</p>	

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F 225	<p>Continued From page 4</p> <p>alleged an employee threw the call light at her. This was true for 1 of 10 sample residents (#2), and all other residents who lived in the facility. Findings included:</p> <p>Resident #2 was admitted to the facility on 8/3/13 with multiple diagnoses which included in part, progressive supranuclear palsy (which inhibits her ability to speak or process quickly), cervical spondylosis, dysphasia, osteoarthritis, and peripheral neuropathy. Hospice services were also initiated on 8/3/13 due to the diagnosis of supranuclear palsy.</p> <p>Resident #2's most recent admission MDS documented in part:</p> <ul style="list-style-type: none"> * Cognitively intact with a BIMS score of 15; * Usually able to make self understood; * Able to understand others; * Extensive assist with one person for bed mobility, transfer, dressing, and personal hygiene; * Extensive assist with 2 people for toilet use; and, * Functional limitation in range of motion in both upper and lower extremities. <p>Resident #2's August 2013 Plan of Care identified problem areas and interventions included:</p> <ul style="list-style-type: none"> * ADL - Pancake call light. Staff to assist as necessary * Bladder Incontinence - Encourage resident to seek assistance with toileting and keep call light in reach; * Altered thought process due to supranuclear palsy which inhibits her ability to speak or process quickly - Determine if delayed reaction to information is due to misunderstanding or communication delay, and allow plenty of time for resident to respond to questions. Resident talks 	F 225	<p>With regards to a story mentioned by the Hospice C.N.A. to the surveyor that was told to her by another Resident earlier in the year, in which according to the story related to her by the Resident, she (the Resident) heard what she called "Love making in the empty bed" in the resident's room. The facility Administrator reported allegation to the State Survey and Certification Agency on 9/27/13, generated the allegation of abuse report, and investigated. Based on the investigation by the Abuse Team Task Force, the allegation was found to be unsubstantiated. The Resident is no longer a Resident of the facility. During the investigation, based on the interview with the Hospice C.N.A., the Hospice C.N.A. mentioned that the Resident said she never saw it happen, instead just heard talking. Therefore based on the investigation it was determined that it was the movie "Twilight" (that has sexual connotation in it), that the Resident was watching and what she may have heard, hence allegation was unsubstantiated. On 10/2/13 the result of the investigation was reported to the State Survey and Certification Agency.</p> <p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.</p> <p>However, to address other residents that may have the potential to be affected by this deficiency, the facility Administrator and/or the facility MSW on 8/29/13, sent all Residents in the facility and/or Residents Representative correspondence via mail their right to file complaints or grievances of any kind without the fear of retribution.</p>

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F 225	<p>Continued From page 5</p> <p>very softly, please ask resident to restate if needed; and</p> <p>* Potential for falls - Keep call light within easy reach, use easy touch style pancake call.</p> <p>On 8/28/13 at 10:15 a.m., during an interview, Resident #2's Interested Party stated they had been informed by Resident #2 that a CNA had thrown the call light at her. The Interested Party indicated this occurred a week or so after Resident #2 was admitted to the facility. The Interested Party added that they were afraid to tell anyone about the incident because they were "Afraid of retaliation." A hospice CNA who was in attendance at the time stated that she too was afraid of retaliation.</p> <p>Note: Please refer to F226 as it pertains to development and operationalization of abuse polycys and procedures.</p> <p>On 8/28/13 at 11:15 a.m., Resident #2's Interested Party and the hospice CNA were asked why they felt afraid of retaliation. The Interested Party stated it was an "Aura" and referred to the hospice CNA who agreed to an interview before leaving for the day.</p> <p>On 8/28/13 at 11:40 a.m., the hospice CNA was interviewed. When asked to explain what made her feel afraid of retaliation she stated, "You kind of get an aura," and began telling the surveyors about a previous resident she had cared for at the facility earlier in the year. The hospice CNA stated this previous resident confided in her details of a night when the resident heard what she called, "Love making" in the empty bed in the resident's room. The hospice CNA stated the "Resident said, 'Please don't say anything'" because the resident was "Mortified they weren't going to</p>	F 225	<p><i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i></p> <p>To ensure that the deficient practice does not recur;</p> <p>On 8/29/13, the company President did a formal write up to the Administrator on not following proper process for abuse investigation and prevention.</p> <p>The facility Administrator and Director of Nursing read and confirmed understanding of the Federal Regulations for F-166, F- 225, and F-226 as evidenced by statement of confirmation signed on 8/29/13.</p> <p>The facility on 8/29/13, developed an "Abuse Team Task Force," that will review all complaints of any nature as potential means of abuse.</p> <p>On 8/29/13, the facility Administrator and Director of Nursing updated the facility's Policy and Procedure for Abuse Investigation and Abuse Prevention Program, including federal guideline definitions and reporting process. This updated Abuse Investigation and Abuse Prevention Program Policy and Procedure was presented and approved by the Survey Team during the week of the Survey.</p> <p>On 9/10/13, the facility "Abuse Team Task Force" introduced themselves during the all staff in-service meeting and in-serviced all staff with regards to reporting any allegation of abuse to the facility "Abuse Team Task Force."</p> <p>An In-serviced to all staff, contract staff, and volunteers was also provided by the "Abuse Team Task Force" starting 8/30/13 through 10/20/13, with regards to the updated Policy and Procedure on Abuse Investigation and Abuse Prevention Program</p>	

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F 225	<p>Continued From page 6</p> <p>answer the call bell, toilet her, etc." The hospice CNA stated she reported it to the hospice LN, as well as LN #3, then to the administrator about 25 minutes later. The hospice CNA stated the resident said, "I wish you didn't say anything." The hospice CNA was asked if she was asked by the facility to provide a written statement about the incident and she stated, "No. It was verbal, cordial. I don't remember signing any kind of document."</p> <p>On 8/28/13 at 2:20 p.m., Resident #2 was asked about the incident with the CNA and call light. The resident stated, "She [CNA #1] threw the call light at me and said, 'Here is your call light [residents name]'" Resident #2 continued, "She [CNA #1] hasn't been the same since, grumpy towards me." The Resident was asked if she reported the incident to anyone and she stated she told her family member who then talked to the Administrator. Resident #2 was asked if she was afraid to inform staff of the incident she stated, "No." When asked why she didn't notify staff, Resident #2 stated, "I'm not a teller."</p> <p>On 8/28/13 at 2:50 p.m., the Administrator was asked to provide documentation of an investigation report regarding the allegation of abuse to Resident #2. The Administrator stated the incident occurred "Two or three weeks ago," and that an evening CNA had complained to her that CNA #1 wasn't nice to Resident #2. The Administrator said she met with Resident #2 and an Interested Party about the allegation of abuse and asked them, "Do you want to write out a formal grievance, and they said no." The Administrator added, "I didn't treat it as a formal grievance. I said, 'Did she truly throw it at you?' And she [Resident #2] said, 'No.'" When asked if</p>	F 225	<p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i></p> <p>Monitoring will be done through:</p> <p>The facility "Abuse Team Task Force," or their designee will check with at least three (3) Residents for abuse issues and to ensure the Residents right to file complaints of any kind without the fear of retribution.</p> <p>The facility "Abuse Team Task Force," or their designee will check with at least (3) employees, and/or contract staff (if available and in the facility), and/or volunteers (if available and in the facility), to ensure their right to file complaints of any kind without the fear of retribution and regarding abuse investigation and prevention.</p> <p>Monitoring will start October 07, 2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility "Abuse Team Task Force," will present findings and/or corrective actions taken to the QA&A Committee during the quarterly QA&A Committee meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p> <p><i>per telephone call E admin checks will be 3rd Res rev week. 11-1-13 3:20 pm KM</i></p>	

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PRINTED: 09/23/2013
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 7</p> <p>there was any documentation about the discussion between the Administrator, Resident #2, and the resident's Interested Party, the Administrator stated, "No. It was more that she felt the aide wasn't being nice, was ignoring her. I guess I should have went through each of those steps." The Administrator continued, "Maybe she's [CNA #1] not always the nicest, or seems as caring. What I did is I brought her [CNA #1] in and asked her if something was going on. I think there was an issue with her attitude." The Administrator continued, "She's been working here all along." When asked if there was counseling or reprimand in CNA #1's file, the Administrator stated, "No. I verbally talked to her but I didn't write up anything."</p> <p>Review of the facility's Abuse Investigations policy documented the following, in part:</p> <ul style="list-style-type: none"> * Policy Statement - All reports of resident abuse, neglect and injuries of an unknown source shall be promptly and thoroughly investigated by facility management; * Policy Interpretation and Implementation - Employees of this facility who have been accused of resident abuse may be reassigned to nonresident care duties or suspended from duty until the results of the investigation have been reviewed by the administrator. <p>The facility failed to investigate all allegations of abuse, and failed to reassign the accused employee to nonresident care duties or suspend the employee to ensure residents were protected from further abuse when an allegation of abuse was not investigated.</p> <p>On 8/28/13 at 5:30 p.m., the Administrator and DON were informed of the abuse investigation</p>	F 225		

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F 225 F 226 SS=J	<p>Continued From page 8 issue. No further information or documentation was provided that resolved the issue.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident, staff, and family interviews; record review, review of abuse policies and procedures, and review of abuse investigation reports; it was determined the facility failed to develop and/or operationalize its abuse policies and procedures when they did not: * Develop policies to ensure residents were protected from exposure to employees who had been accused of abuse; * Ensure residents and/or resident representatives were informed of the outcome of investigations of abuse allegations; * Investigate all allegations of abuse; * Protect all residents when an allegation of abuse should have been investigated and the alleged perpetrator continued to work in the facility; * Ensure that all allegations of abuse/neglect and investigation results were reported to the state survey and certification agency in accordance with state law; * Ensure residents/Interested Parties were not afraid to report allegations of abuse/neglect because of fear of retaliation and intimidation;</p>	F 225 F 226	<p>The facility does ensure that all allegations of abuse or neglect are investigated, and that residents were protected from further abuse when abuse is alleged.</p> <p><i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>Prior to the identification of the allegation by the surveyors, immediately upon notification the facility Administrator on 8/12/13 did meet with Resident #2 and her family and followed up the allegation. Resident #2 and family were asked by the Administrator if they wanted to file a formal grievance and they declined. Resident # 2 was asked by the Administrator "Did she (C.N.A.) really throw it (call light) at you?" and Resident # 2 said "No." Then Resident #2 and family were asked if they believed that abuse occurred and they stated "No."</p> <p>The facility Administrator generated the allegation of abuse report for Resident #2 on 8/28/13, and reported allegation to the State Survey and Certification Agency.</p> <p>The facility Administrator, with the DNS, and MSW present, on 8/29/13, suspended the alleged employee pending the completion of the investigation and obtained statement from the alleged employee involved in the incident.</p> <p>The facility Administrator on 8/30/13 reported the result of investigation on the allegation to the State Survey and Certification Agency.</p>	10/28/13

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F 226	Continued From page 9 and, * Ensure contract staff were trained regarding abuse policies and procedures. This was true for 1 of 10 sample residents (#2). Failure to operationalize the abuse policies and procedures placed Resident #2 and all other residents who lived in the facility at risk for abuse. These failed practices constituted immediate jeopardy to the residents' health and safety. Findings included: 1. Resident #2 was admitted to the facility on 8/3/13 with multiple diagnoses which included in part, progressive supranuclear palsy (which inhibits her ability to speak or process quickly), cervical spondylosis, dysphasia, osteoarthritis, and peripheral neuropathy. Hospice services were also initiated on 8/3/13 due to the diagnosis of supranuclear palsy. Resident #2's most recent admission MDS, dated 8/9/13, documented in part: * Cognitively intact with a BIMS score of 15; * Usually able to make self understood; * Able to understand others; * Extensive assist with one person for bed mobility, transfer, dressing, and personal hygiene; * Extensive assist with 2 people for toilet use; and, * Functional limitation in range of motion in both upper and lower extremities. Resident #2's August 2013 Plan of Care identified problem areas and interventions included: * ADL - Pancake call light. Staff to assist as necessary * Bladder Incontinence - Encourage resident to seek assistance with toileting and keep call light in reach;	F 226	With regards to a story mentioned by the Hospice C.N.A. to the surveyor that was told to her by another Resident earlier in the year, in which according to the story related to her by the Resident, she (the Resident) heard what she called "Love making in the empty bed" in the resident's room. The facility Administrator reported allegation to the State Survey and Certification Agency on 9/27/13, generated the allegation of abuse report, and investigated. Based on the investigation by the Abuse Team Task Force, the allegation was found to be unsubstantiated. The Resident is no longer a Resident of the facility. During the investigation, based on the interview with the Hospice C.N.A., the Hospice C.N.A. mentioned that the Resident said she never saw it happen, instead just heard talking. Therefore based on the investigation it was determined that it was the movie "Twilight" (that has sexual connotation in it), that the Resident was watching and what she may have heard, hence allegation was unsubstantiated. On 10/2/13 the result of the investigation was reported to the State Survey and Certification Agency. Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following: This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, to address other residents that may have the potential to be affected by this deficiency, the facility Administrator and/or the facility MSW on 8/29/13, sent all Residents in the facility and/or Residents Representative correspondence via mail their right to file complaints or grievances of any kind without the fear of retribution.		

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F 226	<p>Continued From page 10</p> <ul style="list-style-type: none"> * Altered thought process due to Supranuclear Palsy which inhibits her ability to speak or process quickly - Determine if delayed reaction to information is due to misunderstanding or communication delay, and allow plenty of time for resident to respond to questions. Resident talks very softly, please ask resident to restate if needed; and * Potential for falls - Keep call light within easy reach, use easy touch style pancake call. <p>On 8/28/13 at 10:15 a.m., during an interview, Resident #2's Interested Party stated they had been informed by Resident #2 that a CNA had thrown the call light at her. The Interested Party indicated this occurred a week or so after Resident #2 was admitted to the facility. The Interested Party added that they were afraid to tell anyone about the incident because they were "Afraid of retaliation." A hospice CNA who was in attendance at the time stated that she too was afraid of retaliation.</p> <p>On 8/28/13 at 11:40 a.m., the hospice CNA was interviewed. When asked to explain what made her feel afraid of retaliation she stated, "You kind of get an aura," and began telling the surveyors about a previous resident she had cared for at the facility earlier in the year. The hospice CNA stated this previous resident confided in her details of a night when the resident heard what she called, "Love making" in the empty bed in the resident's room. The hospice CNA stated the "Resident said, 'Please don't say anything'" because the resident was "Mortified they weren't going to answer the call bell, toilet her, etc," if a report was made. The hospice CNA stated she reported it to the hospice LN, as well as LN #3, then to the administrator about 25 minutes later. The hospice</p>	F 226	<p><i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i></p> <p>To ensure that the deficient practice does not recur:</p> <p>On August 29, 2013, the company President did a formal write up to the Administrator on not following proper process for abuse investigation and prevention.</p> <p>The facility Administrator and Director of Nursing read and confirmed understanding of the Federal Regulations for F-166, F- 225, and F-226 as evidenced by statement of confirmation signed on 8/29/13.</p> <p>The facility on 8/29/13, developed an "Abuse Team Task Force," that will review all complaints of any nature as potential means of abuse.</p> <p>On 8/29/13, the facility Administrator and Director of Nursing updated the facility's Policy and Procedure for Abuse Investigation and Abuse Prevention Program, including federal guideline definitions and reporting process. This updated Abuse Investigation and Abuse Prevention Program Policy and Procedure was presented and approved by the Survey Team during the week of the Survey.</p> <p>On 9/10/13, the facility "Abuse Team Task Force" introduced themselves during the all staff in-service meeting and in-serviced all staff with regards to reporting any allegation of abuse to the facility "Abuse Team Task Force."</p> <p>An In-serviced to all staff, contract staff, and volunteers was also provided by the "Abuse Team Task Force" starting 8/30/13 through 10/20/13, with regards to the updated Policy and Procedure on Abuse Investigation and Abuse Prevention Program</p>		

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F 226	<p>Continued From page 11</p> <p>CNA stated the resident said, "I wish you didn't say anything." The hospice CNA was asked if she was asked by the facility to provide a written statement about the incident and she stated, "No. It was verbal, cordial. I don't remember signing any kind of document." The hospice CNA was asked if she was trained on abuse by the facility. The CNA stated, "No. I remember from schooling."</p> <p>On 8/28/13 at 2:20 p.m., Resident #2 was asked about the incident with the CNA and call light. The resident stated, "She [CNA #1] threw the call light at me and said, 'Here is your call light [residents name].'" Resident #2 continued, "She [CNA #1] hasn't been the same since, grumpy towards me." The Resident was asked if she reported the incident to anyone and she stated she told her family member who then talked to the Administrator. Resident #2 was asked if she was afraid to inform staff of the incident she stated, "No." When asked why she didn't notify staff, Resident #2 stated, "I'm not a teller."</p> <p>On 8/28/13 at 2:50 p.m., the Administrator was asked to provide documentation of an investigation report regarding the allegation of abuse to Resident #2. The Administrator stated the incident occurred "Two or three weeks ago," and that an evening CNA had complained to her that CNA #1 wasn't nice to Resident #2. The Administrator said she met with Resident #2 and an Interested Party about the allegation of abuse and asked them, "Do you want to write out a formal grievance, and they said no." The Administrator added, "I didn't treat it as a formal grievance. I said, 'Did she truly throw it at you?' And she [Resident #2] said, 'No.'" When asked if there was any documentation about the</p>	F 226	<p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i></p> <p>Monitoring will be done through;</p> <p>The facility "Abuse Team Task Force," or their designee will check with at least three (3) Residents for abuse issues and to ensure the Residents right to file complaints of any kind without the fear of retribution.</p> <p>The facility "Abuse Team Task Force," or their designee will check with at least (3) employees, and/or contract staff (if available and in the facility), and/or volunteers (if available and in the facility), to ensure their right to file complaints of any kind without the fear of retribution and regarding abuse investigation and prevention.</p> <p>Monitoring will start October 07, 2013. This will be done <u>weekly x 4, then q 2 weeks x 4, then monthly x 3.</u></p> <p>The facility "Abuse Team Task Force," will present findings and/or corrective actions taken to the QA&A Committee during the quarterly QA&A Committee meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>

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F 226	<p>Continued From page 12</p> <p>discussion between the Administrator, Resident #2, and the resident's Interested Party, the Administrator stated, "No. It was more that she felt the aide wasn't being nice, was ignoring her. I guess I should have went through each of those steps." The Administrator continued, "Maybe she's [CNA 1] not always the nicest, or seems as caring. What I did is I brought her [CNA #1] in and asked her if something was going on. I think there was an issue with her attitude." The Administrator continued, "She's been working here all along." When asked if there was counseling or reprimand in CNA #1's file, the Administrator stated, "No. I verbally talked to her but I didn't write up anything."</p> <p>The facility's Abuse Investigations Policy, 2001 revised 2004, documented in part:</p> <ul style="list-style-type: none"> * Policy Statement - All reports of resident abuse, neglect and injuries of an unknown source shall be promptly and thoroughly investigated by facility management; * Policy Interpretation and Implementation: * Our facility is committed to protecting our residents from abuse by anyone including but not necessarily limited to: facility staff, other residents...and staff from other agencies providing services to our residents; * Should an incident or suspected incident of resident abuse, neglect or injury of an unknown source be reported, the administrator, or his/her designee, will appoint a member of management to investigate the alleged incident; * The administrator will provide to the person in charge of the investigation a completed copy of the "Resident Abuse Report Form" and any supporting documents relative to the alleged incident; * The individual conducting the investigation will, 	F 226		

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F 226	<p>Continued From page 13 as a minimum:</p> <ul style="list-style-type: none"> * Review the completed "Resident Abuse Report Form;" * Review the resident's medical record to determine events leading up to the incident; * Interview the person(s) reporting the incident; * Interview any witnesses to the incident; * Interview the resident (as medically appropriate); * Interview the resident's attending physician as needed to determine the resident's current level of cognitive function and medical condition; * Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; * Interview the resident's roommate, family members, and visitors; * Interview other residents to whom the accused employee provides care or services; and, * Review all events leading up to the alleged incident. * The following guidelines will be used when conducting interviews: <ul style="list-style-type: none"> * Each interview will be conducted separately and in a private location; * The purpose and confidentiality of the interview will be explained thoroughly to each person involved in the interview process; and, * Should a person disclose information that may be self-incriminating, that individual will be informed of his/her rights to terminate the interview until such time as his/her rights are protected. * Witness reports will be reduced to writing. Witnesses will be required to sign and date such reports. (Note: A copy of such reports must be attached to the "Abuse Investigation Report Form."); * The individual in charge of the abuse 	F 226		

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F 226	<p>Continued From page 14</p> <p>investigation will notify the ombudsman that an abuse investigation is being conducted. The ombudsman will be invited to participate in the review process;</p> <ul style="list-style-type: none"> * Should the ombudsman decline the invitation to participate in the investigation, that information will be noted in the investigation record. The ombudsman will be notified of the results of the investigation as well as any corrective measures taken; * While the investigation is being conducted, accused individuals not employed by the facility will be denied unsupervised access to residents. Visits may only be made in designated areas approved by the administrator. Policies governing visitation are outlined in a separate policy in this chapter entitled "Visitation;" * Employees of this facility who have been accused of resident abuse may be reassigned to nonresident care duties or suspended from duty until the results of the investigation have been reviewed by the administrator; <p>NOTE: This policy does not specify how residents will be protected from exposure to employees who have been accused of abuse. This potential for further exposure places all residents at risk of further abuse while an investigation is being conducted.</p> <ul style="list-style-type: none"> * The individual in charge of the investigation will consult daily with the administrator concerning the progress/findings of the investigation; * The administrator will keep the resident and his/her representative (sponsor) informed of the progress of the investigation; * The results of the investigation will be recorded on the "Resident Abuse Investigation Report Form;" * The investigator will give a copy of the 	F 226		

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F 226	<p>Continued From page 15</p> <p>completed "Resident Abuse Investigation Report Form" to the administrator within 4 working days of the reported incident;</p> <p>* The administrator will inform the resident and his/her representative (sponsor) of the results of the investigation and corrective action taken within 2 days of the completion of the investigation;</p> <p>NOTE: At the time Resident #2 and the resident's Interested Party were interviewed on 8/28/13 they still had no follow-up from the incident they reported to the facility during the week of 8/3/13, a total of at least 19 days.</p> <p>* Should the investigation reveal that abuse occurred, the administrator will report such findings to the local police department, the ombudsman, the state licensing agency and others as may be required by state or local laws within 2 days of the results of the completion of the investigation;</p> <p>NOTE: The 2005-1 Informational letter on resident abuse reporting stated, "All allegations must be immediately reported to the facility's Administrator and to the Department's hotline... 'Immediately' means as soon as reasonably possible, and no later than 24 hours from the discovery of the incident... All investigation reports must include the facility's conclusions and actions taken to prevent a repeat occurrence of abuse."</p> <p>* The administrator will provide a written report of the results of all abuse investigations and appropriate action taken to the state survey and certification agency within 5 days of the reported incident;</p> <p>NOTE: This conflicts with the aforementioned statement.</p>	F 226		

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F 226	<p>Continued From page 16</p> <ul style="list-style-type: none"> * Should the investigation reveal that a false report was made/filed, the investigation will cease. Residents, family members, ombudsmen, state agencies, etc., will be notified of the findings; NOTE: The facility did not demonstrate any of those steps had been taken regarding Resident #2's allegation. * Policies governing abuse reporting are outlined in separate policies of this chapter entitled "Reporting Abuse to facility Management" and "Reporting Abuse to State Agencies and Other Entities/Individuals;" * Inquiries concerning abuse reporting and investigation should be referred to the administrator or to the director or nursing services. <p>On 8/28/13 at 5:30 p.m., the Administrator and DON were informed of the immediate jeopardy issue related to the facility's failure to operationalize policies and procedures for training contract employees, protection of residents, and for the prevention, identification, investigation, and reporting of allegations of abuse, neglect, and mistreatment of residents.</p> <p>On 8/30/13 at 8:45 a.m., the facility provided an acceptable plan to abate the immediate jeopardy. The abatement plan documented in part:</p> <ul style="list-style-type: none"> * The Administrator and DON confirmed understanding of Federal Regulation; * The Administrator and DON updated the facility's Policy and Procedure for Abuse Investigations and Abuse Prevention Program, including federal guideline definitions and reporting processes; and, 	F 226		

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F 226	Continued From page 17 * The facility inserviced all staff, contract staff, and volunteers on the Abuse Policy and Procedures and reporting. Staff, contract staff, and volunteers not currently available will be inserviced prior to returning to work. The facility failed to follow its policy to investigate all allegations of abuse; failed to develop policies and procedures ensuring protection of residents or investigation and reporting of allegations of abuse, neglect, or mistreatment; failed to ensure residents were protected from further abuse when an allegation of abuse was not investigated; failed to reassign the employee to nonresident care duties or suspend from duty until results of the investigation were reviewed when an allegation of abuse was not investigated; failed to report the allegation of abuse; and failed to ensure contract staff (Hospice CNA) were trained regarding abuse policies and procedures. These failed practices placed all facility residents at risk for abuse, neglect, and mistreatment.	F 226	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not ensure an environment to maintain or enhance dignity and respect. This was true for 3 of 9 (#s 1, 7, and 9) residents sampled for dignity. The	F 241	10/28/13 The facility does ensure an environment to maintain or enhance dignity and respect. <i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i> Identified C.N.A. caring for Resident #9 was provided with 1:1 education by the Director of Nursing with regards to F-241 on 10/4/13, the importance of not to leaving the resident unattended once care need is identified.

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F 241 Continued From page 18
deficient practice had the potential to cause more than minimal harm when residents were left in their own incontinence, became agitated when incontinent, or became embarrassed at soiled clothing from their meals. Findings included:

[Please see F312 as it pertains to assistance with ADLs, and F323 as it pertains to supervision at meals, and F353 as it pertains to nursing staffing.]

1. Resident #9 was admitted to the facility on 4/12/13 with multiple diagnoses which included anemia, diabetes, Alzheimer's, dementia, and depression.

Resident #9's most recent quarterly MDS assessment, dated 7/16/13, documented in part:

- * Unable to interview to determine BIMS score;
- * Delusions;
- * Total assist of 2 or more people for bed mobility, transfers, locomotion on unit, dressing, toilet use, and personal hygiene;
- * Frequently incontinent of bladder; and,
- * Always incontinent of bowel.

An Accident and Incident Report for Resident #9, dated 6/1/13, at 11:40 p.m. documented in part:

- * Event Type- Fall;
- * Injury - No injury;
- * Location - Resident's room;
- * Cause - Resident health/mental status and other: Incontinent; and,
- * Description of the event, circumstances, and account from Resident - Resident rolled out of bed onto the floor.

The Fall Scene Investigation Report, dated 6/1/13, documented in part:

F 241 The nursing staff assisted resident #7 in room with ADLs once she left the dining room. The nursing staff providing care to Resident #7 during survey were provided 1:1 education with regards to F-241 on 10/5/13 by the Director of Nursing on the importance of not leaving the resident in the dining room.

Resident #1 was moved to assistive dining table on 09/03/13, referred to RD on 09/04/13 for diet recommendations, and evaluated by OT on 09/02/13 for self-feeding. Diet was changed to "finger foods when possible, continue mech soft diet as previous."

Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:

This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.

However, to address other residents who potentially may be affected by this deficiency, the Administrator and Director of Nursing did a visual observation of at least four residents on each shift to ensure that residents are provided with care and dining assistance by 10/5/13.

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- * What type of assistance was resident receiving at time of fall - Alone and unattended;
- * Describe resident's psychological status prior to fall - Unable to use call bell, not able to tell staff when soiled attends;
- * Re-Creation of Last 3 Hours Before Fall - CNA coming on to shift found bed in high position. Lowered bed down. Noticed resident had incontinent episode of stool. Left resident alone safely in bed to answer another resident's alarm and assist nurse in room 7 with dressing change. After finishing and arriving at nurses station, heard thud in resident's room. When entering room observed resident on floor incontinent of stool and urine on floor.

Note: Resident #9 had been incontinent of bowel when the CNA came into the room. However, the resident was left alone in his incontinence while the CNA answered an alarm and assisted a LN.

On 8/30/13 at 11:30 a.m., the DON was interviewed about Resident #9's fall. The DON stated, "This [the Accident and Incident Report] says he was incontinent. It looks like he had been incontinent and she left to answer an alarm."

On 8/30/13 at 11:40 a.m., the Administrator was informed of the dignity issue of Resident #9 being left in his incontinence of bowel. No further information or documentation was provided that resolved the issue.

2. Resident #7 was admitted to the facility on 3/21/13 with multiple diagnoses which included dementia, edema, and diabetes.

F 241 **Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:**

To ensure that the deficient practice does not recur an In-service training was completed on 10/5/13 by Director of Nursing or designee regarding F-241 to all Nursing Staff;
With emphasis on not leaving resident once a care need is identified, providing assistance from dining room following a meal, and providing assistance with eating as needed in dining room.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Director of Nurses or designee will do a visual observation to ensure that nursing staff do not leave resident once a care need is identified, assistance is provided from dining room following a meal, and assistance is provided with eating as needed in the dining room.

Monitoring will start on October 07, 2013.
This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.

The facility Director of Nursing or designee will submit to the Administrator or designee and the QA&A Committee in her quarterly report findings and/or corrective actions taken.

Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.

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F 241	<p>Continued From page 20</p> <p>Resident #7's most recent change of condition MDS assessment, dated 6/25/13, coded: -Severely impaired cognition. -Limited assistance of 1 person for transfers, ambulation, and hygiene. -Limited assistance of 2 people for toileting. -Usually continent of bladder, always continent of bowel.</p> <p>Resident #7's care plan documented she was to receive 1 person limited assistance for transfers, ambulation, and hygiene; and that the she was usually continent of bowel and bladder.</p> <p>On 8/27/13 at 6:25 PM, Resident #7 was noted to be sitting at the dining table with her evening meal. No staff were present in the dining room. Resident #7 finished her meal, then requested assistance to stand and leave the dining room. She became agitated and began to curse when no assistance was available, and eventually stood and ambulated from the dining room on her own. As the resident left the dining room, she was noted with a strong urine odor, and her pants were damp in the groin/buttock area.</p> <p>On 8/28/13 at 12:35 PM, Resident #7 was again observed to request assistance, then eventually stand on her own and leave the dining room. Again, she was noted with a strong urine smell and damp pants.</p> <p>3. Resident #1 was admitted to the facility on 6/2/06 with multiple diagnoses which included hypertension, edema, and osteoarthritis.</p> <p>Resident #1's most recent quarterly MDS assessment, dated 7/2/13, coded:</p>	F 241		

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F 241	<p>Continued From page 21</p> <ul style="list-style-type: none"> -Severely impaired decision making skills. -No rejection of cares. -Limited assistance of 1 person required for eating. <p>On 2/14/12, Resident #1's care plan documented an approach of limited assistance of 1 person to eat. On 8/27/13, this approach was amended to include, "but I do try to feed myself. I need a little help to get me started."</p> <p>On 8/27/13, between 5:30 and 6:00 PM, Resident #1 was observed at meals. At times throughout the meals Resident #1 had assistance to consume her meals, but at times no assistance was available. When assistance was not available, Resident #1 fed herself ambrosia (small pieces of fruit and coconut mixed with whipped cream) and diced canned peaches using her hands. At the end of the meal on 8/27/13, Resident #1 was noted with crumbs from her sandwich, remains of her ambrosia, and pieces of peach covering the front of her shirt and her lap. Those areas were also wet with the juice from her peaches.</p> <p>On 8/29/13 at 6:15 PM, the Administrator and the DNS were informed of the surveyor's observations and concern for resident dignity. The facility offered no further information.</p>	F 241		
F 252 SS=F	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p>	F 252	<p>The facility does ensure a clean, comfortable, and homelike environment.</p> <p><i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i></p>	10/28/13

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F 252	<p>Continued From page 22</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, it was determined the facility did not ensure a clean, comfortable, and homelike environment. This was true for 12 of 13 (#s 1-9, 11-13) sampled residents, and had the potential to impact any resident living in the facility. The deficient practice had the potential to cause more than minimal psychosocial harm when residents were exposed to stained and soiled flooring; walls, chairs, baseboards, and tables soiled and in disrepair; and an unkempt fish tank. Findings included:</p> <p>[NOTE: Please see F241 as it pertains to resident dignity. Please see F323 as it pertains to supervision in the dining room.]</p> <p>On 8/26/13 at 9:50 AM during the initial tour of the facility, on 8/27/13 at 2:25 PM during a walk-through of the general environment, on 8/29/13 at 4:50 PM during the environmental tour with the facility maintenance director, and continually throughout the survey, the following were noted:</p> <p>1. The carpet in the east and west hallway and past the nurse's station was marbled with multiple stains throughout its entire distance (the surveyor was able to count no fewer than 150 separate stains). The area of the carpet near the nurse's station also had many faded areas consistent with bleach coming in contact with the carpet surface. There was a worn traffic pattern from the door of the kitchen, across the carpet, to the dining room (a distance of approximately 20 feet).</p>	F 252	<p>Carpet was cleaned on 9/4/13 and will be replaced by 10/28/13. Area at Nurse's Station and 20 foot span from kitchen door to dining area will be replaced with vinyl by 10/28/13.</p> <p>Resident rooms #1, 2, 4, 14, 15, and 25 will be replaced with new vinyl flooring by 10/28/13.</p> <p>Divider walls were painted on 10/3/13. Wooden top ledge on divider walls were cleaned, sanded where necessary and resealed on 10/2/13. Baseboards will be replaced with new vinyl flooring by 10/28/13.</p> <p>Dining room tables were sanded and beveled edges on tabletops will be cleaned and sanded, completed by Maintenance Director, by 10/23/13.</p> <p>Order was placed for new dining tables on 9/6/13.</p> <p>Every dining room chair was cleaned and inspected by 9/25/13. Order was placed for new dining room chairs on 9/6/13.</p> <p>Fish tank was cleaned on 8/31/13. Fish tank was removed from facility on 9/15/13.</p> <p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:</p> <p>This deficiency has the potential to impact any resident living in the facility.</p> <p>Rounds were completed by Administrator or designee to identify environmental issues on 10/7/13.</p>

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2. Resident room #s 1, 4, 14, 15 and 25 had a black grimy build-up across the threshold of the room, extending approximately 6 inches into the room. Resident room #2 had 4 cracked tiles in the center of the room. Resident rooms #4 and 15 had a marbled waxy built-up substance on the floor throughout the room. [NOTE: The flooring in all of these rooms was square vinyl tiles.]

3. The divider walls between the hallway and the dining room, between the sitting area and the dining room, and between the TV lounge and the dining room were in general disrepair. Specifically: the wooden ledge atop the divider walls had gouges, scratches, and a gummy build-up. The divider walls had scuffed paint, gouges in the paint/wall surface, and black "skid marks" covering the wall near the sitting area for about 1 foot from the floor. The baseboards had come loose from the divider wall in several locations.

4. Seventeen tables in the dining room and activity room had scuffed, scratched, and marred legs. The beveled edges on the tabletops had a gummy/crumby build up substance.

5. Twenty-seven chairs in the dining room and activity room had a gummy build-up on the arms of the chairs, as well as crumbs, dried liquid, and other debris on the frames of the chairs behind the seats.

6. The dining room had a fish tank against the divider wall for the east hallway. There were numerous globs of a black fuzzy substance, ranging from approximately 1 cm to approximately 3 cm in size, suspended in the

F 252

Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure that the deficient practice does not recur an In-service training was completed on 10/5/13 by Administrator regarding F-252 to all Staff; The need to keep environment clean, comfortable, and homelike.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or designee will do a visual observation of the environment to ensure the environment is clean, comfortable, and homelike.

Monitoring will start on October 07, 2013.

This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.

The facility Administrator or Designee will submit to the QA&A Committee their quarterly report findings and/or corrective actions taken.

Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.

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F 252	<p>Continued From page 24</p> <p>water of the tank. Each of these globs had tentacle-like growths protruding in a star pattern from the splotchy center. This substance was also noted to be clinging to the glass sides of the tank, covering approximately 80% of the surface area. The entire fish tank environment had a black hue. There was a scummy substance covering the surface of the water in the tank. On 8/26/13 at 2:35 PM, Resident #6 was sitting with several residents near the fish tank. The residents were asked if they enjoyed looking at the fish. Resident #6 squinted in the direction of the fish tank and stated, "There's fish in there?"</p> <p>On 8/26/13 at 9:30 AM, the Administrator stated the facility had plans to replace all of the flooring in the common areas used by residents.</p> <p>On 8/29/13 at 4:00 PM, the maintenance director was asked about the above items. The maintenance director stated, "I know. In fact, I hope they let me re-do these chairs. I've been doing research on dementia, and I know the flowers (pattern on the chair upholstery) isn't good for people with dementia. They can't see where they're going to sit. Also, I know this brown (paint color on the walls) isn't the best for them either. They need brighter colors."</p> <p>On 8/29/13 at 6:15 PM, the Administrator was informed of these concerns. The facility offered no further information.</p>	F 252	
F 258 SS=E	<p>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS</p> <p>The facility must provide for the maintenance of comfortable sound levels.</p>	F 258	<p>The facility does ensure comfortable sound levels are maintained. 10/28/13</p> <p><i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i></p>

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F 258	<p>Continued From page 25</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure comfortable sound levels were maintained. This had the potential to affect 9 of 9 sample residents (#s 1-9) and all other residents with hearing ability and in the vicinity of the door. The noisy environment had the potential to affect residents' quality of life. Findings included:</p> <p>On 8/27/13 at 9:50 a.m., a key pad was observed by the "Staff Only" door located across the hall from the Nurses' Station. A key pad was also observed on the other side of the door. The Nurses' Station was centrally located with the kitchen and the dining room near by. In addition, residents rooms were located on both sides of the Nurses' Station. The "Staff Only" door knob was locked and could not be turned. However, the lock's latching mechanism did not align with the receptacle in the door frame, and the door could simply be pushed open.</p> <p>Throughout the survey week, many staff were observed going in and out of the "Staff Only" door. Several of the staff entered a code on the key pad and entered quietly through the door. However, many of the staff opened the "Staff Only" door without first entering the code on the key pad. This caused a loud alarm to sound until a code was entered on the key pad on either side of the door. The alarm sounded for 3-5 seconds each time the door was opened before the code was entered.</p> <p>On 8/27/13 at 9:55 a.m., when asked about the</p>	F 258	<p>The door alarm going into staff hallways was replaced on 9/24/13.</p> <p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:</p> <p>This deficiency has the potential to impact any resident that was in the surrounding area.</p> <p>All staff were in-serviced on 10/5/13, by Administrator to ensure that they enter the code first prior to opening the door.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>The Maintenance Director or designee will check functioning of the alarm keypad weekly by adding to the weekly maintenance log by 10/7/13.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>Observation will be done by Administrator or designee to ensure the staff are first entering the code on door keypad prior to opening thus ensuring a comfortable sound level is maintained.</p> <p>Monitoring will start on October 07, 2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Administrator or Designee will submit to the QA&A Committee the quarterly report findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/23/2013
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION & CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET MC CALL, ID 83638	
(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)
F 258	<p>Continued From page 26</p> <p>"Staff Only" door, Housekeeper #8 stated, "It's on a sensor to let us know when someone is going in or out."</p> <p>On 8/27/13 at 10:15 a.m., when asked if the "Staff Only" door was supposed to be locked, the Administrator stated, "No. It's just a push through." When asked what would happen if the door was opened before the key pad code was input, the Administrator stated, "The alarm will let us know."</p> <p>On 8/29/13 from 9:25 a.m. to 10:17 a.m. (52 minutes), 8 of 9 staff were observed to activate the audible alarm when they did not enter the code on one of the key pads on each side of the "Staff Only" door as follows:</p> <ul style="list-style-type: none"> * 9:25 a.m. - Medical Records Supervisor; * 9:26 a.m. - SDC; * 9:28 a.m. - Housekeeper #8; * 9:30 a.m. - DNS; * 9:35 a.m. - Activity Director; * 9:52 a.m. - LN #3; * 10:08 a.m. - LN #3; and, * 10:17 a.m. - Maintenance Supervisor. <p>During the aforementioned 52 minute time frame, 2 residents were observed in the dining room, 6 residents were observed in the common area adjacent to the dining room, and 3 residents were observed moving about in the hallway by the Nurses' Station.</p> <p>Failure to utilize the key pad code to deactivate the audible alarm before going through the "Staff Only" door created unnecessary noise levels in the facility.</p> <p>On 8/29/13 at 6:15 p.m., the Administrator and</p>	F 258	
			(X5) COMPLETION DATE

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F 258	Continued From page 27 DNS were informed of noise issue. No other information or documentation was received from the facility.	F 258		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the comprehensive care plan was reviewed and revised to reflect current resident needs for 2 of 10 sample residents (#2 and #6). The care plan for Resident #2 did not reflect revisions for a modified diet texture, and current approaches used by staff for Resident #6 to increase	F 280	The facility does ensure that the comprehensive care plan is reviewed and revised to reflect current resident needs. <i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i> Diet for Resident #2 was changed to a fortified full liquid diet on 9/24/13. The care plan will remain as Diet per MD order. Specific diet per MD order included in the diet binder at nurse's station for quick reference and update. The facility updated Resident #6 vision and cognitive care plans which included approaches to compensate for her visual and cognitive impairment by 9/27/13. <i>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:</i> This deficiency has the potential to impact all residents' diets and residents with visual and/or cognitive impairment, therefore; The Director of Nursing created a diet binder that will be placed at nurse's station for nursing staff reference by 10/2/13. The facility's CCM or designee will audit vision and/or cognitive care plans for all residents that are identified on MDS with visual and cognitive impairment and update as necessary by 10/7/13.	10/28/13

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F 280	<p>Continued From page 28</p> <p>receptiveness to cares. This had the potential for harm if the residents did not receive appropriate care due to lack of direction in the care plan. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 8/3/13 with multiple diagnoses which included in part, progressive supranuclear palsy, cervical spondylosis, dysphasia, osteoarthritis, and peripheral neuropathy.</p> <p>Resident #2's most recent admission MDS assessment documented in part:</p> <ul style="list-style-type: none"> * Cognitively intact with BIMS score of 15; * Limited assistance with 1 person for eating; * Mechanically altered diet; and, * Therapeutic diet. <p>Resident #2's August 2013 Plan of Care, dated 8/24/13, documented in part:</p> <ul style="list-style-type: none"> * Nutrition - Diet as per MD order. Encourage resident to hold her cup and feed herself as much as she can. Assist as necessary; and, * Bladder - Encourage nectar thick fluids with meals and offer frequently throughout the day. <p>On 8/8/13 a Condition Change Form was filled out for Resident #2 which documented, "She has a puree [with] nectar thick diet but order from AL [assisted living] states mech [mechanical] soft. Family reports she needs puree [with] nectar thick."</p> <p>On 8/12/13 a Condition Change Form was filled out for Resident #2 which documented, "Resident noted to be choking during meals this weekend and seemed to do better with smoothie like consistency drinks."</p>	F 280	<p><i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i></p> <p>The Director of Nursing or designee will in-service all nursing staff on 10/5/13 on the diet binder at nurse's station for reference.</p> <p>All Licensed Nurse's will be in-service by the Director of Nursing or designee on 10/5/13 to update the binder with any change of diet.</p> <p>The facility's Administrator on 10/4/2013 will in-service the IDT on vision and/or cognitive care plans with emphasis on the importance of ensuring approaches to compensate for Residents visual and/or cognitive impairment.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The facility's Director of Nursing or designee will audit the dietary binder to ensure that it is updated with any change of diet. The Administrator or designee will audit to ensure that residents who are identified with visual and/or cognitive impairment have a care plan and approaches to compensate for Residents visual and/or cognitive impairment.</p> <p>Monitoring will start on October 07, 2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. ✓</p> <p>The facility Administrator or Designee will submit to the QA&A Committee in the quarterly report findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>

11-1-13 3:20pm telephone call with Admin discussed the F280 is for care plan + the examples are just examples + be sure to review for all care areas. she agreed KM

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F 280	<p>Continued From page 29</p> <p>On 8/14/13 Resident #2 had a new physician's order which documented, "Puree diet [with] nectar thick liquids." The order was noted by an LPN dated 8/15/13.</p> <p>On 8/15/13 Resident #2 had a new physician's order that documented, "Modified full liquid diet." The order was noted by an LPN dated 8/16/13.</p> <p>On 8/27/13 at 5:46 p.m., CNA #1 and the DON were asked which diet Resident #2 was on. CNA #1 stated, "Pureed with nectar thick liquids." The DON stated, "Its been back and forth" and stated to CNA #1, "It is a full liquid diet like [Resident #8's name]."</p> <p>Note: Resident #2's August 2013 Care Plan documents, "Diet as per MD order." However, it is unclear how staff would know which diet the resident is on due to frequent diet changes.</p> <p>On 8/29/13 at 6:15 p.m., the Administrator and DON were informed of the care plan issue. No further information was provided that resolved the issue.</p> <p>2. Resident #6 was admitted to the facility on 12/16/11 with diagnoses which included Type II Diabetes, peripheral vascular disease, and dementia.</p> <p>Resident #6's most recent quarterly MDS, dated 7/9/13, coded moderately impaired decision making skills, moderately impaired vision, physical and verbal behavioral symptoms directed towards others 1 to 3 days per week, and the need for extensive assistance of one person for bed mobility, transfers, ambulation, dressing, and toileting.</p>	F 280		

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F 280	<p>Continued From page 30</p> <p>Resident #6's care plan documented:</p> <ul style="list-style-type: none"> -Problem area, "[Resident #6] has a [history] of becoming very angry/agitated with other residents and staff. [Resident #6] can become annoyed, agitated, and irritable." Onset date 4/30/13. -Goal, "[Resident #6] will not hit staff [more than] 15 times a month through the next review." Onset date 4/30/13. -Interventions did not include information about Resident #6's visual status or approaches to be used to compensate for her visual impairment. -Problem area, "Altered thought process related to cognitive impairment." Onset date 1/8/2009. -Goal, "Reduce frustration and fearfulness that occurs due to impaired cognition." Onset date 3/9/12. -Interventions included, "Approach [Resident #6] in a calm manner - speak directly to her to increase understanding." Onset date 4/12/11. <p>[NOTE: There was no other information on how Resident #6 should be approached.]</p> <p>On 8/26/13 at 3:00 PM, Resident #6 was sitting near the nurse's station. Resident #6 was approached by LPN # 12. LPN # 12 kneeled down in front of Resident #6, touched her leg, and stated, "[Resident #6], it's [LPN #12]. Are you not feeling well? Let's go down to your room and I can check your blood sugar." The surveyor then stood behind Resident #6 and asked the resident for permission to observe the procedure. Resident #6 did not respond. LPN # 12 stated to the surveyor, "She can't hear you and she can't see you. You have to get around to the front of her, get down to her level, then touch her leg gently to let her know you're there. Otherwise,</p>	F 280		

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F 280	Continued From page 31 you might startle her and she gets agitated." The surveyor then approached Resident #6 as instructed by LPN #12, at which time the resident responded and was receptive to the observation. On 8/28/13 at 9:15 AM, the Administrator and DNS were asked about approaches used for Resident #6. The Administrator and DNS stated Resident #6 had a long history of variable agitation and combativeness with staff, which would even vary within the course of a single day. The DNS described several interventions used by staff once Resident #6 had become agitated. The DNS and Administrator were informed of the approach used by LPN #12, and asked if that information should be found in Resident #6's care plan. The Administrator and DNS agreed Resident #6's care plan should have been updated to include the approach used by LPN #12. The facility offered no further information to resolve this concern.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure staff adhered to professional standards of practice regarding inhaled corticosteroid medication. This was true for 1 of 2 LNs who administered an inhaled medication during	F 281	The facility does ensure that the staff does adhere to professional standards of practice regarding inhaled corticosteroid medication. <i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i> L.N. #2 caring for Resident #11 was provided with 1:1 education by the Director of Nursing with regards to F-281 on 10/6/13 with emphasis on ensuring resident is instructed or encouraged to rinse mouth without swallowing after taking inhaled corticosteroid medication.	10/28/13

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F 281	<p>Continued From page 32</p> <p>medication pass observations. It affected Resident #11 and created the potential for the resident to develop oral candidiasis. Findings included:</p> <p>On 8/27/13 at 3:15 p.m., LN #2 was observed as she administered 1 puff of Advair 250/50 (an antiasthmatic, corticosteroid medication) to Resident #11. After the administration, the LN handed the resident a small plastic glass half full of water. The resident rinsed her mouth with the water for several seconds then swallowed the rinse water. The LN did not instruct or encourage the resident to rinse without swallowing.</p> <p>Immediately afterward, when informed of the observation regarding Resident #11's Advair, LN #2 stated, "She always swallows it. I guess I could have offered her something to spit in."</p> <p>Reconciliation of the medication administration with Resident #11's August 2013 Physician Orders revealed the Advair order included the following, "Please offer H2O [water] mouth rinse after dosing."</p> <p>Note: Regarding Advair, the Nursing 2014 Drug Handbook, documentation included, "ADMINISTRATION Inhalation...After administration, have the patient rinse his mouth without swallowing." And, under PATIENT TEACHING, it included, "Instruct patient to rinse mouth after inhalation to prevent oral candidiasis."</p> <p>On 8/29/13 at 6:15 p.m., the Administrator and DNS were informed of the issue. No other information or documentation was received from the facility which resolved the issue.</p>	F 281	<p><i>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:</i></p> <p>This deficiency has the potential to impact any resident receiving inhaled corticosteroid medication.</p> <p>On 10/6/13 the Director of Nursing identified all residents receiving inhaled corticosteroids and observed the administration by the licensed nurse to ensure that after the inhalation the resident received instruction and encouragement to rinse mouth without swallowing.</p> <p><i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i></p> <p>The Director of Nursing in-serviced all licensed nurses on 10/6/13 regarding F281 with emphasis on the importance of ensuring that after the inhalation of corticosteroids the resident receives instruction and encouragement to rinse mouth without swallowing.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Director of Nursing or designee will observe residents receiving inhaled corticosteroids to ensure that after administration the resident receives instruction and encouragement to rinse mouth without swallowing.</p> <p>Monitoring will start on October 07, 2013. This will be done <u>weekly x 4</u>, then <u>q 2 weeks x 4</u>, then <u>monthly x 3</u>. ✓</p> <p>The facility Director of Nursing or Designee will submit to the QA&A Committee in the quarterly report findings and/or corrective actions taken.</p>	
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F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility did not ensure:</p> <p>a. Physician's orders for the monitoring of blood glucose levels and administration of insulin were clearly written, and administration of insulin and interventions were clearly documented;</p> <p>b. Coordination of care between the facility and hospice providers; and</p> <p>This was true for 2 of 9 residents (#s 2 and 6) sampled for quality of care. This deficient practice had the potential to cause more than minimal harm if a resident did not receive treatment according to their clinical needs, or if aspects of their care and treatment were not adequately communicated with all entities involved in resident care. Findings included:</p> <p>1. The facility's "Nursing Care of the Adult Diabetes Mellitus Resident" policy and procedure, dated 2001 and updated 5/2011, documented, in part: -"Monitor Blood glucose [BG] per MD order. May check Finger stick Blood glucose for signs/symptoms of Hypoglycemia or Hyperglycemia."</p>	F 309	<p>The facility does ensure physician orders for the monitoring of blood glucose levels and administration of insulin were clearly written, and administration of insulin and interventions were clearly documented; and that there is coordination of care between the facility and hospice providers.</p> <p><i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>On 9/30/13 the facility's Director of Nursing or designee obtained an order clarification for Resident #6 for diabetic regimen to ensure physician orders for the monitoring of blood glucose levels and administration of insulin and/or interventions were clearly written.</p> <p>On 10/4/13 the facility's Administrator or designee obtained a coordinated plan of care from St Lukes's Hospice for Resident #2. On 8/29/13 the facility Social Worker obtained documentation from hospice Social Worker. Starting on 8/29/13 the hospice C.N.A. started leaving a "Hospice Aide Note" with each visit.</p> <p><i>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:</i></p> <p>This deficiency has the potential to impact any resident on a sliding scale regimen and is isolated for hospice resident.</p> <p>The facility's Director of Nursing reviewed all residents receiving a sliding scale diabetic regimen on 9/30/13 to ensure physician orders for the monitoring of blood glucose levels and administration of insulin and/or interventions were clearly written.</p>	10/28/13

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F 309	<p>Continued From page 34</p> <p>- "For hypoglycemia (BG < [less than] 70 mg/dl) treat with carbohydrate containing glucose...recheck BG in 15 minutes..."</p> <p>- "Treatment documentation should include: 1. The specific interventions. 2. Follow up blood glucose levels..."</p> <p>[NOTE: The policy did not include where or how the documentation should be completed.]</p> <p>Resident #6 was admitted to the facility on 12/16/11 with diagnoses which included Type II Diabetes, peripheral vascular disease, and dementia.</p> <p>Resident #6's most recent quarterly MDS, dated 7/9/13, coded moderately impaired decision making skills, and the need for extensive assistance of one person for bed mobility, transfers, ambulation, dressing, and toileting.</p> <p>Resident #6's Physician's Orders (recaps) for August 2013 documented: - Order date 4/16/13. "Novolog 100 U/ML (units per milliliter) Susp[ension] Sliding Scale Subcutaneous Three Times Daily with meals 5 U plus [less than] 70 give one amp D 5 [dextrose to increase BG levels] or juice and notify MD., 71-180 = None, 181-250 = 4 U, 251-300 = 6 U, 301-350 = 8 U, [greater than] 400 = Call MD." - Order date 6/18/12. "Lantus 100 U/ML SOL (Insulin Glargine, Recombinant) 17 U subcutaneous [every] AM for diabetes, Do not hold insulin unless resident does not eat at all, then give 1/2 dose."</p> <p>Resident #6's MAR for August 2013 documented: - "12/16/11 BG's right before meals and HS [hour of sleep]", along with spaces to document those values at 7:30 AM, 12:00 noon, 5:30 PM, and</p>	F 309	<p>The facility's Abuse Team Task Force on 9/25/13 will review with hospice the need for Coordinated Plan of Care and documentation to ensure there is an exchange of information between the facility and hospice staff.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>On 10/5/13 the facility's Administrator and Director of Nursing updated the diabetic policy to include <u>where</u> and <u>how</u> the documentation should be completed. The Director of Nursing in-serviced Licensed Nurses on the updated diabetic policy on 10/6/13.</p> <p>Starting 10/7/13 at least one member of the Abuse Team Task Force or designee <u>will meet</u> with hospice staff <u>when they enter facility</u> prior to caring for resident and <u>upon exit</u> of facility to review documentation and address any concerns.</p>

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F 309	<p>Continued From page 35</p> <p>8:00 PM. [NOTE: There were no other areas on Resident #6's MAR to document BG values.] -Spaces to document Novolog administration at 7:30 AM, 12:00 noon, and 5:30 PM, along with the site insulin was administered and the number of units of Novolog administered at each of these times. On 8/12/13 at 5:30 PM, and 8/13/13 at 7:30 AM, the MAR documented, "held." -For Lantus, the same order as noted on the Physician's Orders form. "1/2 dose 8/6" was hand-written with that order on the MAR. Space to document Lantus administration at 7:30 AM, and the site where the Lantus was given. [NOTE: There was no space to document how much the resident had eaten. There was no space to indicate whether the entire dose of Lantus, or the half dose, had been administered.] -The last page of Resident #6's MAR was a "Nurse's Medication Notes" form. Under the heading of "Medication" were columns for date, hour, initials, description and reason. Under the heading of "Results" were columns for description, hour, and initials. This form diabetes-management issues as follows: *8/4/13 at 5:30 PM, BG check of 63, juice given, no signs of hypoglycemia at midnight. *8/13/13 at 7:00 AM, Lantus and Novolog held because the resident slept through breakfast. *8/20/13 at 4:00 PM, BG check of 65, up to 136 at an unspecified time.</p> <p>On 8/26/13 at 3:00 PM, LPN #12 approached Resident #6, expressed concern the resident was not feeling well, and took the resident to her room for a BG check. At 3:10 PM, the BG check was completed. LPN #12 stated to the surveyor, "It's 65." LPN #12 then took Resident #6 to the dining room, offered the resident a glass of orange juice, and sat with the resident until the juice was</p>	F 309	<p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i></p> <p>Monitoring will be done through:</p> <p>The Director of Nursing or designee will audit residents receiving a sliding scale diabetic drug regimen to ensure physician orders for the monitoring of blood glucose levels and administration of insulin and/or interventions were clearly written.</p> <p>At least one member on the Abuse Team Task Force will audit to ensure that Hospice coordinated plan of care and documentation of hospice staff visit are in the Resident chart.</p> <p>Monitoring will start on October 07, 2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Administrator and/or Director of Nursing or their Designee and/ or the Abuse Team Task Force or designee will submit to the QA&A Committee in the quarterly report findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>

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F 309	<p>Continued From page 36 consumed. At 3:30 PM, LPN #12 re-checked Resident #6's BG level.</p> <p>On 8/28/13 at 9:15 AM, the Administrator and DNS were interviewed regarding diabetic management for Resident #6. The DNS reported the following:</p> <ul style="list-style-type: none"> -The DNS stated Resident #6's Novolog insulin was held twice during the month of August (8/12/13 at dinner and 8/13/13 at breakfast) due to the physician's order. The DNS stated she interpreted the current physician's order to stipulate Resident #6's Novolog should be held for a BG reading of less than 70. After reviewing the order, the DNS stated, "However, it's not clear as it is now written." The DNS stated she would contact the physician to get the order clarified. -The DNS stated the nursing staff should check Resident #6's BG anytime she showed signs of hypoglycemia, document those checks, as well as the intervention and follow-up BG within 15 minutes for a BG of less than 70. The DNS stated the documentation could be found on the Nurse's Medication Notes form at the back of the MAR. However, the DNS could not explain why that documentation was not present for 8/12/13 at 8/13/13, when Resident #6's insulin was documented as, "held." Further, the DNS could not state why the time for the follow-up BG, observed by the surveyor on 8/26/13, was not documented. -Regarding the management of Resident #6's morning Lantus dose, the DNS stated the nurse would refer to the resident's meal monitor to decide if the Lantus insulin should be given or held. [NOTE: Resident #6's meal monitor documented the resident had not refused her breakfast meal for the month of August.] The DNS stated the nurses would chart "by exception" 	F 309		
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F 309	<p>Continued From page 37</p> <p>if the resident received only a half-dose of her Lantus due to not eating, on a "Documentation Record Comments" form in the resident's MAR. The DNS stated the hand-written addition on Resident #6's MAR on 8/6/13 was because Resident #6 was supposed to have had surgery that day, and was NPO [nothing by mouth] for breakfast on just that one occasion. The DNS was unable to explain why that addition had been made to Resident # 6's MAR, rather than documented on the Documentation Record Comments form as described by the DNS.</p> <p>On 8/29/13 at 6:15 PM, the DNS provided a new physician's order for Resident #6. The order documented, "For Novolog insulin [before meals] - hold for BG < 70 and give 1 amp D 5 or juice [and] notify MD." However, this did not address the concerns of how unscheduled BGs and interventions should be documented, or how it should be documented should the resident require only half of her Lantus dose.</p> <p>2. Resident #2 was admitted to the facility on 8/3/13 with multiple diagnoses which included in part, progressive supranuclear palsy, cervical spondylosis, dysphasia, osteoarthritis, and peripheral neuropathy. Hospice services were also initiated on 8/3/13 due to the diagnosis of supranuclear palsy.</p> <p>Resident #2's most recent admission MDS documented in part:</p> <ul style="list-style-type: none"> * Cognitively intact with a BIMS score of 15; * Extensive assist with one person for bed mobility, transfer, dressing, and personal hygiene; * Extensive assist with 2 people for toilet use; * Functional limitation in range of motion in both upper and lower extremities: and, * Special Treatments and Programs - Hospice 	F 309		
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F 309	<p>Continued From page 38 care.</p> <p>Resident #2's August 2013 End of Life Plan of Care for the facility documented in part:</p> <ul style="list-style-type: none"> * End of Life - Meet with resident and resident's representative, and hospice to ascertain the level of aggressive intervention the resident should receive, provide education/information on interventions with assistance of hospice care providers, and facilitate conversation between resident, family, hospice agency and facility to ensure wishes and needs are being met; and, * Pain management - Change or titrate pain medications per hospice recommendations and doctors orders. <p>Resident #2's Hospice provider Plan of Care, dated 8/3/13, documented in part:</p> <ul style="list-style-type: none"> * Skilled nursing to assess plan of care for effectiveness; caregiver ability to minimize skin integrity risk factors; caregiver compliance with incontinence care; and caregiver functioning; * Skilled nursing to perform ongoing multisystem assessment monitoring for pain and symptom management; * RN will provide comfort care PRN, work cooperatively with skilled nursing facility staff for develop ongoing plan of care; RN will instruct patient, caregivers, family on expectations with progression of disease process, medication and symptom management, comfort cares, safety measures, coping skills, ADL management, RN will act as liaison between MD., hospice team and skilled nursing facility; * MSS to teach potential effects of non-compliance with plan of care; and, * Aide to assist with personal cares and management of ADL's as needed 	F 309		

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F 309	<p>Continued From page 39</p> <p>On 8/28/13 at 3:35 p.m., the facility Social Worker was asked where the hospice documentation was kept. She showed the surveyors a tab in Resident #2's chart labeled "Hospice". She said that all hospice documentation would be under the "Hospice" tab. The facility Social Worker stated, "I've been talking to the hospice social worker. He's the Chaplin too and he's been working with the family a lot." The facility Social Worker was then asked to provide documentation from the hospice Social Workers visits, and communication between her and the hospice Social Worker. After reviewing the "Hospice" tab, the facility Social Worker stated there were no visit notes by the hospice Social Worker and that she would contact the hospice provider to request copies.</p> <p>On 8/29/13 at 4:30 p.m., the DON was asked if the facility had a coordinated plan of care with the hospice provider. The DON stated the hospice provider was "Supposed to bring in the care plan. If we have it its in the chart."</p> <p>On 8/29/13 at 6:15 p.m., the Administrator and DON were informed that no visit notes by the hospice CNA were found in Resident #2's medical record, and the hospice social services notes were not in the medical record initially, but were provided that day after the surveyor requested them. In addition, they were informed that a coordinated plan of care between the hospice provider and facility was also not found in the resident's medical record. The DON stated, "We did talk about that with them." The Administrator added that they were informed by the hospice provider that a coordinated plan of care was not necessary "Unless its respite." The agreement between the facility and hospice</p>	F 309		
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F 309	Continued From page 40 provider was requested. The agreement between hospice provider and the facility documented in part: * Services To Be Provided By hospice provider: * The hospice provider and facility will communicate with each other either verbally weekly or at each hospice patient visit to ensure that the needs of each hospice patient are addressed and met 24 hours per day. Documentation of such communication shall be included in the hospice provider's chart and the facility chart for each hospice patient; * The coordination of responsibilities for each hospice patient will be in accordance with the coordinated hospice/facility plan of care for that patient; and, * The hospice provider will designate a RN to coordinate the coordinated hospice/facility plan of care for each hospice patient. Note: The facility failed to develop a coordinated plan of care with the hospice provider to guide both providers regarding the resident's assessed needs and goals, and to determine which provider was responsible for which aspects of care. In addition, the facility failed to ensure there was an exchange of information between the facility and hospice social services as well as hospice CNA services. Note: Refer to F514, Documentation, regarding the lack of documentation from the hospice social services visits and hospice CNA visits. No further information or documentation was received from the facility that resolved the issue.	F 309		
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		

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F 312 SS=D	<p>Continued From page 41</p> <p>DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review, it was determined the facility did not ensure residents received necessary care and services to maintain good grooming and personal hygiene. This was true for 2 of 9 (#s 1 and 7) residents sampled for ADL assistance. The deficient practice had the potential to cause more than minimal harm when residents did not receive adequate assistance for meal consumption or toileting needs. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 6/2/06 with multiple diagnoses which included hypertension, edema, and osteoarthritis.</p> <p>Resident #1's most recent quarterly MDS assessment, dated 7/2/13, coded: -Severely impaired decision making skills. -No rejection of cares. -Limited assistance of 1 person required for eating.</p> <p>On 2/14/12, Resident #1's care plan documented an approach of limited assistance of 1 person to eat. On 8/27/13, this approach was amended to include, "but I do try to feed myself. I need a little help to get me started."</p>	F 312	<p>The facility does ensure that residents receive the necessary care and services to maintain good grooming and personal hygiene.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #1 was moved to assistive dining table on 09/03/13, referred to RD on 09/04/13 for diet recommendations, and evaluated by OT on 09/02/13 for self-feeding. Diet was changed to "finger foods when possible, continue mech soft diet as previous."</p> <p>The nursing staff assisted resident #7 in room with ADLs once she left the dining room. The nursing staff providing care to Resident #7 during survey were provided 1:1 education with regards to F-312 on 10/5/13 by the Director of Nursing on the importance of not leaving the resident in the dining room.</p> <p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:</p> <p>This deficiency has the potential to impact any residents needing assistance in dining area.</p> <p>The Occupational Therapist evaluated eating assistance needed for other residents in dining room on 10/2/13.</p>

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F 312	<p>Continued From page 42</p> <p>On 8/27/13, at 5:50 PM, Resident #1 was served her evening meal in the dining room, consisting of a sandwich, soup, juice, and ambrosia (small pieces of fruit and coconut mixed with whipped cream). No staff were cueing or assisting the resident. Resident #1 began to feed herself her sandwich. At 6:10 PM, after her sandwich was consumed, Resident #1 picked up her bowl of ambrosia, lifted it to her mouth, tilted her head back, and began to lick the contents directly from the bowl. Once this occurred, the Administrator then sat down at the table with Resident #1, and cued/assisted to use her spoon. Resident #1 began to slowly feed herself her ambrosia with her spoon, making her spoon dance through the air in front of her between each bite. Resident #1 required cues to dip her spoon in the bowl and take the next bite. At 6:20 PM, the Administrator left the table, and Resident #1 was again unassisted. After the administrator left, Resident #1 dropped her spoon and began to feed herself her ambrosia with her fingers. CNA #11 approached Resident #1 at her table and cued/assisted Resident #1 to lift the bowl to eat directly from the bowl, rather than use her fingers. CNA #11 then cued Resident #1 to use her fork to eat the ambrosia, but Resident #1 continued to eat directly from the bowl. After approximately 2 minutes, CNA #11 left the table to assist another resident. At 6:50 PM, Resident #1 was served a bowl of diced canned peaches. There was no assistance available at the table. Resident #1 began to eat her peaches with her fingers.</p> <p>On 8/29/13 at 2:30 PM, LN #1 was asked about meal assistance for Resident #1. LN #1 stated the facility had recently noticed Resident #1 was requiring more assistance, and had asked for a</p>	F 312	<p>The Administrator and Director of Nursing did a visual observation on 10/5/13 of at least four residents at each meal to ensure during meal service that residents are provided with eating assistance when needed in dining room and are provided with assistance upon completion of their meal.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur an In-service training was completed on 10/5/13 by Director of Nursing or designee regarding F-312 to all Nursing Staff; ✓ With emphasis on providing assistance from dining room following a meal, and providing assistance with eating as needed in the dining room.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Director of Nurses or designee will do a visual observation to ensure that assistance is provided from dining room following a meal, and assistance is provided with eating as needed in the dining room.</p> <p>Monitoring will start on October 07, 2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. ✓</p> <p>The facility Director of Nursing or designee will submit to the Administrator or designee and the QA&A Committee in her quarterly report findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>	

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therapy evaluation on 8/27/13.

2. Resident #7 was admitted to the facility on 3/21/13 with multiple diagnoses which included dementia, edema, and diabetes.

Resident #7's most recent change of condition MDS assessment, dated 6/25/13, coded:
-Severely impaired cognition.
-Limited assistance of 1 person for transfers, ambulation, and hygiene.
-Limited assistance of 2 people for toileting.
-Usually continent of bladder, always continent of bowel.

Resident #7's care plan documented she was to receive 1 person limited assistance for transfers, ambulation, and hygiene; and that she was usually continent of bowel and bladder.

On 8/27/13 at 6:25 PM, Resident #7 was sitting at the dining table with her evening meal. No staff were present in the dining room. Resident #7 finished her meal, then requested assistance to stand and leave the dining room. No staff were available to respond to her request. Resident #7 became agitated, and began to call others in the room "cowards" and "bi****es" (expletive). Resident #7 attempted to stand unassisted, using her walker and the table top for support. The legs of her walker were entangled with the leg of the table. As Resident #7 stood, and for her first 3 steps, she experienced a slight loss of balance to her left, which she struggled to correct. Resident #7 stated, "How do I get the hell out of here? I need the bathroom." As Resident #7 left the dining room, she was noted with a strong urine odor, and her pants were damp in the groin/buttock area.

F 312

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F 312	Continued From page 44 On 8/28/13 at 12:35 PM, during a lunch meal observation, Resident #7 was again observed to request assistance, then eventually stand on her own and leave the dining room. There was one staff member and 19 residents in the dining room at the time. Resident #7 stated, "Where's the damn toilet?" as she passed the surveyor. Again, Resident #7 was noted with a strong urine smell and damp pants. On 8/29/13 at 6:15 PM, the Administrator and DNS were informed of this observation and the surveyor's concerns. The facility offered no further information. F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES SS=G Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility did not ensure a resident who entered the facility without pressure sores, did not develop pressure sores. This was true for 2 of 5 residents (#1 and 10) sampled for pressure ulcers. The deficient practice caused harm when Resident #1 developed multiple Stage	F 312	F 314 The facility does ensure that residents who enter the facility without a pressure sore, do not develop pressure sore unless the individual's clinical condition demonstrate that they were unavoidable. <i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i> Resident #1 wound #B treatment was changed on 9/20/13. Plan of Care was updated on 9/27/13 regarding the new treatment plan. Resident #1, wound A(1) and A(2) wounds healed on 05/03/13 and 05/01/13 respectively. Resident #10 is currently not a Resident of the facility, was discharged from facility on 07/30/13. L.N. #3 received 1:1 education by Director of Nursing on 10/6/13 on F-314 regarding the importance of monitoring, implementing preventative measures, and/or updating care plans on skin changes if indicated, to promote healing and/or prevent new pressure sore from developing unless the individual's clinical condition demonstrate that they were unavoidable.

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F 314 Continued From page 45
II pressure sores. Findings included:

1. Resident #1 was admitted to the facility on 6/2/06 with multiple diagnoses which included hypertension, edema, and osteoarthritis.

Resident #1's most recent quarterly MDS assessment, dated 7/2/13, coded:

- Severely impaired decision making skills.
- No rejection of cares.
- Dependent on 2 persons for bed mobility, transfers, and dressing.
- 1 stage 2 pressure ulcer present, which was not present or present at a lesser degree on the previous assessment.

Resident #1's care plan documented:

- Required total assistance of 1 or 2 persons for bed mobility.
- If resident is resistive, wait a few minutes and re-approach.
- Approach several times if resistance continues.
- Step away and re-approach if resident becomes agitated due to inability to communicate needs.
- Observe ulcers on right and left heel, left little toe, start date listed as 3/13/13.
- Pressure relieving air mattress, start date 2/7/13.
- Foam boots on except when cares are being given, Prevalon boots on when in bed, start date 4/16/13. This approach also had a hand-written addition of, "Green boots when up", although no date was noted for this addition.
- "Reposition routinely", start date 4/16/13.

Resident #1's Norton Pressure Ulcer Scale Scores documented:

10/2/12 - Score of 6, indicating high risk for pressure ulcer development.
1/8/13 - Score of 6, high risk.

F 314 **Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:**

This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.

However, Residents that are assessed at high risk for skin breakdown may have the potential to be affected by this deficiency; therefore the facility established a wound team that completed skin assessments on all residents assessed as high risk for skin breakdown according to Norton Skin Assessment by 10/6/13.

Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure that the deficient practice does not recur an In-service training was completed on 10/6/2013 by Director of Nursing regarding F-314 to all Licensed Nurses; highlighting the importance of monitoring, implementing preventative measures, and/or updating care plans on skin changes if indicated, to promote healing and/or prevent new pressure sore from developing unless the individual's clinical condition demonstrate that they were unavoidable.

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F 314	Continued From page 46 4/2/13 - Score of 9, high risk. 7/5/13 - Score of 9, high risk. Resident #1's Wound/Skin Record sheets contained spaces to document, at the date of each assessment, Stage, Size, and Depth of the wound; Response to Treatment; and Plan of Care Updated. Four wounds were documented for Resident #1. a. Wound A, onset date 1/8/13, 2 cm x 0.5 cm dark red area to right heel. -1/15/13 - Stage: "?" Size: "1 cm". Response to Treatment: "Improved." Plan of Care Updated and Depth were both blank. -1/24/13 - Stage, Depth, and Plan of Care Updated were all blank. Size: "1 cm. Response to Treatment: "Improved". -1/27/13 - Stage: "II", Size: "1 cm". Depth: "sup[erficial]." Response to Treatment and Plan of Care Updated were blank. -2/7/13 - Stage: "II", Size: "2 cm." Depth: ".01" cm. Response to Treatment: "Deteriorated." Plan of Care Updated did not document a care plan update, but documented, "dry blister." -2/15/13 - Stage: "?" Size: "1 cm". Depth: blank. Response to Treatment: "Improved." Plan of Care Updated: "blister 1/2 off." -2/20/13 - Stage: blank. Size: "1 cm." Depth: blank. Response to Treatment: "Improved." Plan of Care Updated: "Blister off. Monitor for 1 [week]." -2/27/13 - Healed. [NOTE: The "Plan of Care Updated" section was blank or inaccurate 5 of 6 weeks.] b. Resident #1's Wound/Skin Record sheets documented for Site B, onset date 1/8/13, a 0.5 x 1.5 cm area to the left heel, documented as,	F 314	<i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i> Monitoring will be done through: The Wound Team will review Residents with pressure sore to ensure monitoring, implementation of preventative measures, and/or updating care plans on skin changes if indicated, to promote healing and/or prevent new pressure sore from developing unless the individual's clinical condition demonstrate that they were unavoidable. The Wound Team will review Residents who are at high risk, to ensure implementation of preventative measures, and/or updating care plans if indicated, to prevent new pressure sore from developing unless the individual's clinical condition demonstrate that they were unavoidable. Monitoring will start on October 07, 2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. The facility Director of Nursing or Designee will submit to the Administrator or designee and the QA&A Committee in her quarterly report findings and/or corrective actions taken by the Wound Team. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		

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F 314	<p>Continued From page 47</p> <p>"clear yellow drainage - open", with progression as follows:</p> <p>-1/15/13 - Stage and Plan of Care Updated were blank. Size: 0.5 cm. Depth: 0.2 cm. Response to Treatment : "Improved."</p> <p>-1/24/13 - Stage, Response to Treatment, and Plan of Care Updated were all blank. Size : 0.5 cm. Depth: 0.2 cm.</p> <p>-1/27/13 - Stage and Plan of Care Updated were blank. Size: 0.5 cm. Depth: 0.2 cm. Response to Treatment: "No Change."</p> <p>-2/7/13 - Stage: "II". Size: 2 cm. Depth: 0.1 cm. Response to Treatment: "Deteriorated." Plan of Care Updated: "Req[uest] for air mattress."</p> <p>-2/15/13 - Stage: "II", Size: 3.5 cm. Depth: 0.3 cm. Response to Treatment and Plan of Care Updated were blank. [NOTE: Even though the wound had increased in size and depth, there was no documentation of new interventions on this date.]</p> <p>-2/20/13 - Stage: "II", Size: 3.5 cm. Depth: blank. Response to Treatment: "Improved." Plan of Care Updated: blank.</p> <p>-2/27/13 - Stage: blank. Size: 3.0 x 2.5 cm. Depth: 0.2 cm. Response to Treatment: "Improved." Plan of Care Updated: "Cont[inue] tx [treatment]. Healing. Bleeds [with] dressing [change]."</p> <p>-3/7/13 - Stage : "II". Size: 1.5 x 1.0 cm. Depth: 0.2 cm. Response to Treatment: "Improved." Plan of Care Updated: blank.</p> <p>-3/13/13 - Stage: "II". Size: 1.0 x 1.0 cm. Depth: 0.2 cm. Response to Treatment: "No Change." Plan of Care Updated: "Has a 0.3 [cm] round area white top of beefy area."</p> <p>-3/20/13 - Stage: "II". Size: 1.4 x 0.8 cm. Depth: blank. Response to Treatment: "Healed". Plan of Care Updated: "0.2 [cm] deep."</p> <p>-3/28/13 - Stage: "II". Size: 1.3 x 0.8 cm. Depth:</p>	F 314		
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F 314	Continued From page 48 0.2 cm. Response to Treatment: "No Change." Plan of Care Updated: blank. -4/5/13 - Stage: "II". Size: 1.3 x 0.8 cm. Depth: 0.2 cm. Response to Treatment: "No Change." Plan of Care Updated: "appears smaller [and] less deep. [No complaints] of pain." -4/16/13 - Stage: "II". Size: 1.5 x 0.2 cm. Depth: 0.2 cm. Response to Treatment: "Improved." Plan of Care Updated: blank. -4/25/13 - Stage: "II". Size: 1.2 x 0.6 cm. Depth: 0.2 cm. Response to Treatment: "Improved." Plan of Care Updated: blank. -5/3/13 - Stage: "II". Size: 1.0 x 0.6 cm. Depth: 0.2 cm. Response to Treatment: blank. Plan of Care Updated: blank. -5/22/13 - Stage: "II". Size: 0.5 x 0.5 cm. Depth: 0.2 cm. Response to Treatment: "Improved." Plan of Care Updated: blank. -5/29/13. Stage: "II". Size: 0.4 x 0.3 cm. Depth: 0.1 cm. Response to Treatment: "Improved." Plan of Care Updated: "hard ridge around outside." -6/5/13 - Stage: blank. Size: 0.2 x 0.3 cm. Depth: 0.1 cm. Response to Treatment: "Improved." Plan of Care Updated: blank. -6/12/13 - Stage: "II". Size: 0.3 x 0.2 cm. Depth: 0.1 cm. Response to Treatment: "Healed." Plan of Care Updated: blank. -6/19/13 - Stage: "II". Size: 0.2 x 0.2 cm. Depth: 0.1 cm. Response to Treatment: blank. Plan of Care Update": blank. -6/26/13 - Stage: "II". Size: 0.3 cm. Depth: 0.1 cm. Response to Treatment: blank. Plan of Care Updated: blank. -7/7/13 - Stage: "II". Size: dry blister removed." Depth: blank. Response to Treatment: "Healed." Plan of Care Updated: "Continue skin prep to protect heel." -7/11/13 - Stage: blank. Size: 0.3 cm. Depth: 0. Response to Treatment: blank. Plan of Care	F 314			

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F 314	<p>Continued From page 49</p> <p>Updated: blank.</p> <p>-7/19/13 - Stage: blank. Size: 0.3 cm. Depth: 0. Response to Treatment: blank. Plan of Care Updated: blank.</p> <p>-7/24/13 - Stage: blank. Size: 0.4 x 0.3 cm Depth: blank. Response to Treatment: blank. Plan of Care Updated: "[change] [treatment] to skin prep."</p> <p>-7/31/13 - Stage: blank. Size: 1 cm. Depth: blank. Response to Treatment: "Deteriorated." Plan of Care Updated: "scab bigger."</p> <p>-8/8/13 - Stage: blank. Size: 0.5 cm. Depth: 0. Response to Treatment: "Improved." Plan of Care Updated: blank.</p> <p>-8/22/13 - Stage: "II?". Size: 0.3 cm. Depth: "?". Response to Treatment: "Improved." Plan of Care Updated: blank.</p> <p>[NOTE: The Plan of Care Update section was blank 19 of 26 of these assessments.]</p> <p>[NOTE: Resident #1's care plan did not document to float her heels until 4/16/13, more than 3 months after the pressure ulcers to her heels were first noted.]</p> <p>c. [NOTE: For the purposes of clarity to the reader, Examples c. and d. will be designated as wound A (1) and A (2), respectively, even though facility wound documentation refers to both of the wounds in these examples as Wound A.]</p> <p>A separate Wound/Skin Record sheet for Resident #1 documented for Site A (1), onset date 3/9/13, a location of "left foot". A pre-printed diagram on the form had been marked to indicate the affected area was on the bottom of the resident's left foot, just below her little toe:</p> <p>-3/9/13 - Stage: "I". Size: 0.5 cm. Depth: 0.1 cm. "Response to Treatment": blank. "Plan of Care</p>	F 314	

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Updated: blank.

-3/13/13 - Stage: "I". Size: 0.5 cm. Depth: 0.2 cm. "Response to Treatment": "No Change." "Plan of Care Updated": "[change treatment]."

-3/20/13 - Stage: "I". Size: 0.2 cm. Depth: 0.2 cm. "Response to Treatment": "Improved." "Plan of Care Updated": blank.

-3/21/13. Stage: "II". Size: .05 cm "round". Depth: 0.2 cm. "Response to Treatment": blank. "Plan of Care Updated": "Callous came off. Bleeding well. [No signs or symptoms] of infection."

-3/28/13 - Stage: "II". Size: 0.5 cm "round". Depth: 0.2 cm "open". "Response to Treatment": "No Change". "Plan of Care Updated": blank.

-4/5/13 - Stage "I". Size: 0.5 cm "round". Depth: 0.2 cm "open". "Response to Treatment": "No Change". "Plan of Care Updated": blank.

-4/16/13 - Stage: "I". Size: 0.5 cm. Doth 0.2 cm. "Response to Treatment": blank. "Plan of Care Updated": blank.

-4/25/13 - Stage: "0". Size: 1 cm "blood blister". Depth: blank. "Response to Treatment": blank. "Plan of Care Updated": "blood blister only."

-5/3/13 - Healed.

d. A separate Wound/Skin Record sheet for Resident #1 documented for Site A (2), onset date 4/16/13, for a location of, "[bottom of] [left] little toe" a 0.5 cm x 0.2 cm wound, as follows [NOTE: The diagram on the form indicating the location of this wound was the same as for the previous wound]:

-4/25/13 - Stage: "II". Size: "blister 1.0 [cm]". Depth: 3 cm. "Response to Treatment": blank. "Plan of Care Updated": blank.

-5/1/13 - Healed.

On 8/29/13 at 2:30 PM, LN #3, identified as the facility wound nurse, was asked about the areas

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F 314	<p>Continued From page 51</p> <p>on Resident #1's heels.</p> <p>*LN #3 stated the areas on Resident #1's heels were discovered on the morning of 1/8/13, when the resident was assisted to get up for the day. LN #3 stated the areas were identified as pressure ulcers, as they developed over a bony prominence. LN #3 stated the areas had not been noted prior to 1/8/13.</p> <p>*LN #3 stated since the facility had identified the resident as being at high risk for skin breakdown, she would have had either "blue boots" (padded boots) on, or staff would have used "green boots" (padded boots with a hard bottom) if the resident was walking. LN #3 stated she was not sure whether there were other measures in place, such as floating the resident's heels, positioning her from side to side, etc., before the areas on the heels were noted on 1/8/13.</p> <p>*When asked what the presumed cause of the pressure ulcers on Resident #1's heels was, LN #3 stated, "[Resident #1] is a really hard person. I would guess she wasn't being turned every 2 hours. She is very resistive, very fearful. Sometimes if you get down and talk directly into her face, she will calm down." LN #3 stated if Resident #1 had been resistive to being turned, "I would have expected them to at least try to turn her. And she had some shoes that were starting to rub, so after those areas opened we stopped using the shoes."</p> <p>*LN #3, when asked about staging the wounds on Resident #1's heels, stated initially the wounds were considered unstageable because they were blisters. LN #3 stated after the blisters opened, the areas were staged as Stage II pressure ulcers.</p> <p>*LN #3, when asked why the air mattress was not implemented until 2/7/13 when the wounds were discovered on 1/8/13 stated, "First we put her in</p>	F 314		

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F 314	<p>Continued From page 52</p> <p>the blue boots because the pressure was isolated to her heels. But the boots didn't work, so we got the air mattress." [NOTE: The blue boots were identified as an intervention already in place when the areas on Resident #1's heels initially developed.]</p> <p>*LN #3, when asked why the wound to the left heel was noted as healed on 3/20/13 and 6/12/13, stated, "The wound did not heal. I marked the wrong box [on the form]. The wound continued all along."</p> <p>On 8/29/13 at 2:30 PM, LN #3 was asked about the areas to Resident #1's left foot, near her toe. LN #3 stated, "We don't really know what happened there. It was a little pin prick thing there, under the green boot." LN #3 initially stated the facility could not identify a pressure point associated with those areas. LN #3 was asked about if the blisters to Resident #1's left foot would be considered pressure ulcers. LN #3 stated, "Because she had the boot there, yeah, it was probably pressure." LN #3 was asked what the facility had identified as a solution to resolve the areas to Resident #1's left foot. LN #3 stated, "We discovered a little piece of the boot had a screw inside it. We removed that piece of the boot, and we haven't had any further problems since."</p> <p>On 8/29/13 at 6:15 PM, the Administrator and DNS were informed of the surveyor's findings. On 9/4/13 at 7:00 AM, the facility faxed additional information for this issue. However, the additional information did not resolve the concerns.</p>	F 314		

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F 314	Continued From page 53 2. Resident #10 was admitted to the facility on 7/16/13 with multiple diagnoses which included failure to thrive, esophageal stricture, atrial fibrillation, chronic kidney disease, and congestive heart failure. Resident #10 was discharged to home on 7/30/13. Resident #10's most recent admission MDS assessment, dated 7/22/13, documented in part: * Skin conditions - Moisture Associated Skin Damage (MASD); * Applications of ointments/medications other than to feet; and, * No healed or unhealed pressure ulcers. Resident #10's most recent CAA, dated 7/22/13, triggered Pressure Ulcer which documented in part: * CAA triggers due to ADL assistance is needed and resident tends to stay in bed frequently or sit in recliner; * Impact - Potential for loss of skin integrity due to pressure and urinary incontinence; * Strength - Able to make needs known when cued; and * Interventions - Assess skin with cares. Encourage mobility, keep skin clean and dry. Resident #10's July 2013 Care Plan documented	F 314		

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F 314	<p>Continued From page 54 in part:</p> <ul style="list-style-type: none"> * Problem - At risk for skin breakdown related to poor intake, hydration, mobility, incontinence; * Interventions - Keep skin clean and dry, linen smooth and wrinkle free; pillow under buttocks while in recliner; resident uses a pressure reducing mattress on bed; remind/assist resident to toilet frequently, change soiled undergarments and clean skin; and barrier cream to peri area after incontinent episodes per MD orders. <p>A Norton Plus Pressure Ulcer Scale, dated 7/16/13, documented a total score of 7 which indicates Resident #10 was at high risk for development of pressure ulcers.</p> <p>Resident #10's Nursing Admission Assessment, dated 7/16/13, documented skin conditions noted on admission. The assessment form included a diagram of the human body to locate and identify skin conditions. On the diagram a circle was made on the coccyx area with the label, "Red," which indicated Resident #10 had redness to the coccyx area.</p> <p>Resident #10's Nurse's Notes, dated 7/16/13 (day of admission) to 7/30/13 documented in part:</p> <ul style="list-style-type: none"> * 7/16/13 - Slight redness on coccyx; * 7/17/13 - Skin intact; * 7/19/13 - Buttocks red, small blister in upper coccyx area noted, skin barrier cream applied; * 7/24/13 - Some incontinence excoriation noted to coccyx, barrier cream applied; * 7/26/13 - Resident reports buttocks are sore, encouraged staff to place a pillow under buttocks while in recliner for comfort and pain relief; <p>Note: A pillow is not an effective device for reducing pressure as they typically bottom out.</p> <ul style="list-style-type: none"> * 7/26/13 - Resident with contact dermatitis to 	F 314		

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F 314	<p>Continued From page 55</p> <p>coccyx; * 7/26/13 - Coccyx remains red with roughened skin over tail bone; * 7/30/13 - Some skin breakdown noted on buttocks, staff use barrier cream with cares; and, * 7/30/13 - Noted skin to buttocks reddened related to incontinence and resident sliding self in chair. Resident is able to off load and moves self in chair. Resident often incontinent of bowel and bladder, received frequent perineal care with barrier applications to protect skin.</p> <p>On 8/28/13 at 3:00 p.m., Resident #10's responsible party stated that Resident #10 was supposed to be turned every 2 hours, and went home with sores on bilateral buttocks. The responsible party stated the resident had to go to the "Wound clinic after discharge." and described the sores as "Apricot" size. The responsible party said the resident had "No sores on admit." Resident #10's responsible party stated on one occasion there was no barrier cream for the buttocks and it had to be requested.</p> <p>On 8/30/13 at 10:19 a.m., LN #3 was interviewed regarding Resident #10's skin breakdown to the coccyx area. The LN stated the resident came from the hospital with excoriated, sloughing skin breakdown on the coccyx. LN #3 added, "I know it got better. Then with loose stools it got red again." When asked what interventions were in place to prevent skin breakdown to the coccyx the LN stated, "Trying to keep him dry in toileting. [The resident was] trying to toilet self but didn't make it." LN #3 said the resident would sit in the recliner frequently and was, "Encouraged to go back to bed for at least an hour." When asked if Resident #10 was on a scheduled turning program the LN stated she didn't know about</p>	F 314		

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F 314	Continued From page 56 during the day, but they were "Turning [him] at least twice at night." LN #3 was asked what Resident #10's coccyx looked like on the day of discharge. The LN stated, "I did see him that morning. I want to say it was just red because [staff's name] stated that." When asked if the resident had a pressure ulcer to the coccyx the LN responded, "No." Note: LN #3 stated Resident #10 was admitted from the hospital with excoriated, sloughing skin breakdown on the coccyx. However, the admission skin assessment documented the coccyx was red, but the facility did not measure the redness, did not monitor the area daily, and had no care plan for repositioning at prescribed intervals. Additionally, there was no documentation that distinguished the differentiation between moisture associated skin damage versus a pressure ulcer, and inconsistent documentation regarding the location of skin breakdown. On 8/30/13 at 11:40 a.m., the Administrator and DON were informed of the skin breakdown issue. However, no further information or documentation was provided that resolved the issue.	F 314	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	The facility does provide adequate supervision to prevent falls and ensure proper usage of a standing lift to prevent accidents.. <i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i>

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F 323	<p>Continued From page 57</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to provide adequate supervision to prevent falls and failed to ensure proper usage of a standing lift to prevent accidents. This was true for 2 of 10 sample residents (#7 and #9), and all other residents in the main dining room. The lack of supervision and improper use of the standing lift placed residents at risk for serious injury. Findings included:</p> <ol style="list-style-type: none"> 1. Resident #9 was admitted to the facility on 4/12/13 with multiple diagnoses which included anemia, diabetes, Alzheimer's, dementia, and depression. <p>Resident #9's most recent quarterly MDS assessment, dated 7/16/13, documented in part:</p> <ul style="list-style-type: none"> * Unable to interview to determine BIMS score; * Delusions; * Total assist of 2 or more people for bed mobility, transfers, locomotion on unit, dressing, toilet use, and personal hygiene; * Frequently incontinent of bladder; and, * Always incontinent of bowel. <p>A. An Accident and Incident Report for Resident #9, dated 6/1/13, at 11:40 p.m. documented in part:</p> <ul style="list-style-type: none"> * Event Type- Fall; * Injury - No injury; * Location - Resident's room; * Cause - Resident health/mental status and other: Incontinent; and, * Description of the event, circumstances, and account from Resident - Resident rolled out of 	F 323	<p>C.N.A. caring for Resident #9 on Incident (A) was provided with 1:1 education by the Director of Nursing with regards to F-323 on 10/4/13, with emphasis on the importance of not leaving the resident unattended once care need is identified.</p> <p>C.N.A.s caring for Resident #9 on Incident (B) was provided with 1:1 education by the Director of Nursing with regards to F-323 on 10/6/13, with emphasis on proper usage of a standing lift.</p> <p>The nursing staff assisted resident #7 in room with ADLs once she left the dining room. The nursing staff providing care to Resident #7 during survey were provided 1:1 education with regards to F-323 on 10/6/13 by the Director of Nursing on the importance of not leaving the resident in the dining room.</p> <p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:</p> <p>However, to address other residents who potentially may be affected by this deficiency; the Administrator and Director of Nursing did a visual observation of at least four residents on each shift to ensure that residents receive adequate assistance once care needs are identified, upon completion of their meals, and to ensure proper usage of a stand lift by 10/6/13.</p>	

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F 323	<p>Continued From page 58 bed onto the floor.</p> <p>The Fall Scene Investigation Report, dated 6/1/13, documented in part: * Factors observed at time of fall - Resident slipped, wearing regular socks; * Fall summary - Found on the floor (unwitnessed); * What was the resident doing during or just prior to fall - Rolling/sliding out of bed; * What type of assistance was resident receiving at time of fall - Alone and unattended; * Describe resident's psychological status prior to fall - Unable to use call bed, not able to tell staff when soiled attends; * Re-Creation of Last 3 Hours Before Fall - CNA coming on to shift found bed in high position. Lowered bed down. Noticed resident had incontinent episode of stool. Left resident alone safely in bed to answer another resident's alarm and assist nurse in another room with a dressing change. After finishing and arriving at nurses station, heard thud in resident's room. When entering room observed resident on floor incontinent of stool and urine on floor.</p> <p>Note: Resident #9 had been incontinent of bowel when the CNA came into the room. The CNA lowered the bed and left the room to answer an alarm and assist a LN. During the time Resident #9 was left alone and unattended at the side of the bed, he fell.</p> <p>On 8/30/13 at 11:30 a.m., the DON was interviewed about Resident #9's fall. The DON stated, "It looks like he had been incontinent and she left to answer an alarm."</p> <p>On 8/30/13 at 11:40 a.m., the Administrator and</p>	F 323	<p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur the facility Director of Nursing or designee trained all C.N.A.s staff on stand lift transfers on 10/6/13.</p> <p>An In-service training was completed on 10/6/13 by Director of Nursing regarding F-323 to all Nursing Staff; The importance of residents receiving adequate assistance once care needs are identified, and upon completion of their meals in the dining room.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Director of Nurses or designee will do a visual observation to ensure residents receiving adequate assistance once care needs are identified, upon completion of their meals in the dining room, and to ensure proper usage of a stand lift.</p> <p>Monitoring will start on October 07, 2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Director of Nursing or designee will submit to the Administrator or designee and the QA&A Committee in her quarterly report findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>	
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F 323	<p>Continued From page 59</p> <p>DON were notified of the supervision issue. No further information or documentation was provided that resolved the issue.</p> <p>B. An Accident and Incident Report for Resident #9, dated 4/26/13, at 3:00 p.m. documented in part:</p> <ul style="list-style-type: none"> * Event Type- Fall and improper use of equipment by staff; * Injury - No injury; * Location - Resident's room; * Cause - Resident non-compliance, equipment, and staff handling; and, * Description of the event, circumstances, and account from Resident - During stand lift transfer off commode with 2 person assist, resident slid out of sling down staff member's leg to the floor. <p>The Fall Scene Investigation Report, dated 4/12/13, documented in part:</p> <ul style="list-style-type: none"> * Factors observed at time of fall - Resident slipped through stand lift straps/sling; * Fall summary - Intercepted fall (resident lowered to floor); * What was the resident doing during or just prior to fall - Sitting on toilet chair; * What type of assistance was resident receiving at time of fall - Assisted per care plan; * Describe resident's psychological status prior to fall - Alert with confusion; * Describe resident's psychological status prior to fall - Uncooperative, has periods of being agitated and uncooperative; * Re-Creation of Last 3 Hours Before Fall - Resident was being transferred from commode via stand lift and 2 assist. Resident slid one arm between sling straps and was lowered down staff's leg to floor; and, * Conclusion - Stand lift was not secure when 	F 323	

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F 323

Continued From page 60
attempted transfer of uncooperative resident. Staff used sling improperly-training given for proper use.

On 8/30/13 at 10:35 a.m., the DON was interviewed regarding Resident #9's fall. The DON stated the employee was fairly new and had been given improper instruction on how to use the equipment. The DON added, "It wasn't as secure as it should have been. [He] ended up sliding out." The DON stated there was a one on one inservice with the employee which included discussion and demonstration on the proper use of the stand lift.

Note: The CNA had been improperly trained on the use of the stand lift equipment which resulted in Resident #9's fall.

On 8/30/13 at 11:40 a.m., the Administrator and DON were notified of the improper use of equipment issues. No further information or documentation was provided that resolved the issue.

2. On 8/27/13, between 6:25 and 6:30 PM, Resident #s 1, 6, 7, 8, and 9 were in the dining room eating their evening meal. There were no staff in the dining room to supervise the residents during this time. During this observation, Resident #7 asked for assistance to stand, became agitated and began name-calling when staff was not available, and stood on her own, with an unsteady gait as she began to walk from the dining room.

On 8/28/13 at 12:35 PM, Resident #7 was again observed to request assistance to leave the

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F 323 Continued From page 61
dining room and use the toilet. Again she stood on her own to ambulate. There was one staff member in the dining room, with 19 residents eating lunch, when this occurred.

[NOTE: Please see F 312 as it pertains to ADL assistance.]

On 8/29/13 at 6:15 PM, the Administrator and DNS were informed of this observation and surveyor concerns with supervision in the dining room. The facility offered no further information to resolve this concern.

F 329 SS=D 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

F 323

F 329 10/28/13

The facility does ensure that residents do not receive unnecessary medication.

Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:

Resident #4 was started at the lower dose on 8/21/13. ✓

Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:

This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.

However, this deficiency has the potential to impact any residents receiving a physician order medication change, therefore;

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F 329	<p>Continued From page 62</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure 1 of 9 sample residents (#4) did not receive unnecessary medication. This was true when Resident #4 received higher dosages of Zoloft, an antidepressant medication, for six days after the physician decreased the dosage. Excessive amounts of Zoloft created the potential for the resident to experience adverse reactions involving the central nervous, cardiovascular, gastrointestinal, musculoskeletal, and integumentary systems. Findings included:</p> <p>Resident #4 was admitted to the facility on 6/4/12 with multiple diagnoses which included personal history of traumatic fracture, general osteoarthritis, muscle weakness, unspecified urinary obstruction, and vascular dementia with delirium.</p> <p>The resident's August 2013 Physician Orders included the following medications and the date each was ordered: * Zoloft (brand name Sertraline) 50 mg, 1 tablet PO (by mouth) daily - 6/4/12; * Risperdal 0.5 mg, 1 tablet PO at hour of sleep - 6/4/12; and, * Trazodone 50 mg, 1 tablet PO at hour of sleep - 6/4/12.</p> <p>A Pharmacy Consultation Report, dated 8/7/13, recommendation to the resident's physician documented, in part, "Please review the orders</p>	F 329	<p>The facility ordered a date stamp on 9/3/13 to be used by Medical Records or Licensed Nursing staff when medication order change is received. Medical Records developed a log of when medication order changes are returned from physician. Log was started on 10/1/13.</p> <p><i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i></p> <p>To ensure that the deficient practice does not recur an In-service training was completed on 10/6/13 by Director of Nursing regarding F-329 to all Licensed Nurses; regarding the importance of residents not receiving unnecessary medication by updating medication order change once received from the physician and to date stamp when received.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i></p> <p>Monitoring will be done through:</p> <p>The Director of Nursing or designee will review at least ten physician order medication changes to make sure that they are date stamped upon receipt from physician and that the order is transcribed on the day it was date stamped.</p> <p>Monitoring will start on October 07, 2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Director of Nursing or designee will submit to the Administrator or designee and the QA&A Committee her quarterly report findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>	

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F 329	<p>Continued From page 63</p> <p>for Risperdal, Trazodone and Sertraline and either order a dose reduction or write a note mentioning why a dose reduction would not be appropriate."</p> <p>The physician's response, dated 8/14/13, documented, "I accept the recommendation(s) above WITH THE FOLLOWING MODIFICATION(S): Reduce Sertraline to 25 mg PO Q [every] am [morning]."</p> <p>Below the physician's signature was written, "Noted [staff's name, RN] 8/20/13." To the right of this entry was, "Faxed to Pharmacy 8/20/13 1540 [3:40 p.m.] [staff's initial]."</p> <p>Resident #4's August 2013 MAR documented Zoloft 50 mg was administered to the resident daily from 8/1 through 8/20/13. It also documented the first dose of Zoloft 25 mg was given on 8/21/13, then daily thereafter.</p> <p>On 8/29/13 at 10:50 a.m., the DNS was asked about Zoloft 50 mg administered to Resident #4 for 6 days after the physician reduced it to 25 mg daily. The DNS stated the physician's order was not received at the facility until 8/20/13. The DNS agreed, however, that "noted" did not mean received and the document did not include a date it was received at the facility. The DNS said she would check with the pharmacy to find out when they sent the recommendation to the physician and when the facility received the order.</p> <p>On 8/29/13 at 11:00 a.m., with the DNS present, the Medical Records Supervisor (MRS) stated she was also the facility's transport person and that she made daily deliveries and/or pick-ups to the local medical clinic. The MRS provided a</p>	F 329		

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F 329	<p>Continued From page 64</p> <p>Telephone Order Log and said it was used to track when documents, such as physician orders, communications, and requests were delivered to the medical clinic for a physician's response and/or signature. The MRS pointed to an entry that noted Resident #4's "Pharm[acy] consult" was delivered to the clinic on 8/13/13 and it was signed on 8/14/13. When asked when the physician's order was received at the facility, the MRS stated, "I don't track when I pick things up." The DNS and the MRS both indicated that previous efforts to send documents to the medical clinic via facsimile (fax) did not work because it frequently took up to 2 weeks to get a response back from the physician/clinic.</p> <p>Resident #4 was administered double the amount of Zoloft, 50 mg, daily for 6 days after the physician ordered the dosage decreased to 25 mg.</p> <p>On 8/29/13 at 6:15 p.m., the Administrator was also informed of the issue. No other information or documentation was received from the facility which resolved the issue.</p>	F 329		
F 353 SS=F	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing</p>	F 353	<p>The facility does ensure there is adequate staffing to provide for the needs and well-being of each resident.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>On those days mentioned in the <i>Statement of deficiencies-form CMS-2567</i>, the facility was in compliance with the <i>State guidelines on the 2.4 hours per patient day</i>.</p> <p>Staffing schedule was reviewed and completed by the Director of Nursing on 10/1/13.</p>	10/28/13

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F 353	<p>Continued From page 65</p> <p>care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on a resident group interview, review of a 3-week nursing schedule, record review, observations, and resident and staff interviews, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of each resident. This affected 5 of 9 sample residents (#s 1, 6, 7, 8, and 9) and 4 of 7 residents who attended the group interview. And, it had the potential to affect all other residents who lived in the facility. This failure created the potential for psychosocial and physical harm for all residents in the facility. Findings include:</p> <p>1. On 8/27/13 at 1:30 p.m., a resident group interview with 7 residents was conducted by 2 surveyors. When asked, "Are there enough staff here to take care of everyone?" 2 residents answered "No" and 2 other residents nodded in agreement. One of the resident stated, "Not enough help in the dining room." When asked if there was a particular time when there was not enough help, the resident stated, "All meals, all the time!" Another resident stated, "At times not</p>	F 353	<p><i>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:</i></p> <p>Residents in the facility may have the potential to be affected by this deficiency:</p> <p>Therefore, by word of mouth and listing in job service the facility recruited additional C.N.A.s. ✓</p> <p><i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i></p> <p>On 10/4/13, The Administrator and Director of Nursing did a visual observation of at least four (4) Residents on each shift to ensure that Residents' care needs are being met.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i></p> <p>Monitoring will be done through:</p> <p>The Administrator or designee will do a visual observation during her scheduled rounds to ensure that Residents care needs are being met. ✓</p> <p>Monitoring will start on October 07, 2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. ✓</p> <p>The facility Administrator or designee will present to the QA&A Committee her quarterly report findings and/or corrective actions taken during the quarterly QA&A meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>

I know this memo is confusing. Sorry Km

Admin: Per telephone call 11-1-13
another km: 20 pm, Jac hired 3 CNAs.
one quit without notice. (quit)
Technically up 3, added 5 = 2 quit, so has
more staff Km

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F 353	<p>Continued From page 66 quite enough [staff]."</p> <p>2. A review of a Three-Week Nursing Schedule for the weeks of 8/4/13, 8/11/13 and 8/23/13 revealed the average number of residents (census) in the facility was 27.1. During those weeks, the highest census, 28, occurred 8 days; and, the lowest census, 26, occurred 5 days.</p> <p>The calculated number of nursing staff hours worked per resident per day during the aforementioned 3-week time frame included: * 8/17/13 (Saturday) = 2.5; * 8/18/13 (Sunday) = 2.4689; and * 8/19/13 (Monday) = 2.88.</p> <p>3. On 8/27/13, between 5:30 and 6:00 p.m., during a dinner meal, Resident #1 was observed with intermittent assistance to consume her meal. When assistance was not available, the resident fed herself ambrosia (small pieces of fruit and coconut mixed with whipped cream) and diced canned peaches using her hands. By the end of the meal, crumbs from her sandwich, remains of her ambrosia, and pieces of peach covered the front of the resident's shirt and lap. And, the resident's shirt and lap were wet with the peach juice.</p> <p>Refer to F214, Dignity, and F312, ADL Care for Dependent Residents, for details of both.</p> <p>4. a. On 8/27/13, for 5 minutes, between 6:25 and 6:30 p.m., Resident #s 1, 6, 7, 8, and 9 were in the dining room eating their evening meal. However, there were no staff in the dining room to supervise or assist the residents during this time. Also, during this time, Resident #7 called out for assistance, became agitated, and began</p>	F 353		

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F 353 Continued From page 67

name-calling when there was no one to assist her. Resident #7 then stood on her own, and with an unsteady gait began to walk out of the dining room. In addition, the resident was noted with a strong urine odor, and the resident's pants were damp in the groin/buttock area.

b. On 8/28/13 at 12:35 p.m., Resident #7 was again observed to request assistance to leave the dining room and use the toilet. Again the resident stood on her own to ambulate. There was one staff member in the dining room, with 19 residents eating lunch, when this occurred. And, Resident #7 was again noted with a strong urine smell and damp pants.

Refer to F241, Dignity; F312, ADL Care for Dependent Residents; and F323, regarding the lack of supervision to prevent accidents/falls, for details.

5. A Fall Scene Investigation Report, dated 6/1/13, documented Resident #9 was incontinent of bowel when a CNA entered the resident's room, lowered the bed, then left the resident alone to answer another resident's alarm and to assist a LN.

a. The CNA left Resident #9 alone with the bowel incontinence.

Refer to F214, Dignity, for details.

b. The CNA lowered Resident #9's bed then left the room to answer another resident's alarm and to assist a LN. Resident #9 fell during the time he was left alone and unattended.

Refer to F323, for details regarding the lack of

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F 353 Continued From page 68 supervision to prevent accidents/falls. F 353

On 8/29/13 at 9:00 a.m., the staffing issues were discussed with the Administrator and the DNS. Both of them stated they had placed advertisements for multiple positions, including LN and CNA positions. The Administrator also stated that, "Around the first of August," she had discussed the staffing issue with the facility's President.

At 1:45 p.m., the Administrator provided copies of advertisements, dated 3/14/13, for a Social Service Director position; 3/21/13, for a Physical Therapist position; 6/13/13, 6/27/13, and 7/3/13, for full time night nurse and evening CNA positions; and, 8/15/13 and 8/22/13, for a full time CNA position. The Administrator stated that another health care provider in the area had been actively recruiting the facility's staff.

The failure to provide adequate nursing staff affected residents' dignity and their ADL status during dining and when personal care was needed. The failure to provide adequate nursing staff also increased the potential for residents' to experience harm related to falls and/or accidents.

No other information or documentation was received from the facility which resolved the staffing issue.

F 371 483.35(i) FOOD PROCURE, SS=F STORE/PREPARE/SERVE - SANITARY

F 371 The facility does ensure that food is stored, prepared, and served under sanitary conditions. 11/22/13

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and

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OCT 29 2013

FACILITY STANDARDS

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F 371	<p>Continued From page 69</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure food was stored, prepared, and served under sanitary conditions. This had the potential to affect 9 of 9 sample residents (#s 1-9) and all other residents who dined in the facility. This failure created the potential for cross contamination of food and for residents to be exposed to potential sources of pathogens. Findings include:</p> <p>Note: The 2009 FDA Food Code Chapter 2, Hair Restraints, subpart 2-402.11 Effectiveness, indicated, "(A) Except as provided in ¶ (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles."</p> <p>NOTE: The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, subpart 4-601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils indicated, "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." And,</p>	F 371	<p><i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>On 08/26/2013 the FSS removed the fan from the dietary department.</p> <p>On 8/26/13 the FSS cleaned the microwave.</p> <p>On 8/26/13 the FSS or designee cleaned stove backsplash, warming shelf and oven.</p> <p>On 8/26/13 the FSS removed the cookie sheet type tray from fridge and replaced with clean one.</p> <p>On 8/26/13 the FSS cleaned the pale yellow splatter marks in main refrigerator.</p> <p>On 8/26/13 the FSS or designee cleaned the storage containers on the bottom shelf of the stainless steel work table.</p> <p>On 8/26/13 the FSS or designee cleaned and deiced the ceiling fans in the reach-in freezer.</p> <p>On 8/26/13 the FSS or designee cleaned the gasket on the produce refrigerator door.</p> <p>On 8/26/13 the FSS or designee cleaned the dry storage room door.</p> <p>On 8/26/13 the FSS or designee cleaned the back door (north). By 10/10/2013 the Maintenance Supervisor will install a kick plate on bottom portion of door.</p> <p>By 11/22/13 the facility will replace the flooring in the warewashing area.</p> <p>By 11/22/13 the facility will replace the flooring in the dishwashing sink area.</p>	

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F 371 Continued From page 70
subpart 4-602.13 Nonfood Contact Surfaces,
"Non food-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues."

a) On 8/26/13 from 9:35 a.m. to 10:45 a.m., during an initial tour of the facility's kitchen, and with the Food Service Supervisor (FSS) in attendance, the following conditions were observed:

1. A table top fan by the 2-compartment sink in the kitchen had dust particles on the front and the back of the wire cage. Also, a grimy, black substance covered more than half of each of the 3 fan blades and was thickest along the outer edge of each blade. The FSS stated, "I cleaned this a few days ago [as he touched the wire cage]." He said, however, that the fan blades could not be cleaned because the wire cage could not be opened. The FSS pointed to two zip tie connectors that held the front and the back of the wire cage together and indicated that they could not be removed.

2. The inside of the microwave door was dotted with tiny bits of tan and brown debris. The debris felt bumpy. The inside top of the microwave had several brown splatter marks. And, there were reddish, brown specs and off-white flecks of debris on the outside of the microwave on the right side near the control panel. When asked if the microwave had been used that morning, the FSS stated, "No."

3. A build-up of black and brown grime was on the lower half of the left 2/3 of the stove backsplash. The warming shelf over the back of the stove was entirely covered with a fine layer of a light colored substance that was sticky to the touch. The inside glass in the oven door and the

F 371 The floor was mopped on 8/26/13 and flakes were swept by FSS in dry storage area. By 11/22/13 the facility will replace the flooring in the main kitchen area.

The FSS was provided with 1:1 education regarding wearing beard net by Administrator on 10/06/2013.

Cook #5 was provided with 1:1 education regarding wearing hairnets when entering kitchen on 10/06/2013.

Dietary Staff #6 was provided with 1:1 education regarding wearing hairnets when entering kitchen 10/06/2013.

Hairnet boxes were installed at entrance doors outside kitchen area on 09/26/2013.

Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:

This deficiency has the potential to impact any residents in the facility.

The facility Administrator on 10/5/13 included in the cleaning schedule the stove backsplash / warming shelf / oven, refrigerators, reach-in freezer, the storage containers under the stainless steel work table, the doors, and the floors.

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F 371	<p>Continued From page 71</p> <p>bottom of the inside of the oven was covered with a sticky, black substance. Also, there was an accumulation of a black flaky substance in both front corners in the oven. When asked if the stove, warming shelf, or oven had been used to prepare breakfast that morning, the FSS stated, "No."</p> <p>4. One of 4 cookie sheet type trays on a rack in the left side of the main refrigerator had light brown grime, from 1/2 to 2 inches wide, along the sides and light brown and tan crumbs in all 4 corners. The FSS acknowledged the dirty tray and removed 2 packages of sliced cheese, 1 package of flour tortilla, and 1 bottle of Dijon mustard from the tray. Then, the FSS removed the tray from the refrigerator and placed it in the dishwashing sink.</p> <p>5. Four large, pale yellow splatter marks were on the inside bottom of the middle section of the main refrigerator. The FSS stated, "I must have spilled orange juice this morning."</p> <p>6. The lids on 4 of 10 storage containers on the bottom shelf of the stainless steel work table at the front of the kitchen had a light colored grimy build-up and light colored crumbs on them. The 4 containers contained: whole wheat flour, sugar, oats, and pancake mix.</p> <p>7. Both of the ceiling mounted fans in the reach-in freezer were covered with a thick layer of frost/ice. An approximately 2 inch thick build-up of frost/ice covered more than 1/2 of the fan on the right; and, an approximately 1 inch thick build-up of frost/ice covered almost 1/2 of the fan on the left. The FSS said he had not noticed the frost/ice build-up before and indicated it had just happened.</p> <p>8. The gasket on the produce refrigerator door and the front of the inside of the refrigerator, where the two meet, had brown streaks and blobs</p>	F 371	<p><i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i></p> <p>To ensure that the deficient practice does not recur an In-service training was completed on 10/5/2013 by Administrator regarding F-371 to all Dietary Staff; the importance of ensuring food is stored, prepared, and served under sanitary conditions.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i></p> <p>Monitoring will be done through:</p> <p>The Administrator or designee will complete sanitary inspections in the dietary department.</p> <p>Monitoring will start on October 07, 2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Administrator or designee will submit to the QA&A Committee in her quarterly report findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>

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F 371	<p>Continued From page 72</p> <p>of a brown debris, that felt sticky to the touch, on them. The FSS agreed the gasket and inside front of the refrigerator were dirty.</p> <p>9. Nine of the 1 foot square floor tiles to the left of the water heater in the Dry Storage room were broken and/or dislodged with 1 inch to 3 inch wide gaps between the tiles. The subfloor was visible between the gaps and dozens of grains of rice were observed in three of the gaps. In addition, several tiny, light brown, dry flakes were observed on the floor tiles to the right of the water heater. The FSS acknowledged the broken and misaligned floor tiles, the rice in the gaps, and the dry flakes on the floor.</p> <p>10. The Dry Storage room door had blackened areas about 3 inches wide by 12 inches tall above and about 12 inches below the door knob, inside and out.</p> <p>11. The back door, which led to the hallway with the ice machine, had a black grimy substance all the way across the bottom and about 2 feet up from the bottom. Just above the grimy area were numerous white and gray 2-3 inch long horizontal streaks.</p> <p>12. Three 2 inch sections of floor tiles were missing under the counter to the right of the warewashing machine. Additionally, 4 extra floor tiles were on top of the floor tiles adjacent to the area of the missing sections of floor tiles.</p> <p>13. Two 1 foot square floor tiles were cracked and 21 of the 1 foot square floor tiles were misaligned in front of the dishwashing sink. There were gaps, about 1/8 to 1/4 inch wide, inbetween the misaligned tiles. Three of those gaps were black.</p> <p>14. There were forty-one cracked and/or chipped 1 foot square floor tiles in the main kitchen area. In addition, the entire kitchen floor, including the dishwashing/ware washing area, was dirty with</p>	F 371		
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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET MC CALL, ID 83638
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F 371 Continued From page 73 F 371

light tan and brown splotches and darker brown and black splotches through out, especially around the stove, the stainless steel work table, the dishwashing sinks, and the ware washing machine. The FSS said the floor had been mopped the night before.

15. The FSS' beard was not covered by any type of hair restraint during the tour of the kitchen. The FSS acknowledged that his beard was not covered and stated, "The guy [surveyor] last time said it was okay."

16. At 10:20 a.m., the FSS and the surveyor observed as Cook #5 entered the kitchen and walked around in the kitchen without a hair restraint on her head. After about 1 minute, the cook walked to the cabinet between the opening to the dishwashing area and the window to the ware washing machine, removed a white coat from one of the drawers and put it on. Cook #5 then walked about 15 feet around the reach-in freezer, which was in the middle of the room, to an upper cabinet to the right of the 2 compartment sink, and got a hair net. The cook then walked about 12 feet to the mirror above the handwashing sink by the back door and put on the hair net. When asked if there was an area in the kitchen where staff could be without a hair restraint, the FSS stated, "Nowhere really."

17. At 10:30 a.m., the FSS and the surveyor observed as Dietary Staff (DS) #6 entered the kitchen with her below the shoulders length hair unrestrained, went to the drawer where the white coats/aprons were stored, removed one of each and put them on, then walked about 15 feet around the reach-in freezer, removed a hair net and put it on over her hair. The FSS looked at the surveyor but said nothing.

b) On 8/26/13 at 2:30 p.m. many of the

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F 371 Continued From page 74

forementioned conditions noted above were observed to be cleaned. However, the following conditions were again observed:

1. There were still grains of rice in the gaps between the broken/misaligned floor tiles to the left of the water heater and dry flakes on the floor tiles to the right of the water heater in the Dry Storage room. The FSS stated, "I missed that." He got a broom and dust pan and immediately swept up the rice and dry flakes. The FSS said the dry flakes were, "Probably onion flakes."
2. The back door and the Dry Storage room door had been cleaned and were free of the blackened areas. However, more short horizontal marks were noted where the black grime had been on the lower 2 feet of the back door.
3. The flooring in the main part of the kitchen and the traffic areas in the dishwashing and warewashing areas had been cleaned. However, the flooring under the dishwashing sink and the warewashing machine were still dirty.
4. There was no change regarding the cracked, broken, and misaligned floor tiles in the main kitchen area, the dishwashing area, the warewashing area, or the Dry Storage room.

Note: The table top fan was no longer by the 2 compartment sink. The FSS stated that the fan had been removed from the kitchen. In addition, the FSS had shaved his beard and all of the dietary staff in the kitchen wore a hair restraint.

On 8/26/13 at 4:00 p.m., the Administrator and Staff Development Coordinator (SDC) were informed of the aforementioned conditions in the kitchen. The Administrator stated, "I guess we need to clean our kitchen." The Administrator added, "We redid the tiles by the dishwasher last year, but I think they move with water."

F 371

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F 371 Continued From page 75
Subsequent observations in the kitchen on 8/27/13 at 11:50 a.m. and 5:25 p.m. and 8/29/13 at 6:00 p.m. revealed all of the dietary staff wore a hair restraint.

On 8/29/13 at 6:00 p.m., at the surveyor's request, DS #6 agreed to provide copies of the cleaning schedules for the kitchen. Copies of 3 cleaning schedules for August 2013 were received at 6:45 p.m.

The 3 cleaning schedules included: "Daily Cleaning Schedule - To be completed by each Helper" and 2 "Daily Cleaning Schedule - To be completed by each Cook" with one noted as "AM" and the other as "PM."

All of the cleaning schedules listed items to be cleaned or tasks to be done. However, none of the cleaning schedules included the stove backsplash/warming shelf/oven, the refrigerators, the reach-in freezer, the storage containers under the stainless steel work table, the doors, or the floors.

No other information or documentation was received from the facility that resolved the sanitation issues in the kitchen.

F 371

F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS
SS=D

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically

F 431 The facility does ensure that expired medications were not available for administration to residents.

10/28/13

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F 431	<p>Continued From page 76 reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure expired medications were not available for administration to residents. This created the potential for sub-optimal efficacy for any resident who could have received the expired anticoagulant medication, Lovenox. Findings included: On 8/29/13 at about 2:45 p.m., during an inspection of the IV E-Kit (intravenous emergency</p>	F 431	<p><i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>The E-kit identified was sent to the facility by the contracted pharmacy by mistake without the label indicating the earliest day the medication inside the E-kit will expire.</p> <p>The facility Director of Nursing with a License Nurse on 9/11/13, destroyed the 2 pre-filled syringes of expired lovenox identified in the E-kit.</p> <p><i>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:</i></p> <p><i>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, to address other Residents that may have the potential to be affected by this deficiency:</i></p> <p>The Director of Nursing on 8/30/13 informed the contracting pharmacy of the expired medication in the E-kit that was sent back to the facility, that this particular e-kit did not have the label indicating when the earliest medication would expire.</p> <p><i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i></p> <p>To ensure that the deficient practice does not recur; an In-service training was completed on 10/5/13 by the Director of Nursing or designee regarding F-431 to all License Nurses, to ensure the E-kit being received from pharmacy, is checked for the label indicating when the earliest date the medication in the e-kit will expire.</p>	

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F 431	Continued From page 77 kit) in the Medication Room, with LN #4 in attendance, 2 pre-filled syringes of Lovenox 100 mg/ml (milligrams per milliliter), both expired in January 2013, were observed. LN #4 acknowledged the 2 expired Lovenox syringes and stated, "We don't give these." The LN added, "We will waste them. I will have my DNS waste them with me." About that time, the DNS entered the Medication Room and she was informed of the expired Lovenox. The DNS stated, "I agree" and, "That IV E-Kit just came." The DNS indicated that she would contact the pharmacy about the expired Lovenox. On 8/29/13 at 6:15 p.m., the Administrator was also informed of the expired medication. No other information or documentation was received from the facility which resolved the issue.	F 431	<i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i> Monitoring will be done through: The Director of Nursing or designee will check E-kit in the med room to ensure that the E-kit has the label indicating when is the earliest date the medication in the e-kit will expire. Monitoring will start on October 07, 2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. The facility Director of Nursing or designee will submit to the Administrator or designee and the QA&A Committee in her quarterly report findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441	The facility does ensure that staff adheres to infection control protocols. <i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i> C.N.A. #7 who was observed caring for Resident # 1 was provided 1:1 education by the Director of Nursing on 10/5/13 with regards to F-441, on the importance of adhering to infection control as it relates to hand hygiene between assisting with perineal care after toileting and assisting with oral hygiene.	10/28/13

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F 441	<p>Continued From page 78</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff adhered to infection control protocols. This was true for 1 of 10 sample residents (#1) when gloves were not changed and hand hygiene not performed between assisting with perineal care after toileting and assisting with oral hygiene. This failed practice increased the potential for the spread of infection in the facility. Findings included:</p> <p>Resident #1 was admitted to the facility on 6/2/06 with multiple diagnoses which included hypertension, edema, and osteoarthritis.</p> <p>Resident #1's most recent quarterly MDS assessment, dated 7/2/13, coded:</p>	F 441	<p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:</p> <p><i>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, to address other Residents that may have the potential to be affected by this deficiency:</i></p> <p>On 10/6/13 the facility Director of Nursing or designee in-serviced all C.N.A. staff on F-441 with emphasis on adhering to infection control as it relates to hand hygiene between assisting with perineal care after toileting and assisting with oral hygiene.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur:</p> <p>The Staff Development Coordinator completed skills checks for hand hygiene on all C.N.A. staff by 10/5/13.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Director of Nursing or designee will observe minimum of 3 staff to ensure infection control is practice with regards to hand hygiene between assisting with perineal care after toileting and assisting with oral hygiene.</p> <p>Monitoring will start on October 07, 2013. ✓ This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p>	

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F 441	<p>Continued From page 79</p> <ul style="list-style-type: none"> -Severely impaired decision making skills. -No rejection of cares. -Dependent on 2 staff persons for assistance with transfers, toileting, and hygiene. <p>On 8/27/13 at 9:30 AM, CNA # 7 and CNA #13 were observed caring for Resident #1. During this time, CNA #7 was observed to assist Resident #1 onto the toilet. CNA #7 re-entered the resident's room, obtained a paper towel from the dispenser, and set the paper towel next to the sink. CNA #7 then opened a drawer in the resident's room, removed a toothbrush and toothpaste, and set them on the paper towel. CNA #7 returned to the bathroom and assisted Resident #1 with perineal hygiene and to get her off of the toilet. CNA #7 brought Resident #1 back into the room in her wheelchair, set the resident in front of the sink, picked up the toothbrush, applied toothpaste, and attempted to brush the resident's teeth. At no time was CNA #7 observed to change her gloves or wash her hands. CNA #7 did not offer Resident #1 the opportunity to wash her hands after the resident used the restroom. CNA # 7 was asked about handwashing when providing resident cares. CNA #7 stated she should have changed her gloves and washed her hands before she set up supplies for oral care, and again right after Resident #1 used the toilet. CNA # 7 also stated she should have offered an opportunity for Resident #1 to wash her hands. CNA # 7 stated, "Sometimes I forget."</p> <p>On 8/29/13 at 6:15 PM, the Administrator and DNS were informed of the surveyor's findings. The facility offered no further information.</p>	F 441	<p>The facility Director of Nursing or Licensed Nurse Designee will submit to the Administrator or designee and the QA&A Committee in her quarterly report findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>	
F 463 SS=F	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	F 463	The facility does ensure a call system is available in all toilet and bathing facilities.	10/28/13

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F 463	<p>Continued From page 80</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure a call system was available in all toilet and bathing facilities. This was true for 12 of 13 (#s 1-9, 11-13) sampled residents, and had the potential to impact any resident being bathed in the facility. The deficient practice had the potential to cause more than minimal harm if residents and/or staff assisting residents to bathe could not alert others in the event of an emergency. Findings included:</p> <p>On 8/29/13 at 4:00 PM, during the environmental tour with the maintenance director, it was noted that the East and West shower rooms each had a toilet, bathtub, and two shower stalls. There was a call light pull cord next to each toilet. There was an outlet for a call light cord next to each tub, however, there was no call light cord installed in the outlet. There were no call lights for the shower stalls. The maintenance director was asked if there was a call system available for the tubs or shower stalls. The maintenance director stated he had worked in the facility for 2 years, and they had not had call systems available for the shower stalls for at least that period of time. The maintenance director stated he would place a call cord in the outlets available at the bathtubs.</p> <p>On 8/29/13 at 6:15 PM, the Administrator and DNS were informed of this concern. The facility</p>	F 463	<p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>The facility hired an electrical contractor to install call lights near shower stalls on 10/3/13. The Maintenance Director put a call light cord in the outlets available at the bathtubs on 10/1/13.</p> <p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:</p> <p>To address other Residents that may have the potential to be affected by this deficiency:</p> <p>On 10/7/13, the Maintenance Director added to his monthly maintenance checks to ensure that the call light system in the shower rooms are in place and functioning.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur; Starting on 10/7/13 the Maintenance Director or designee will do a monthly call light system check in the shower rooms to make sure that they are in place and are functional.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Administrator or designee will visually inspect call light system shower rooms to ensure that they are in place and are functional.</p> <p>Monitoring will start on October 07, 2013. ✓ This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p>

admin 11-1-13 3:20pm
call lights done, installed.
xm

The Administrator or designee will submit to the and the QA&A Committee in her quarterly report findings and/or corrective actions taken.

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F 463 F 490 SS=F	<p>Continued From page 81 offered no further information.</p> <p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews, review of the facility's abuse investigations, review of the facility's policies and procedures on abuse, and record review, it was determined the Administrator, DON, and management team failed to manage the facility to ensure the safety and well being of each resident. They failed to immediately and thoroughly investigate allegations of abuse and report those allegations to the appropriate agencies. In addition, they failed to protect residents from further abuse. These failed practices affected 1 of 13 sampled resident (#2) and had the potential to affect all residents residing in the facility.</p> <p>Specifically, the Administrator, DON, and management team failed to:</p> <ol style="list-style-type: none"> 1. Ensure immediate and thorough investigations were conducted when allegations of staff-to-resident abuse were reported. Refer to F225 for findings of immediate jeopardy for Resident #2. 2. Ensure residents were protected from further 	F 463 F 490	<p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p> <p>The facility Administrator, DON, and Management Team does manage the facility to ensure the safety and well being of each resident.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Prior to the identification of the allegation by the surveyors, immediately upon notification the facility Administrator on 8/12/13 did meet with Resident #2 and her family and followed up the allegation. Resident #2 and family were asked by the Administrator if they wanted to file a formal grievance and they declined. Resident # 2 was asked by the Administrator "Did she (C.N.A.) really throw it (call light) at you?" and Resident # 2 said "No." Then Resident #2 and family were asked if they believed that abuse occurred and they stated "No."</p> <p>The facility Administrator generated the allegation of abuse report for Resident #2 on 8/28/13, and reported allegation to the State Survey and Certification Agency.</p> <p>The facility Administrator, with the DNS, and MSW present, on 8/29/13, suspended the alleged employee pending the completion of the investigation and obtained statement from the alleged employee involved in the incident.</p> <p>The facility Administrator on 8/30/13 reported the result of investigation on the allegation to the State Survey and Certification Agency.</p>	10/28/13

F- 490 SS= F
§483.75 - EFFECTIVE
ADMINISTRATION / RESIDENT
WELL-BEING

However, to address other residents that may have the potential to be affected by this deficiency, the facility Administrator and/or the facility MSW on 8/29/13, sent all Residents in the facility and/or Residents Representative correspondence via mail their right to file complaints or grievances of any kind without the fear of retribution.

With regards to a story mentioned by the Hospice C.N.A. to the surveyor that was told to her by another Resident earlier in the year, in which according to the story related to her by the Resident, she (the Resident) heard what she called "Love making in the empty bed" in the resident's room. The facility Administrator reported allegation to the State Survey and Certification Agency on 9/27/13, generated the allegation of abuse report, and investigated. Based on the investigation by the Abuse Team Task Force, the allegation was found to be unsubstantiated.

The Resident is no longer a Resident of the facility. During the investigation, based on the interview with the Hospice C.N.A., the Hospice C.N.A. mentioned that the Resident said she never saw it happen, instead just heard talking. Therefore based on the investigation it was determined that it was the movie "Twilight" (that has sexual connotation in it), that the Resident was watching and what she may have heard, hence allegation was unsubstantiated. On 10/2/13 the result of the investigation was reported to the State Survey and Certification Agency.

Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:

This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.

However, to address other residents that may have the potential to be affected by this deficiency, the facility Administrator and/or the facility MSW on 8/29/13, sent all Residents in the facility and/or Residents Representative correspondence via mail their right to file complaints or grievances of any kind without the fear of retribution.

Page 82A

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OCT - 8 2013

FACILITY STANDARDS

Continuation:

F-490 SS=F

§483.75 – EFFECTIVE
ADMINISTRATION / RESIDENT
WELL-BEING

Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:

To ensure that the deficient practice does not recur:

On August 29, 2013, the company President did a formal write up to the Administrator on not following proper process for abuse investigation and prevention.

The facility Administrator and Director of Nursing read and confirmed understanding of the Federal Regulations for F-166, F-225, and F-226 as evidenced by statement of confirmation signed on 8/29/13.

The facility on 8/29/13, developed an "Abuse Team Task Force," that will review all complaints of any nature as potential means of abuse.

On 8/29/13, the facility Administrator and Director of Nursing updated the facility's Policy and Procedure for Abuse Investigation and Abuse Prevention Program, including federal guideline definitions and reporting process. This updated Abuse Investigation and Abuse Prevention Program Policy and Procedure was presented and approved by the Survey Team during the week of the Survey.

On 9/10/13, the facility "Abuse Team Task Force" introduced themselves during the all staff in-service meeting and in-serviced all staff with regards to reporting any allegation of abuse to the facility "Abuse Team Task Force."

An In-serviced to all staff, contract staff, and volunteers was also provided by the "Abuse Team Task Force" starting 8/30/13 through 10/20/13, with regards to the updated Policy and Procedure on Abuse Investigation and Abuse Prevention Program

82-B

Continuation:

F- 490 SS= F

§483.75 – EFFECTIVE

ADMINISTRATION / RESIDENT

WELL-BEING

How the corrective action(s) will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through;

The facility "Abuse Team Task Force," or their designee will check with at least three (3) Residents for abuse issues and to ensure the Residents right to file complaints of any kind without the fear of retribution.

The facility "Abuse Team Task Force," or their designee will check with at least (3) employees, and/or contract staff (if available and in the facility), and/or volunteers (if available and in the facility), to ensure their right to file complaints of any kind without the fear of retribution and regarding abuse investigation and prevention.

Monitoring will start October 07, 2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.

The facility "Abuse Team Task Force," will present findings and/or corrective actions taken to the QA&A Committee during the quarterly QA&A Committee meeting.

Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.

10/28/13

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135082	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION & CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET MC CALL, ID 83638	
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F 490	Continued From page 82 abuse when a staff member was allowed to continue to provide direct resident care after an abuse allegation was made. Refer to findings of immediate jeopardy at F226. On 8/28/13 at 5:35 PM, the Administrator and the Director of Nursing were informed of the concerns regarding the Administrative team. The facility provided no other information or documentation to resolve the concern.	F 490	
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure that nurse aides were able to demonstrate competency in skills and techniques necessary to care for resident's needs. This was true for 1 of 10 sample residents (#2) when the wheelchair brakes were not locked before a transfer. The failed practice created the potential for injury to the resident, including the possibility for falls, fractures, subluxation (incomplete or partial dislocation) of the shoulder(s), and skin breakdown. Findings include: Resident #2 was admitted to the facility on 8/3/13 with multiple diagnoses which included in part, progressive supranuclear palsy, cervical	F 498	10/28/13 The facility does ensure that nurse aides were able to demonstrate competency in skills and techniques necessary to care for residents needs. <i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i> C.N.A. #7 who was observed not locking the wheelchair brakes while transferring Resident # 2 ✓ was provided 1:1 education by Director of Nursing on 10/4/13 regarding F-498 with importance of locking brakes on wheelchair with transfers. <i>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:</i> <i>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, to address other Residents that may have the potential to be affected by this deficiency;</i> However, to address other residents who potentially may be affected by this deficiency, the Administrator and Director of Nursing did a visual observation of at least four residents on each shift to ensure that wheelchair brakes are locked with transferred by 10/5/13.

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F 498	<p>Continued From page 83</p> <p>spondylosis, dysphasia, osteoarthritis, and peripheral neuropathy.</p> <p>Resident #2's August 2013 Plan of Care documents in part:</p> <ul style="list-style-type: none"> * Potential for falls - Encourage resident to call for assistance. Adjustable bed for ease of movement and transfers. Alarm per order. Non skid mat. Toilet as necessary. Anticipate needs; and * Bladder incontinence - Encourage resident to seek assistance with toileting and keep call light in reach. <p>Resident #2's most recent admission MDS documented in part:</p> <ul style="list-style-type: none"> * Cognitively intact with a BIMS score of 15; * Extensive assist with one person for bed mobility, transfer, dressing, and personal hygiene; * Extensive assist with 2 people for toilet use; and, * Functional limitation in range of motion in both upper and lower extremities. <p>On 8/27/13 at 9:15 a.m., Resident #2 was observed being transferred from the toilet to the wheelchair by CNA #7. The brakes on the wheelchair were observed in the unlocked position for the entire transfer. After the transfer, CNA #7 was asked if the brakes were locked. The CNA stated, "Yes." The surveyor stated, "They don't look locked." CNA #7 responded, "It wasn't all the way down" and attempted to push down the brake on the right wheel. However, the brake did not lock. The surveyor added, "The other one wasn't locked either." There was no further response from the CNA.</p> <p>On 8/29/13 at 6:15 p.m., the Administrator and DON were informed of the transfer issue. No</p>	F 498	<p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur;</p> <p>On 10/6/13 the facility Director of Nursing or designee in-serviced all C.N.A. staff regarding F-498 on requirement to lock wheelchair brakes when transferring residents.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Director of Nursing or designee will observe minimum of 3 transfers of residents from wheelchairs by C.N.A. to ensure that C.N.A.'s are locking the wheelchair brakes when transferring residents.</p> <p>Monitoring will start on October 07, 2013. ✓ This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Director of Nursing or Licensed Nurse Designee will submit to the Administrator or designee and the QA&A Committee in her quarterly report findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>

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F 498 F 514 SS=D	<p>Continued From page 84</p> <p>further information was provided that resolved the issue.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents' medical records were complete. This was true for 2 of 6 sample residents (#2 and #4). This failure created the potential for medical decisions based on incomplete information. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 6/4/12 with multiple diagnoses which included personal history of traumatic fracture, general osteoarthritis, muscle weakness, unspecified urinary obstruction, and vascular dementia with delirium.</p> <p>The resident's recapitulation of Physician Orders</p>	F 498 F 514	<p>The facility does ensure residents' medical records are complete.</p> <p><i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>On 9/4/13 Resident # 4 physician order on the stasis ulcer dressing change, the site was corrected. ✓</p> <p>The facility obtained wound clinic notes on Resident #4 on 8/29/13. ✓</p> <p>The facility Social Worker obtained Hospice Social Worker notes on 8/29/13. The Hospice C.N.A. started leaving visit notes on 8/29/13. ✓</p> <p><i>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:</i></p> <p>This deficiency is an isolated deficiency.</p> <p>On 10/6/13, the Director of Nursing reviewed Residents with wound treatment orders to ensure that appropriate site of the wound is transcribed.</p> <p>A letter was send to the wound clinic on 10/5/13, by the Administrator with regards to making sure that documentation is sent to the facility following a Resident appointment at the wound clinic.</p> <p>On 9/25/13 the facility Administrator met with the Hospice Director to discuss the importance of ensuring the hospice staff provide the facility with their documentation of the scheduled visit with the resident.</p>	10/28/13

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F 514	<p>Continued From page 85</p> <p>for August 2013 included an order for dressing changes every 3 days and as needed to the right foot arch/instep. The order was dated 6/11/13.</p> <p>On 8/28/13 at about 9:40 a.m., when asked about Resident #4's foot wound, LN #3, who identified herself as the wound nurse, stated it was actually the resident's left foot and she had stasis ulcers on the foot and anterior ankle. LN #3 stated the resident had been seen at a wound clinic on 7/19/13 and 8/2/13 regarding the stasis ulcers. When asked for the wound clinic visit notes, LN #3 reviewed the resident's clinical record then stated, "No, I did not find them." The LN indicated she would contact the wound clinic to request their documentation.</p> <p>On 8/29/13 at 6:15 p.m., the Administrator and DNS were informed of the documentation issue. However, no other information or documentation was received from the facility regarding Resident #4's wound clinic visits.</p> <p>2. Resident #2 was admitted to the facility on 8/3/13 with multiple diagnoses which included in part, progressive supranuclear palsy, cervical spondylosis, dysphasia, osteoarthritis, and peripheral neuropathy. Hospice services were also initiated on 8/3/13 due to the diagnosis of supranuclear palsy.</p> <p>Resident #2's most recent admission MDS documented in part:</p> <ul style="list-style-type: none"> * Cognitively intact with a BIMS score of 15; and * Special Treatments and Programs - Hospice care. <p>The hospice provider's Plan of Care for Resident #2 documented the following:</p> <ul style="list-style-type: none"> * Skilled Nursing - 1 to 3 visits per week for 11 	F 514	<p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>The facility Medical Records by 10/5/13, will develop a wound clinic visit log and crosscheck that documentation is provided following appointment.</p> <p>The Administrator or designee will in-service all License Nurses on 10/6/13, on requirements of F514 to make sure that when transcribing wound treatment orders that the appropriate site of the wound is transcribed.</p> <p>Starting 10/7/13 a member of the facility Abuse Team Task Force will entrance and exit with all Hospice staff on visits. Clinical documentation will be reviewed for completeness and filed in resident chart.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135082	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/30/2013
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F 514	<p>Continued From page 86 weeks, and 2 PRN visits; * Aide - 1 to 5 visits per week for 10 weeks; and, * MSS - 1 to 4 per month for 3 months.</p> <p>On 8/28/13 at 11:45 a.m., the hospice CNA was interviewed. When asked about her frequency of visits with Resident #2 she stated, "I've had her 3 weeks now. I'm here 5 days a week. Monday through Friday usually." The hospice CNA stated she comes in at 10:00 a.m. for 2 hours. The CNA added, "Yesterday [8/27/13] I stayed 3 hours."</p> <p>On 8/28/13 at 3:35 p.m., the Social Worker was interviewed regarding Resident #2 and hospice services. The Social Worker stated, "I've been talking to the hospice Social Worker. He's the Chaplain too and he's been working with the family a lot." The Social Worker was then asked to provide documentation from the hospice Social Worker's visits, and communication between her and the hospice Social Worker. After reviewing the "Hospice" tab, the Social Worker stated there were no visit notes by the hospice Social Worker and that she would contact the hospice provider to request copies.</p> <p>Note: Facility staff stated any documentation for hospice services would be under the "Hospice" tab in Resident #2's medical record. However, there was no documentation from the hospice Social Worker (which was later provided), and no documentation from Resident #2's primary hospice CNA.</p> <p>On 8/29/13 at 6:15 p.m., the Administrator and DON were informed of the hospice documentation issue. No further information or documentation was provided that resolved the issue.</p>	F 514	<p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i></p> <p>Monitoring will be done through:</p> <p>The Director of Nursing or designee will review wound treatment orders to ensure that the appropriate site of the wound is transcribed.</p> <p>The Director of Nursing or designee will review wound clinic visit log to ensure that documentation is sent to the facility following an appointment to the wound clinic.</p> <p>The Administrator or designee will review hospice visit log and check hospice tab to make sure the documentation is filed in the resident's chart.</p> <p>Monitoring will start on October 07, 2013. ✓ This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Director of Nursing or designee and Administrator or designee will submit to the QA&A Committee in their quarterly report findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>	

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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001590	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2013
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NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET MC CALL, ID 83638
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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the recent State Licensure survey. The survey team included: Nina Sanderson BSW LSW, Team Coordinator Linda Kelly RN Lauren Hoard BSN RN	C 000		
C 107	02.100.02,b Written Policies/Procedures b. The administrator shall be responsible for establishing and assuring the implementation of written policies and procedures for each service offered by the facility, or through arrangements with an outside service and of the operation of its physical plant. The policies and procedures shall further clearly set out any instructions or conditions imposed as a result of religious beliefs of the owner or administrator. The administrator shall see that these policies and procedures are adhered to and shall make them available to authorized representatives of the Department. If a service is provided through arrangements with an outside agency or consultant, a written contract or agreement shall be established outlining the expectations of both parties. This Rule is not met as evidenced by: Please see F 490 as it pertains to facility	C 107	See Federal Tag F490.	10/28/13

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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 10/4/13
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Bureau of Facility Standards

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C 107	Continued From page 1 administration.	C 107		
C 111	02.100,02,f Provide for Sufficient/Qualified Staff f. The administrator shall be responsible for providing sufficient and qualified staff to carry out all of the basic services offered by the facility, i.e., food services, housekeeping, maintenance, nursing, laundry, etc. This REQUIREMENT is not met as evidenced by: Refer to F353 as it related to adequate staffing levels to meet residents' needs.	C 111	See Federal Tag F353.	10/28/13
C 123	02.100,03,c,vii Free from Abuse or Restraints vii. Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient/resident from injury to himself or to others; This Rule is not met as evidenced by: Refer to F225 and F226 as it related to abuse.	C 123	See Federal Tag F225 and F226.	10/28/13
C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by:	C 125	See Federal Tag F164 and F241.	10/28/13

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET MC CALL, ID 83638
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C 125	Continued From page 2 Refer to F164 and F241 as they related to privacy during treatment and to dignity.	C 125		
C 168	02.100,12,c Record of all Incidents/Accidents c. An incident-accident record shall be kept of all incidents or accidents sustained by employees, patients/residents, or visitors in the facility and shall include the following information: This Rule is not met as evidenced by: Refer to F225 and F226 related to allegations of abuse.	C 168	See Federal Tag F225 and F226.	10/28/13
C 175	02.100,12,f Immediate Investigation of Incident/Injury f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Refer to F225 and F226 as it relates to investigating allegations of abuse	C 175	See Federal Tag F225 and F226.	10/28/13
C 176	02.105,01 Personnel Policies 105. PERSONNEL. 01. Personnel Policies. Personnel policies shall be developed and implemented and shall include: This Rule is not met as evidenced by: Refer to F226 as it relates to implementing policies and procedures.	C 176	See Federal Tag F226.	

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C 212	Continued From page 3	C 212		
C 212	02.105,a,ii Basic Procedures with Residents ii. Basic procedures relative to patient/resident care; This Rule is not met as evidenced by: Refer to F498 as it related to CNA proficiency with transferring residents.	C 212	See Federal Tag F498.	10/28/13
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F371 as it related to unsanitary conditions in the kitchen.	C 325	See Federal Tag F371.	10/28/13
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Please see F 252 as it pertains to clean, comfortable, homelike environment.	C 361	See Federal Tag F252.	10/28/13
C 644	02.150,01,a,i Handwashing Techniques a. Methods of maintaining	C 644	See Federal Tag F441.	10/28/13

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C 644	Continued From page 4 sanitary conditions in the facility such as: i. Handwashing techniques. This Rule is not met as evidenced by: Refer to F441 as it related to hand hygiene.	C 644		
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it relates to revising care plans.	C 782	See Federal Tag F280.	10/28/13
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please see F 309 as it pertains to diabetic management, coordination of care with hospice, and timely implementation of medication changes. Please see F 312 as it pertains to ADL assistance.	C 784	See Federal Tag F309 and F312.	10/28/13
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)	C 789	See Federal Tag F314.	10/28/13

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C 789	Continued From page 5 hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please see F 314 as it pertains to pressure ulcers.	C 789			
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as it relates to falls and supervision.	C 790	See Federal Tag F323.	10/28/13	
C 792	02.200,03,b,viii Comfortable Environment viii. Maintenance of a comfortable environment free from soiled linens, beds or clothing, inappropriate application of restraints and any other factors which interfere with the proper care of the patients/residents; This Rule is not met as evidenced by: Refer to F258 as it related to unnecessary noise.	C 792	See Federal Tag F258.	10/28/13	
C 797	02.200,03,c Documentation of Nursing Assessments c. Nursing staff shall document on the patient/resident medical record, any assessments of the patient/resident, any interventions taken, effect of interventions, significant changes and observations and the administration of medications, treatments and any other services provided. Entries shall be made at the	C 797	See Federal Tag F309.	10/28/13	

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C 797	Continued From page 6 time the action occurs and shall be signed by the person making the entry and shall provide the time and date of the occurrence. At a minimum, a monthly summary of the patient's/resident's condition and reactions to care shall be written by a licensed nursing staff person. This Rule is not met as evidenced by: Refer to F309 regarding lack of documentation for hospice services.	C 797		
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Refer to F281 as it related to professional standards regarding the administration of Advair and to F329 as it related to unnecessary medication.	C 798	See Federal Tag F281 and F329.	10/28/13
C 821	02.201,01,b Removal of Expired Meds b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days.	C 821	See Federal Tag F431.	10/28/13

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C 821	Continued From page 7 This Rule is not met as evidenced by: Refer to F431 as it related to expired medication in an emergency kit.	C 821		
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 as it related to the completeness of residents' clinical records.	C 881	See Federal Tag F514.	10/28/13
C 887	02.203,02,f Progress Notes f. Progress notes by physicians, nurses, physical therapists, social worker, dietitian, and other health care personnel shall be recorded indicating observations to provide a full descriptive, chronological picture of the patient/resident during his stay in the facility. The writer shall date and sign each entry stating his specialty. This Rule is not met as evidenced by: Refer to F514 as it relates to complete medical records.	C 887	See Federal Tag F514.	10/28/13