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 3050 0001 2125 6140

September 18, 2014

Richard M. Ord, Administrator
Meridian Center Genesis Healthcare
1351 West Pine Avenue
Meridian, ID 83642-5031

Provider #: 135125

Dear Mr. Ord:

On **September 4, 2014**, a Complaint Investigation survey was conducted at Meridian Center Genesis Healthcare by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 1, 2014**. Failure to submit an acceptable PoC by **October 1, 2014**, may result in the imposition of civil monetary penalties by **October 21, 2014**.

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

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

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

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

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

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

  b. <u>Frequency</u> 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. <u>Start date</u> of the audits;

- Include dates when corrective action will be completed <u>in column (X5)</u>.

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.*

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 4, 2015,** if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (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. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

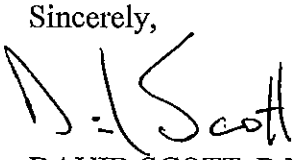
- BFS Letters (06/30/11)

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

This request must be received by **October 1, 2014**. If your request for informal dispute resolution is received after **October 1, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135125	MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	DATE SURVEY COMPLETE: 9/4/2014
NAME OF PROVIDER OR SUPPLIER MERIDIAN CENTER GENESIS HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1351 WEST PINE AVENUE MERIDIAN, ID		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 153	483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS

The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.

This REQUIREMENT is not met as evidenced by:
Based on review of the facility's policy, Admission Pack and the community standard price for photocopies, it was determined the facility's charge for copies exceeded the community standard price.

Resident #4's Power of Attorney (POA) requested a paper copy of the resident's medical record. The facility copied 281 pages at 25 cents a copy for a total of 281 copies, for which the POA was charged seventy-five dollars and twenty-five cents.

On 9/4/14 at 3:30 PM the survey team contacted a local commercial copy center to determine the community standard for copies. The employee identified for standard 8 1/2 x 11 back and white photocopies the price was thirteen cents a copy for staff to make the copies.

On 9/4/14 at 4:15 PM the facility was asked for a copy of the its policy on copying costs and if the facility calculated its cost on the community standard price for making copies. The Regional Vice President (RVP) stated he would provide the survey team with the facility's policy.

On 9/4/14 at 4:45 PM the facility provided the survey team with an unofficial typed policy for copying costs which documented the following: "Effective June 11, 2013 copying cost for records in paper form is 0.25 cents per page. Payment is due at time of receipt of records." The Policy was not signed or dated. No further information was provided to resolve this concern.

RECEIVED
OCT - 2 2014
FACILITY STANDARDS

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

PRINTED: 09/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135125		C 09/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER GENESIS HEALTHCARE	1351 WEST PINE AVENUE MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during a complaint investigation at your facility. The survey team included: Amy Barkley, RN, BSN, Team Coordinator Sherri Case, QMRP, LSW Susan Gollobit, RN Nina Sanderson, LSW The survey team entered the facility on 9/2/14 and exited the facility on 9/4/14. Survey Definitions: abx. = antibiotic appt. = appointment ASAP = As Soon As Possible BFS = Bureau of Facility Standards BID = Two times a day C&S = Culture and Sensitivity C. Diff = Clostridium difficile cm = Centimeters CNA = Certified Nurse Aide d/c'd = Discontinued DON/DNS = Director of Nursing d/t = Due to DW = Dry Weight ECF = Extended Care Facility EDW = Estimated Dry Weight ER = Emergency Room GI = Gastroenterologist H&P = History and Physical HD = Hemodialysis Doctor ICU = Intensive Care Unit IM = Intramuscular IDT = Interdisciplinary Team IPN = Interdisciplinary Progress Notes IV = Intravenous	F 000	RECEIVED OCT - 2 2014 FACILITY STANDARDS	

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

Richard Administrator 10/1/14

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 000	Continued From page 1	F 000		

LOC = Level of Consciousness
LN = Licensed Nurse
LSW/SW = Licensed Social Worker
MAR = Medication Administration Record
MD = Medical Doctor
MDS = Minimum Data Set assessment
meds = medications
ml = Milliliters
NAS = No Added Salt
NP = Nurse Practioner
NOD = Notice of Discharge
O&P = Ova and Parasite
PICC = Periferally Inserted Central Catheter
Pt = Patient
RD = Registered Dietician
RNC = Regional Nurse Consultant
r/t = related to
RVP = Regional Vice President
SDTI = Suspected Deep Tissue Injury
S/SX = Signs and Symptoms
SQ = Subcutaneous
TBI = Traumatic Brain Injury
Temp. = Temperature
TID = Three times a day
UA = Urinalysis
WN = Wound Care Nurse

"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Genesis Meridian Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."

F 157 SS=E 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial

Compliance Date 10/~~15~~/14
10/17/14
Per facility Request 10/14/14

F157 E

Residents' effected

1: Resident #1 was discharged from the center on 9/22/14.
10/22/14.

Resident #2 was discharged from the center on 6/27/14.
per facility request 10/30/14

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F 157	Continued From page 2 status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to immediately notify residents' family members or physicians of significant changes in their medical status. This was true for 4 of 6 (#s 1- 4) sampled residents. These failures created the potential for harm when the residents' physicians and families were not able to make decisions and initiate treatments based on the needs of the residents. Findings included: 1. Resident #1 was admitted to the facility on 7/10/14 with diagnoses which included muscular	F 157	Resident #3 was discharged from the center on 5/25/14. Resident #4 was discharged from the center on 5/30/14. Residents' with the potential to be effected 2: A review of resident MAR's for the last 30 days will be completed by the DON or designee on or before 10/14/14 for blood glucose parameters, and readings that require follow up including physician and responsible party notification. Resident assessment and follow up physician and responsible party notification will be completed by the licensed nurse on or before10/14/14. New orders will be implemented by the licensed nurse at the time ordered by the MD. A review of the medical record including MAR's and TAR's for the last 30 days will be completed by the DON or designee on or before 10/14/14 to ensure-responsible party notification for physicians orders including labs, medications, oxygen, CPAP, and treatments. Additionally review progress notes for last 30 days for any changes of condition without	

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F 157	Continued From page 3 wasting, hip fracture, type II diabetes, and neuralgia. A 7/14/14 IPN documented the physician was notified of a laboratory BG level of 42 on 7/14/14. The medical record also included a 7/16/14 fax to the physician of a morning BG of 43 on 7/16/14. The medical record did not include documentation that a family member had been notified of either of these critically low BG levels. On 9/3/14 at 1:50 p.m. the DON stated the family should have been notified of the critical BG levels if the physician was informed of the low BG levels. The DON was asked for documentation the family was informed. No documentation of family notification was provided. 2. Resident #2 was admitted to the facility from an acute care hospital on 5/13/14 with multiple diagnoses which included left lower extremity cellulitis with MRSA colonization, bilateral heel decubitus ulcers, thoracic paraplegia with neurogenic bowel and bladder, and history of anoxic brain injury. Resident #2's admission MDS assessment, dated 5/20/14, coded: *BIMS of 11, indicating moderately impaired cognitive skills; and *Very important to have family involved in care discussions. Resident #2's record contained a Consent for Treatment and Release of Information form and a Health Care Decision Making form. The forms documented the resident had selected a family member to act as his surrogate health care	F 157	physician or responsible party notifications will be completed by DON or designee on or before 10/14/14. Follow up notifications will be completed by the licensed nurse on or before 10/14/14. Residents admitted in the last 30 days interagency/inter-facility orders were reviewed against admission orders to ensure proper transcription of orders including fluid restrictions, diet orders, medications are accurate with clarifications obtained from MD for discrepancy noted on or before 10/14/14 by DON or designee. A review of MAR's and TAR's for the last 30 days will be completed by DON or designee on or before 10/14/14 to ensure that physician ordered parameters for medications and antibiotic orders are completed and or administered timely per order. Any findings will be reported to the MD on or before 10/14/14. Systemic Change 3: Licensed nurses will be re-educated by DON or designee on or before 10/14/14 related to following physician orders for medication, and	

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F 157	Continued From page 4 decision maker, and was to be kept informed of changes in the resident's condition. Resident #2's record documented the following changes in his condition, medications, or treatments without documentation his specified family was notified: *5/26/14, the facility requested an order from the physician to discontinue the use of the resident's CPAP machine. *5/28/14, new orders for labs, more frequent dressing changes to his pressure ulcers, and new positioning orders following an Infectious Disease Clinic appointment for two Stage 3 pressure ulcers and cellulitis. Please see F 314 for details. *6/6/14, an abrasion to the resident's fifth finger on his right hand. *6/11/14, the development of an SDTI to the resident's coccyx, and the facility's new plan to ask the resident to "off load" every hour while in his wheelchair. Please see F 314 for details. *6/14/14, new order for oxygen, but no orders for the CPAP to be re-initiated. Please see F 328 for details. On 9/4/14 at 8:15 AM, the DNS and Wound Nurse (WN) were asked about family notification. The WN stated the facility should have notified the resident's father or left a message with each of the above changes. The WN stated, "Sometimes it has hard to get in touch with [the family member]." On 9/4/14 at 4:30 PM, the Administrator, DNS, RNC, and RVP were informed of these findings. On 9/8/14, the facility faxed additional information to BFS, however that information did not resolve the concerns.	F 157	treatment administration including following parameters for blood glucose, blood pressure, and completing notifications MD and family as indicated for values outside of given parameters, missed doses of medications or treatments, and new orders. Nursing staff will be re-educated on notifying physician and responsible party of changes in resident condition. The Director of Nursing will educate and implement the process of new admission-order-validation on or before 10/14/14 through chart check during clinical morning meeting and reading of the 24 hour report to the clinical interdisciplinary team with record review to ensure transcription accuracy, timely responsible party and physician notifications were made, timely order implementation, and effectiveness of interventions, and potential modifications to the care plan for those residents who have had a change of condition requiring physician intervention to ensure physician and responsible party notification. Review 4: Beginning the week of 10/15/14, an audit of 5 resident records to include	

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F 157	Continued From page 5 3. Resident # 3 was admitted to the facility on 5/10/14 with diagnoses that included atrial fibrillation, Coronary Artery Disease, Diabetes Mellitus (DM), and pneumonia. The resident's Admit Nursing Assessment, dated 5/10/14, documented: -Edema: "No." -Integumentary/Feet: "Other" was documented on the diagram on the lateral aspect, upper portion of the right lower leg, and medial aspect of the left ankle area. There was no description of what "other" was. -Skin Description: "Pink." The Admission MDS, dated 5/17/14, documented the resident had intact cognition, did not reject cares, was at high risk for developing pressure ulcers, had no unhealed pressure ulcers, no venous and arterial ulcer, or other ulcers, wounds or skin problems. A Change of Condition Documentation form, dated 5/24/14 at 2:00 PM, documented: -Reason you are calling the Physician: "Skin blister, top of R [right] foot." -Assessment: Skin Concern-Location of skin concern: "[R marked over with an L for Left] foot [top]." -Nursing Progress note: "... Dressing to shin directly above last [changed] on 5/16. [Changed] dressing...." This was the first and only note in the record that documented a dressing to the shin of the left leg. There was no description of the left shin and the reason why there was a dressing on it. There was no documentation the Physician had been notified of the need for a dressing to the left shin, or	F 157	review of MARS and TARS will be completed by the Director of Nursing or designee to ensure that physician orders are clarified and that notifications to physician and resident/ responsible party are made for residents with changes in condition, include oxygen, CPAP, labs, fluid restrictions, new physician orders, or blood glucose or blood pressure or heart rate outside of physician ordered parameter, missed medications and or treatments to include parameter with physician and responsible party notifications completed as needed. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be compiled and reported to the QA/PI committee for review and remedial intervention monthly X3 months or until resolved. The Director of Nursing is responsible for monitoring and follow-up.	

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F 157	Continued From page 6 orders to treat the shin with a dressing. An ER physician's report from the hospital, dated 5/25/14, documented: *History of Present Illness: -"...presents with his children for evaluation of areas of redness, swelling and blistering to bilateral legs. The symptoms are moderate in severity." *Physical Exam: -"No focal areas of crepitus or pain. Strength 5/5 throughout. He has pretibial edema which is bilateral and pitting. He has evidence of a cellulitis that is nearly circumferential of his right lower extremity and on portions of the dorsal aspect of his left foot and anterior aspect of his left shin." On 9/3/14 at 9:40 AM, the surveyor asked the DON and Corporate Consultant for an assessment of the wound that had a dressing to the left shin, when the physician was notified and the treatment plan the physician ordered. No comments were offered or further information provided. 4. Resident #4 was admitted to the facility on 5/6/14 with multiple diagnoses to include aftercare healing traumatic fracture of the pelvis, End Stage Renal Disease (ESRD), diarrhea, and joint pain in the shoulder region, pelvic region, and thigh. On 5/30/14, the resident was transfered from the Dialysis Center to a local hospital where she was admitted with Septic shock secondary to Clostridium difficile, hypotension, and persistent diarrhea. a. The resident's Interagency/Interfacility Physician's Orders dated 5/6/14 documented the following orders: - Low Potassium diet.	F 157		

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F 157	Continued From page 7 - Less than 1.5 Liters of fluid every day. - Metoprolol XL 25 mg by mouth once daily. Do not take if systolic blood pressure is less than 110. Do not take on dialysis days. The resident's All Active facility Orders for May 2014 and MAR documented: - Metoprolol Succinate ER 12.5 mg tablet by mouth on Tuesday, Thursday, Saturday, and Sunday. Do not give if systolic blood pressure is less than 100, Heart Rate (HR) less than 55. Do not give on dialysis days. The All Active Orders for May 2014 signed by the resident's physician did not include low potassium diet or the fluid restriction of less than 1.5 Liters of fluid every day. In addition, The Interagency/Interfacility Physician's order and the All Active Order for the Metoprolol were not the same. There was no evidence the physician was notified to clarify the Metoprolol order. The May 2014 MAR documented the resident received 13 doses of Metoprolol. However, the blood pressure was documented as taken only 1 time prior to administration of the medication. The resident's heart rate was not documented as checked prior to administration of any of the 13 doses. There was no evidence the MD was notified of this. b. IPN dated 5/14/14 at 5:43 PM documented, "[Resident #4] has fever with chills note post treatment, temperature 99.1 F, and patient was incontinent of stool (diarrhea-foul smelling). MD notified and orders given for Blood Cultures x 2 and Tylenol. Orders faxed to facility and report given to [Nurse]. "	F 157		

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F 157	Continued From page 8 The MAR for 5/15/14 at 8:00 AM documented the resident received her first dose of an antibiotic, missed her second dose at 4:00 PM and received her "third" dose at 12:00 AM. The May 2014 MAR documented the resident missed 4 out of 18 doses of the antibiotic. There was no evidence the physician was notified of the missed doses. On 9/3/14 at 10:00 AM, the surveyor asked the DNS and RNC to provide information and documentation related to the above findings. The DNS stated, "I don't know." The RNC stated they would look through the resident's record for the requested information. On 9/4/14 at 1:20 PM, the RNC stated she was unable to provide information or documentation to resolve the identified concerns. Refer to F309 for additional information related to this resident's condition.	F 157		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone 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. Except as provided in paragraph (e)(3) of this	F 164	Compliance Date F164 D Residents' effected 1: Resident #1 was discharged from the center on 9/22/14.	Chg per facility request 10/30/14 RC 10/22/14 10/~~15~~ 17/14 Chg per facility request 10/14/14 RC

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F 164	Continued From page 9 section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. 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. 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents' clinical records remained confidential. This was true for 1 of 6 sampled residents (Resident #1). The deficient practice had the potential to cause loss of self-esteem when personal health information was reviewed by an assisted living facility (ALF) without authorization. Findings included: Resident #1 was admitted to the facility on 7/10/14 with diagnoses which included muscular wasting, hip fracture, type II diabetes, and neuralgia. An 8/5/14 Interdisciplinary Progress Note (IPN) documented a care conference was held and the family decided to have the resident remain at the facility to participate in physical/occupational therapy.	F 164	Other residents 2: Review of current residents' with potential discharge plans to return to assisted living facilities or community to ensure that records are maintained confidentially and were only accessed by those with documented consents was completed by Social Work on or before 10/14/14 with no further findings noted. System Change 3: Center staff were re-educated by the nurse educator on or before 10/14/14 ensuring that each resident pending discharge has written permission form the resident or responsible party consenting to the release of medical information to the discharging facility or agency. Review 4: Beginning the week of 10/15/14 an audit of 5 residents recently or pending discharge will be completed by the Administrator or designee to ensure that records are maintained confidentially and that medical information is not released without resident or responsible party consent to discharging facility. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be	

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F 164	Continued From page 10	F 164		
	The resident's 8/6/15 Care Plan (CP) with a Focus of "Family and (resident name) have expressed desire for ..... to remain a long term care resident ...."		compiled and reported to the QA/PI committee for review and remedial intervention monthly X3 months or until resolved. The Administrator is responsible for monitoring and follow-up.	
	An 8/29/14 IPN documented the facility had informed an ALF that the resident was insulin dependent due to a diagnosis of diabetes.			
	On 9/4/14 at 10:15 a.m. Social Worker #2 (SW #2) stated a decision was made at a care conference that Resident #1 would remain at the facility and move from the rehabilitation unit to the long term care side. SW #2 stated there had been no discussion with the family regarding the resident moving to an ALF, but a nurse, "just showed up" to evaluate the resident for placement at an ALF. The surveyor asked for documentation the facility that the ALF had authorization to review the resident's medical information. SW #2 stated she would review the resident's medical record for documentation. No further information was provided.		chg per facility request 10/30/14 KR 10/22/14	
	The Administrator, DON and Nurse Consultant were informed of the above concern on 9/4/14 at 4:10 p.m. The facility provided no further information.		Compliance date	10/~~15~~17/14
F 201 SS=D	483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT	F 2	F 201 D Resident effected 1: Resident #6 was interviewed and assessed on 10/01/14 by administrator and ADON with no adverse effect related to the notice of discharge. Resident #6's responsible party was notified of the withdrawal of the notice of discharge by the administrator. The resident's responsible party voiced no concerns and had no additional questions.	chg per facility request 10/14/14 KR
	The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;		Resident #6 was assessed by ADON on 10/01/14 related to noted history of wandering and intrusive behaviors.	

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F 201	Continued From page 11 The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; The safety of individuals in the facility is endangered; The health of individuals in the facility would otherwise be endangered; The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or The facility ceases to operate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to identify a clinically appropriate reason to involuntarily discharge a resident from the facility. This was true for 1 of 1 residents (#6) sampled for involuntary discharge. The deficient practice had the potential to cause psychosocial harm if the resident was unnecessarily transferred to an unfamiliar setting where it would be more difficult for his family to visit. Findings included: BFS Informational Letter 2014-02 documented, "...The decision to involuntarily discharge a resident must be the choice of last resort. The	F 201	Resident #6's care plan was updated by ADON on 10/01/14 to include interventions, and increased supervision. Other Residents 2: Review of resident with active discharge plans will be completed by social work on or before 10/14/14. There were no other discharge notices that had been provided or planned to be provided to any other residents. System Change 3: Regional Vice President to provide education on or before 10/14/14 to center administrator, Director of Nursing, Social Services Directors, and nurse management team on requirements for discharge including ensuring that any further discharge notice is in line with policy and regulatory requirements and will be reviewed by the interdisciplinary team to include assessments completed, documented resident/ family care conferences with understanding of reason for discharge unless for immediate safety concern, with documentation of attempted and failed interventions, and documented physician involvement.	

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F 201	Continued From page 12 resident's record must document the facility's efforts to resolve the situation before the decision for transfer is made..." Resident #6 was admitted to the facility on 12/6/13 with multiple diagnoses which included history of traumatic brain injury (TBI) associated dementia, and left hemiparesis. Resident #6's most recent quarterly MDS assessment, dated 7/21/14, coded: *BIMS of 3, indicating severely impaired cognitive skills; *Behaviors not directed at others, and not impacting the resident or others, 4 to 6 days out of the past 7 days; *No wandering; *Did not ambulate; and *Extensive assistance of 1 required for wheelchair mobility on and off the unit. On 8/15/14, the facility issued a written Notice of Discharge (NOD) to Resident #6. The notice documented the resident would be discharged from the facility to another long-term care facility on 9/15/14. The letter was signed by the facility's Administrator. The letter did not contain information as to why the resident was being discharged. On 9/3/14 at 9:00 AM, the Administrator was asked about the NOD for Resident #6. The Administrator stated as far as he knew, the resident was being discharged for "behaviors." The Administrator stated he believed the target behaviors for this resident were intrusive wandering, and turning off lights in other resident rooms. The Administrator stated there had also been two occasions "a few months ago, maybe	F 201	Review 4: Beginning the week of 10/15/14 a review of 5 residents with planned or recent discharges will be reviewed by the Administrator or designee for discharge notice. If a discharge notice is required the audit will ensure that policy and regulatory requirements are met. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be compiled and reported to the QA/PI committee for review and remedial intervention monthly X3 months or until resolved. The Administrator is responsible for monitoring and follow-up.	

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F 201	Continued From page 13	F 201		

four months ago," when the resident drank mouthwash. The Administrator was uncertain how frequent or persistent the identified behaviors were. The Administrator could not identify any specific event or series of events prompting the NOD, nor what the facility had done to alter the resident's behaviors. The Administrator stated the facility's social workers had been, "heavily involved" with the situation, and had advised the resident would benefit from a smaller environment, hence the notice of discharge. The Administrator stated he did not believe the resident's physician had been aware of or involved in the NOD. The Administrator stated, I talked to [BFS] last week. I know I was supposed to redo the letter. I haven't done that, because I intend to withdraw it." The Administrator stated he had attempted to notify the resident's responsible party, but that person had not returned his call. The Administrator stated he had not rescinded the notice in writing.

Resident #6's Behavior Monitoring and Interventions Sheets (BMIS) for July 2014 documented two occurrences of intrusive wandering, which occurred on day shift 7/1/14, and improved when the resident was re-directed. All other areas of the July BMIS were blank, indicating no target behaviors had occurred. The resident's BMIS for August 2014, the month the NOD was issued, documented 2 occurrences of, "irritable," once on 8/9/14 and once on 8/14/14. One of these occurrences improved when an intervention was implemented. Resident #2 was also documented to have 3 occurrences of "intrusive wandering" on day shift 8/5/14. The occurrences were all documented to have improved when the resident was engaged in an activity. No further behaviors for the resident were

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F 201	Continued From page 14 documented. On 9/3/14 at approximately 2:15 PM, the Administrator provided the survey team with documentation he had spoken with the resident's responsible party on the telephone, and had verbally withdrawn the NOD. Please refer to F 250 for additional details regarding Resident #6.	F 201		
F 202 SS=D	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility did not consult a physician, or otherwise document safety concerns, before determining a resident should be involuntarily discharged from the facility. This was true for 1 of 1 residents (#6) sampled for involuntary discharge. The deficient practice had the potential to cause harm if the resident was discharged from the facility without an evaluation by a physician as to potential physiological changes. Findings included:		Chg per facility request 10/30/14 10/22/14 Compliance Date F 202 D Resident effected 1: Resident #6 was interviewed and assessed on 10/01/14 by administrator and ADON with no adverse effect related to the notice of discharge. Resident #6's responsible party was notified of the withdrawal of the notice of discharge by the administrator. The resident's responsible party voiced no concerns and had no additional questions. Resident #6 was assessed by ADON on 10/01/14 related to noted history of wandering and intrusive behaviors.	10/~~15~~ 17/14 Chg. per facility request 10/14/14

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F 202	Continued From page 15 Please see F 201 for diagnoses and MDS details for Resident #6. On 5/12/14, a psychiatric progress note for Resident #6 documented, "...Staff report that overall the patient is doing very well. Aggressive episodes have gone down. He continues to have baseline confusion and agitation that is related to confusion and the staff are able to manage it with non-drug strategies..." The plan was for the resident to receive further psychiatric follow-up only as needed. On 6/3/14, a physician's progress note for Resident #6 documented, "...seen again today for a routine evaluation...of...TBI with associated dementia, with disinhibition and inappropriate aggression, agitation, and sexual disinhibition...being seen...from a psychiatric standpoint...these seem to have settled down reasonably well..." On 7/22/14, a physician's progress note for Resident #6 documented, "...Staff reports he has had no inappropriate interactions or behaviors..." None of these progress notes documented the resident's needs could not be met in the facility, nor that the health and safety of the resident or others was compromised. There was no documentation that the facility had notified the psychiatrist the resident was being discharged for behavioral concerns, or requested an "as needed" visit. On 8/15/14, the facility issued a Notice of Discharge (NOD) to Resident #6. Please see F 201 for additional details.	F 202	Resident #6's care plan was updated by ADON on 10/01/14 to include interventions, and increased supervision. Other Residents 2: Review of resident with active discharge plans will be completed by social work on or before 10/14/14. There were no other discharge notices that had been provided or planned to be provided to any other residents. System Change 3: Regional Vice President to provide education on or before 10/14/14 to center administrator, Director of Nursing, Social Services Directors, and nurse management team on requirements for discharge including ensuring that any further discharge notice is in line with policy and regulatory requirements and will be reviewed by the interdisciplinary team to include assessments completed, documented resident/ family care conferences with understanding of reason for discharge unless for immediate safety concern, with documentation of attempted and failed interventions, and documented physician involvement.	

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F 202	Continued From page 16 On 9/3/14 at 9:00 AM, the facility's Administrator stated the NOD had been issued due to resident behaviors, although could not be specific about the nature or persistence of the behaviors. The Administrator stated he did not believe the resident's physician was aware the facility planned to discharge the resident involuntarily. The Administrator was informed of the above statements documented by the physician and the psychiatrist in the resident's record. The Administrator offered no comment. On 9/4/14 at approximately 2:15 PM, the Administrator provided documentation the facility had verbally rescinded the NOD.		Review 4: Beginning the week of 10/15/14 a review of 5 residents with planned or recent discharges will be reviewed by the Administrator or designee for discharge notice. If a discharge notice is required the audit will ensure that policy and regulatory requirements are met. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be compiled and reported to the QA/PI committee for review and remedial intervention monthly X3 months or until resolved. The Administrator is responsible for monitoring and follow-up. Chg per facility request 10/30/14 10/22/14	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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. 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		Compliance Date F225 D Residents effected 1: Resident #2 was discharged from the center on 06/27/2014. Other Residents 2: A review of risk management reports for the last 30 days will be completed by the Director of Nursing or designee on or before 10/14/14 to ensure injuries of unknown origin 10/~~15~~/14 ~~17~~ Chg per facility request 10/14/14	

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F 225	Continued From page 17 through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure complete investigations were conducted for all injuries of unknown origin, or report those injuries. This was true for 1 of 6 residents (#2) sampled for incident investigation. The deficient practice had the potential to cause harm if a resident had experienced abuse or neglect without the facility thoroughly investigating that possibility. Findings included: Please refer to BFS Informational Letter #2014-04 for requirements regarding investigation components and reporting for any injury of unknown origin. Resident #2 was admitted to the facility from an acute care hospital on 5/13/14 with multiple diagnoses which included left lower extremity	F 225	were reported to the department of health per policy and regulatory requirement, incidents are fully investigation and include obtained witness statements from staff who cared for resident prior to noted occurrence prior to event conclusion and the ability to rule out abuse. No further findings were noted. A skin sweep will be completed by nurse managers on or before 10/14/14 for any unidentified skin issue. Any identified concerns will be reported to MD and follow up will be completed including investigation. System Change 3: Center staff will be educated by DON or designee on or before 10/14/14 related to incident investigation including the timely reporting of event, obtaining witness statements, resident statement, and completion of a thorough investigation prior to determining root cause of event or ruling out abuse. The Administrator and Director of Nursing will be educated on incident investigation by the Manager of Clinical Operations on or before 10/10/14 including event reporting guidelines, policy for event	

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F 225	Continued From page 18 cellulitis with MRSA colonization, bilateral heel decubitus ulcers, thoracic paraplegia with neurogenic bowel and bladder, and history of anoxic brain injury. Resident #2's admission MDS assessment, dated 5/20/14, coded: *Extensive assist of 2 for bed mobility, transfers, dressing, personal hygiene, and bathing; *Indwelling foley catheter present, incontinent of bowel, dependent on 2 persons for toileting; On 5/19/14 at 11:30 PM, a Change of Condition Documentation in Resident #2's Nurse's Progress Notes (PNs) documented, "Was alerted by staff on end of shift res[ident] was noted to have a scab on his penis last Thursday (5/15/14) but forgot to tell anyone. On inspection res was found to have an irregular skin tear on his scrotum 4 X 2 cm (centimeters) approx(imately) 0.5 (cm) in depth, bleeding...Attempted to steri-strip would not hold. Abrasion to [left] shaft of penis, measures 1.2 X 0.2 cm...sent to ER [emergency room] for wound care to scrotum...returned from ER [at 3:30 AM]. No sutures..." On 5/19/14 at 10:45 PM, a facility Risk Management System (I/A) documented the resident had a "self-inflicted injury" of a skin tear and an abrasion. The form documented an LPN noted an abrasion to the resident's penis four days prior, which had not been reported, as well as the area to his scrotum, which was discovered on the date the I/A was completed. The "root cause conclusion" was documented as, "The skin tear was not witnessed, but seems likely it was caused by extra tubing from the foley catheter catching the skin of the scrotum and tearing the skin. Catheter to be securely attached to leg with	F 225	investigation that includes obtaining witness statements, resident statements, and staff statements for at least 48 hours for events of unknown origin. Incident reports will be reviewed in the morning clinical meeting by the IDT beginning 10/14/14 to ensure that components of the investigation are completed including witness and staff statements, resident statement, complete investigation, and review to ensure that reporting guidelines have been met. Review 4: Beginning the week of 10/15/14, 5 resident incident reports will be audited by the Director Nursing or designee to ensure that investigations are complete, root cause is determined, and that guidelines for reporting to the department of health are followed as indicated. These audits will be completed weekly X4 weeks and monthly X2 months. The Director of Nursing will compile the results of these audits and report to the QA/PI committee for review and remedial intervention monthly X3 months or until resolved. The Director of Nursing is responsible for monitoring and follow-up.	

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F 225	Continued From page 19 no extra tubing..." The I/A did not document: *A statement from the identified LPN as to whether or not there was an abrasion present on the resident's penis four days prior, or what may have caused that injury; *Interviews with staff having contact with the resident in the 24 hours prior to the discovery of the skin tear on his scrotum, and who had contact with the resident during the period of time during which he may have had an abrasion on his penis. *Further explanation of how the injuries were determined to be "self-inflicted." Additionally, if the injuries were determined to have been self-inflicted, how the additional catheter tubing was identified as the root cause. *Whether the "securement device", documented on the resident's TAR as changed on 5/15/14, could have been a factor in causing the abrasion to the resident's penis. *How the facility concluded abuse or neglect could be ruled out as causing the resident's injuries. Niether the injuries, nor the results of the investigation, were reported to BFS. On 9/4/14 at 8:15 AM, the DNS stated the investigative report already provided to the surveyor was the entirety of the investigation the facility conducted. The DNS stated since the nurse on duty had identified the catheter as the likely cause of the resident's injuries, the facility did not feel further investigation was warranted. The DNS stated she had not known, until asked about the incident report, that an LPN stated the injury to the resident's penis may have been several days old by the time the injury to his	F 225		

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F 225	Continued From page 20 scrotum was discovered. The DNS stated the facility initiated an investigation into that possibility on 9/3/14. The DNS stated she could not tell, from the documentation how abuse or neglect had been ruled out as a factor in these injuries. On 9/4/14 at 4:30 PM, the Administrator, DNS, RVP, and RNC were notified of these findings. The facility offered no further information.	F 225	Chg per facility request 10/30/14 M Compliance Date	10/~~31~~/14
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and information received from the Ombudsman's office, it was determined the facility failed to provide medically necessary social services. This was true for 4 of 6 residents (#s 1, 2, 3 and 6) sampled for social services. Resident #s 2, 3, and 6 had the potential for harm with the lack of social services involvement in the onging development of discharge plans. Resident #1 had the potential for harm when the facility did not involve social services after the resident had expressed suicidal ideation. Findings included: 1. Resident #2 was admitted to the facility from an acute care hospital on 5/13/14 with multiple diagnoses which included left lower extremity cellulitis with MRSA colonization, bilateral heel	F	F 250 E Resident #1 discharged from Meridian Center on 09/22/2014 because he improved to ALF level of care. Resident #2 discharged from Meridian Center on 06/27/2014. Resident #3 discharged for Meridian Center on 5/25/14. 1: Resident #6 was interviewed and assessed on 10/01/14 by administrator and ADON with no adverse effect related to the notice of discharge. Resident #6's responsible party was notified of the withdrawal of the notice of discharge by the administrator. The resident's responsible party voiced no concerns and had no additional questions.	Chg per facility request 10/4/14

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F 250	Continued From page 21 decubitus ulcers, thoracic paraplegia with neurogenic bowel and bladder, and history of anoxic brain injury. Resident #2's H&P from the acute care hospital, dated 5/8/14 and documented as faxed to the facility on 5/13/14, documented: * "...in the last month, he developed sores on his heels...Neglect. Home situation probably not abusive, but they likely need more help/professional supervision/respite." Resident #2's admission MDS assessment, dated 5/20/14, coded the resident had moderately impaired cognitive skills, and required 2 persons to assist with bed mobility, transfers, dressing, bathing, personal hygiene, and toileting. On 5/23/14 at 1:38 PM, an IPN in the Social Services (SSPN) section of Resident #2's record documented a care conference was held to discuss discharge planning, however, the resident and family were not present. On 6/13/14 at 1:30 PM, a SSPN documented a second care conference to discuss discharge planning, with the resident's family member present. Three facility staff were also documented as present at the meeting. The SSPN documented no further information as to the content of the care conference. On 6/27/14 (Friday), Resident #2's record documented a Notice of Medicare Non-Coverage letter, which documented the resident's skilled nursing coverage would end on 6/29/14. On 6/27/14 at 8:30 AM, a SSPN documented, "Discharge note...[identified family	F 250	Resident #6 was assessed by ADON on 10/01/14 related to noted history of wandering and intrusive behaviors. Resident #6's care plan was updated by ADON on 10/01/14 to include interventions, and increased supervision. Resident #6's MD and responsible party were updated by ADON on 10/01/14 with no orders recived. Other residents Review of resident's medical record and discharges for the last 30 days was completed by the social services director or designee on or before 10/14/14 to identify any signs or symptoms of untreated depression or unaddressed verbalizations of wanting to die. An IDT review of current resident will be completed by the IDT on or before 10/14/14 related to any concerns related to residents with undiagnosed depression or statements of wanting to die. Review of discharges within the last 30 days will be completed by the	

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F 250	Continued From page 22 member]...called this AM and said he was picking up [the resident]. SW [social worker] explained the need for a [discharge] order from the doctor before discharging in order to avoid an [against medical advice] status. [Family member] agreed to wait. Received order for [discharge] around 4 PM. Home health agency not picked. [Family member] not sure if the [home health] was something he needed. [Discharged without] picking out agency. SW to call 6/30/14 to readdress." It was not clear how the first SSPN had been made at 8:30 in the morning, but referred to events which did not occur until 4:00 in the afternoon. There was no documentation the physician was notified the resident was discharged without home health services arranged as ordered. There was no documentation the facility had educated the resident's family member regarding the benefits of home health in terms of the resident's medical needs, or attempted to identify and overcome barriers. There was no documentation in the SSPNs that the concern for neglect in the home, as identified by the acute care hospital's H&P, had been addressed. It was not clear from the documentation why follow-up would not be conducted with the resident for 3 days after discharge to arrange home health services. On 6/27/14 at 9:00 AM, a Nurse's Interdisciplinary Progress Note (NN) documented, "Visited this [patient] to discuss stay in facility...[Patient] spoke of [discharging] soon. Social Services have been notified and are working [with resident' family member] for [discharge]..." On 6/27/14 at 2:39 PM, a physician's order for	F 250	Licensed Social Worker on or before 10/14/14 to ensure that medical records have been reviewed, needed services were identified, communication with resident, responsible party, outside agencies, and physician are complete, and services were implemented in a timely manner. Review of discharges in the last 30 days will be completed by the Director of Nursing or designee on or 10/14/14 to ensure that discharge instructions included review of medications and treatments for resident and responsible party or caregiver. The DON or designee on or before 10/14/14 will do Follow-up calls regarding discharge instructions that were noted to not be communicated at time of discharge. A review of residents with current discharge plans was completed by DON or designee on or before 10/14/14 to ensure family participation and smooth transition. Systemic change 3. Nursing staff will be re-educated by the Nurse Practice Educator or designee on or before 10/14/14 on the	

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F 250	Continued From page 23 discharge was faxed to the facility. The order documented, "May discharge home, continue same medications, call in 30 day supply. Home health needed for nursing wound care and [medication management], physical/occupational therapy evaluation and treatment, bath aide. Supplies needed - TED hose [compression stockings], legs to be elevated above level of heart most times." There was no indication on the physician's order as to why TED hose were ordered upon discharge for a resident who had Stage 3 pressure ulcers to each heel. On 6/27/14 at 5:00 PM, Resident #2's NN documented, "[Patient] given [discharge] instructions. All meds (that patient's family member allowed) called to [name of pharmacy]...patient has other meds at home. PICC line left in place. [Patient] to follow up with [name of clinic] regarding PICC and lab. Patient also given Lovenox shots X 8 and patient's father received verbal instructions on how to give SQ injections..." On 6/27/14, a, "Resident's Recapitulation of Stay Discharge Plan and Instructions" form in Resident #2's record documented: *"Reason for Discharge/Discharge Diagnosis" was documented as, "End of insurance coverage." *"...Home health nursing to be ordered for nursing wound care...Follow up needed [with primary care physician's name] ..." *No additional treatment instructions were documented on the form. A "Discharge Medication Program" form, signed by the resident's family member on 6/27/14, documented a list of medications the resident	F 250	discharge process including the completion of discharge instructions that include education and instructions to discharging resident / caregivers related to medications, discontinuance of medications and treatments that are to be continued after discharge. Social Services staff will be educated by the Divisional Corporate Consultant on or before 10/14/14 related to discharge planning process including review of the medical record upon admission, communication with resident and resident family and physician, reason for discharge, identification of needed services, and planning for and obtaining services in a timely manner prior to discharge. Center clinical staff will be educated on or before 10/14/14 by nurse educator related to identifying and communicating resident change of condition including signs and symptoms of depression including verbalizations of wanting to die. Notification of MD and resident responsible party, and communication with social services so an assessment can be completed and needed intervention can be implemented in a timely manner.	

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F 250	Continued From page 24 was receiving at the time of discharge. No treatments were documented on the form. When Resident #2's TAR for 6/27/14 (the time of discharge) was reviewed, the following items were found to be ordered for the resident in the facility, but not addressed on the discharge instructions or the discharge medication lists: *Apply emollient lotion to skin daily; *Change dressing to heels daily, with specific wound care orders documented; *Cleanse skin tear to scrotum with wound cleanser twice daily and as needed; *Float heels with pillows while in bed; *Indwelling foley catheter, with catheter care and monitoring of output daily; *Daily skin checks from the waist down; *Elevate legs above the heart for 4 hours daily, around mid-day; *Jock strap for scrotal support; *Monitoring an abrasion to the resident's second toe on his left foot; *Offloading boots to both feet at all times; *Dressing change to a suspected deep tissue injury on the resident's coccyx, daily and as needed; *Ensure the resident was offloading every hour; *Care of the resident's PICC line site daily; *Flushing the PICC line twice per day; and *Oxygen use at 3 liters per minute to maintain oxygen saturations above 90 percent. *Additionally, TED hose had not been ordered or used for the resident during his stay in the facility. On 6/30/14 at 8:00 AM, three days after the resident discharged from the facility, a SSPN documented, "[Phone call] with [Resident #2's father]. Chose [name of home health agency]. SW to fax request today for [home health]	F 250	4. Beginning the week of 10/15/14 an audit of 5 residents who have planned/ or recent discharges will be completed by the Director of Nursing or designee to ensure that discharge instructions are complete and include documentation of medications and treatments that are to be continued at time of resident discharge. An audit of 5 residents will be reviewed by the Director of Nursing or designee to ensure that discharge services are implemented arranged for prior to resident discharge and that medical records have been reviewed to ensure that barriers to resident safe discharge have been assessed, and services are implemented prior to discharge. 5 resident records will be reviewed by the Director of Nursing or designee to ensure that residents with signs or symptoms of depression are identified including statements of wanting to be dead and treatments and interventions are implemented timely	

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F 250	Continued From page 25 services." On 7/3/14, 6 days after the resident discharged from the facility, a SSPN in Resident #2's medical record documented, "Please refer to attached email for remainder of discharge note." There was a copy of an intra-facility email attached, signed by LSW #1. The email originated from the facility's Administrator on 7/3/14, stated the "wound clinic" had left a message on the Administrator's phone to clarify whether or not home health care had been set up for the resident. The email message from the Administrator documented, "The wound clinic...are concerned with the elderly [family member] watching him..." LSW #1's emailed response documented: *The first agency of choice for the resident was faxed information on 6/30/14, three days after the resident discharged from the facility. There was no documentation the agency was contacted to ensure the referral could be accepted, only that information was faxed. *That agency notified LSW #1 on 7/1/14, four days after discharge, that they would be unable to accept the resident's case. *LSW #1's email documented she made contact with a second agency on 7/1/14, but was informed they would also be unable to accept the case. *On 7/2/14, five days after discharge, a third home health agency was contacted and agreed to take the case. It was unclear, from the email or SSPN, when the home health agency was able to initiate services for the discharged resident, or what condition the resident was in by the time home health services were initiated.	F 250		

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F 250	Continued From page 26 On 9/3/14 at 1:30 PM, LSW #1 was asked about the discharge plan for Resident #2. LSW #1 stated: *Resident #2 discharged to the same living situation in the community as prior to his hospitalization, with his [family member] as his caregiver. *She had not seen the documentation in the resident's H&P regarding the concern for neglect and the need for additional services in the home. Therefore, these issues were not addressed by the facility as either a part of the resident's stay or a part of the discharge. *No additional support was offered to the resident or his family as part of the discharge plan. *The facility had not followed up with the resident to ensure home health services were initiated by the agency contacted, or to check on the resident's well-being in a potentiall negligent situation. *The facility had made no addditional community contacts in light of the wound clinic expressing concern with the safety of the home environment. *When home health was ordered as part of a resident's discharge, she usually tried to set it up before the resident went home. However, LSW #1 stated, "It may take a day, or a few days, depending on how busy I am, and whether or not the person has told me which agency they would like to use." *LSW #1 was unable to state whether or not the facility had addressed the possibility of home health services upon discharge at the care conference documented in the SSPN on 6/13/14. LSW #1 stated she was unable to tell, from the documentation, what was discussed. *LSW #1 stated she had tried to call Resident #2's family member "a couple of times" during the resident's stay, but left messages because the	F 250		

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F 250	Continued From page 27 resident's father did not answer the phone. The LSW stated she did not document this when it occurred. The LSW could not state how many times she attempted to contact the resident's family member, nor when those attempts were made. *LSW #1 did not know why Resident #2 discharged from the facility when he did. LSW #1 stated, "One day his family member just came in and said he was taking him (the resident) home today. So I faxed the doctor with a request for orders, and we got them and he went home. That's all I know." When asked about the statement on the resident's Recapitulation of Stay form that the resident discharged due to the end of his Medicare coverage, LSW #1 stated, "That could be. I don't know." When asked if she would generally be aware when the end of coverage was pending for a resident, so as to finalize the details of the discharge plan, LSW #1 did not reply. *LSW #1 stated she started working on Resident #2's discharge as soon as the resident's family member requested it, but had not worked on it prior to that day. LSW #1 stated, "He told me he didn't think they needed home health, and didn't name an agency, so I didn't set it up." LSW #1 stated she had not attempted to identify what the barriers were to the family accepting home health services for the resident, or what she had done to overcome those barriers. LSW #1 stated, "They do have the right to refuse, so I just let it go at that." LSW #1 stated she did not believe the resident's physician had been notified the resident was discharging without follow-up services in place. *LSW #1 stated she did not know who, when, or how the resident's PICC line, wounds, or Lovenox injections were to be managed after the resident	F 250		

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F 250	Continued From page 28 discharged. LSW #1 did not know who in the home would be available to help with ADLs for the resident, other than his elderly father. On 9/3/14 at 2:30 PM, the RNC and RVP were informed of the concern with Resident #2's discharge plan. On 9/8/14 the facility faxed BFS additional information regarding Resident #2. However, the information did not resolve the concerns. 2. Resident #6 was admitted to the facility on 12/6/13 with multiple diagnoses which included history of traumatic brain injury (TBI) associated dementia, and left hemiparesis. Resident #6's most recent quarterly MDS assessment, dated 7/21/14, coded: *BIMS of 3, indicating severely impaired cognitive skills; *Behaviors not directed at others, and not impacting the resident or others, 4 to 6 days out of the past 7 days; *No wandering; *Did not ambulate; and *Extensive assistance of 1 required for wheelchair mobility on and off the unit. On 8/15/14, the facility issued a Notice of Discharge (NOD) to Resident #6, indicating the resident was to be transferred to a facility in another town on 9/15/14. Please refer to BFS Informational Letter #2014-02 for specific requirements when this notice has been issued to a resident. On 9/3/14 at 9:00 AM, the surveyors met with the Administrator to ask about the Discharge Notice for Resident #6. The Administrator stated, "Social	F 250		

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F 250	Continued From page 29 Services has been heavily involved. You will have to ask them." Resident #6's SSPNs documented dated 2/26/14, 3/7/14, 4/11/14, 4/14/14, 4/23/14, and 6/20/14 documented the facility was encouraging and assisting the resident's sister to find a smaller facility for the resident, which they felt would be able to provide "increased supervision." It was not clear from the SSPNs why these components would be beneficial to the resident. No behavioral concerns were documented. By the SSPN on 6/20/14, the resident's sister had determined she felt the resident was doing well in his current setting, and if the facility wished to continue to pursue discharge for the resident. it would be on an involuntary basis. There was no further documentation in the SSPNs, either leading up to the NOD on 8/15/14, nor following the NOD by the time the survey was conducted on 9/4/14. Target behaviors were documented to have occurred rarely during the months of July and August 2014. Please see F 201 for details. Neither the physician's or psychiatrist's progress notes documented the resident's behaviors could not be managed in the facility. Please see F 202 for details. On 9/3/14 at 1:30 PM, LSW #1 was interviewed regarding Resident #6. LSW #1 stated she had taken over management of Resident #6's case "about a month, maybe two months ago." LSW #1 stated she did not know much about the resident, other than, "It has been requested that he be discharged according to behaviors." LSW #1 stated she was not familiar with the specifics of the resident's behaviors, as she had only been following him a short time. LSW #1 stated the	F 250		

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F 250	Continued From page 30 request for the resident to discharge had only been made verbally, and had never been issued in writing to the resident. LSW #1 stated LSW #2 would have more information. On 9/3/14 at 1:55 PM, LSW #2 was asked about Resident #6. LSW #2 stated Resident #6 had a history of wandering intrusively, but did not know how persistent or problematic the behavior had been recently. LSW #2 stated she had worked on discharging the resident for a number of months at the request of the nursing staff, but had turned the case over to LSW #1 in "late April or early May, long before the discharge notice was issued." LSW #1 stated the resident's representative did not feel the discharge was necessary, and wanted the resident to remain in the facility. LSW #1 stated, "I talked to his sister and she just didn't see the need (for the move). She wanted to keep him close. I had multiple conversations with her trying to convince her." On 9/4/14 at 11:25 AM, Resident #6 was observed sitting in a high-back wheelchair by the nurse's station, near the entrance to the 200 hall. His left lower leg was in a brace, and placed on a slightly elevated footrest. His left arm was propped on an armrest. He was slowly moving his wheelchair back and forth in a rocking motion, using his right foot. A housekeeper with a laundry cart approached the resident and asked him to back up slightly, so she could pass him with the cart. The resident sat for 10 seconds in his wheelchair before responding to the request, then moved his wheelchair backwards approximately 5 feet and stopped. It took the resident 20 seconds to complete this task. He made no further attempts to move his wheelchair at that time.	F 250		

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F 250	Continued From page 31 Neither LSW #1 nor LSW #2 could explain what, specifically, had prompted the facility to issue a written NOD. There was no documentation of social services involvement leading up to the NOD being issued, nor afterwards. There was no documentation the facility administration had been informed of the decision of Resident #6's family for him to remain in the facility. On 9/4/14 at 4:30 PM, the Administrator, DNS, RVP, and RNC were informed of the findings. The facility offered no further information. 3. Resident #3 was admitted to the facility on 5/10/14 with diagnoses that included atrial fibrillation, Coronary Artery Disease, Diabetes Mellitus (DM), and pneumonia. The resident's Admission MDS dated 5/17/14 documented intact cognition. The resident's Admission Physician orders, dated 5/10/14, documented to "plan for discharge." The resident's PT [Physical Therapy] evaluation, dated 5/12/14, documented the resident's goals were to "get stronger and go home." A PT progress note which was not dated, documented the resident was able to show good progress with mobility while on PT services and made progress toward the resident's long term goals. The PT documented it was felt that the patient was not ready for discharge; however, the patient chose to discharge despite education, and returned to the facility as the family did not feel the resident was appropriate for discharge. An IPN care conference note, completed by the LSW on 5/16/14, documented no family was	F 250		

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F 250	Continued From page 32 present, the resident was an active man and was looking forward to going back to his own home. A Physician's Discharge Summary report, dated 5/19/14, documented the projected date of discharge was 5/21/14. The patient had improved and would not be going home with Home Health as the patient "knows that he will be successful at home." An IDT LN note, dated 5/21/14 at 11:00 AM, documented the resident had been discharged to home this day and time, and the resident was assisted to the vehicle in good spirits. NOTE: A line had been crossed through it and "error" written on it. An IDT LN note, dated 5/21/14 at 9:30 PM, documented the resident's vital signs and the resident had been moved to a different room. An IDT Nurse note, dated 5/25/14 at 2:45 PM, documented the resident had been taken to the hospital by a family member. An IDT note written by the LSW on 5/25/14 documented: -"Discharge note- [Resident's name] had initially planned to discharge to his own home. When [Resident's name] got home he had his family bring him back to the rehabilitation side of [facility name]. Where the discharge plan changed to [resident's name] going in to Assisted Living...." On 9/3/14 at 10:35 AM, the surveyor asked LSW #1 if she had been involved in the discharge plan of the resident, to facilitate a successful transition to home which included the continuation of PT. LSW #1 stated the resident sounded familiar but	F 250		

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F 250	Continued From page 33 she was not sure, she would look to see what she could find. The documentation was not provided to the surveyor. On 9/4/14 at 11:35 AM, the surveyor followed up with LSW #1, and asked if she had any documentation that showed she had provided a discharge plan for the resident. The LSW stated she had not written any information down, she had her own notes which were "chicken scratch." The resident had gone home on the 5/21 and had returned to the facility the same day. The surveyor asked LSW #1 if she had met with the resident when he returned to the facility and she replied she would have to check the file.	F 250		
	On 9/4/14 at 4:30 PM, the Administrator, DON, and Corporate Consultant were notified of the findings. On 9/8/14 the surveyor received a fax from the facility which did not resolve the concerns. 4. Resident #1 was admitted to the facility on 7/10/14 with diagnoses which included muscular wasting, hip fracture, type II diabetes, and neuralgia. The resident's 9/2014 recapitulation Physician Orders included an order for Escitalopram Oxalate (antidepressant) 10 mg daily with a start date of 8/26/14. An 8/21/14 Daily Therapy Note documented the therapist had informed the unit manager the resident stated he, "just wants to go to the grave." An 8/26/14 Nursing Home Visit from the physician documented the resident stated he did not want to be at the facility and "is wondering if there is			

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F 250	Continued From page 34 anyone around [who] would be willing to euthanize him." Social Services assessed the resident on 8/27/14 as having minimal depression; however, a suicide assessment had not been done nor was there any documented evidence Social Services had addressed these verbalizations. The resident's 8/26/14 Care Plan documented behaviors of sadness/depression as exhibited by isolation and tearfulness "related to current health status" however, it did not identify the resident's verbalizations of wanting to die. Identified Care Plan interventions included: Administer medication, encourage family involvement and encourage verbalization of feelings. All interventions were dated 8/26/14. There were no interventions for suicidal statements. The record included two undated Behavior Monitoring and Intervention forms (BMIs), one for tearfulness and another for statements of wanting to die and/or self-isolation, which were handwritten on the forms as behavior symptoms. The BMIs did not document any behaviors. On 9/4/14 at 8:45 a.m. Physical Therapist #9 stated the resident initially refused to participate in therapy as the resident was depressed and saw no reason to get out of bed. On 9/4/14 at 10:45 a.m., Social Worker #2 (SW#2) was asked if the resident's behavior for depression had been monitored prior to the antidepressant being administered. SW#2 stated the resident had been assessed on 8/27/14 as having minimal depression [indicating depression	F 250		

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F 250	Continued From page 35 was not present]. SW#2 stated she had not been informed of the resident stating he wanted to be euthanized on 8/26/14, but she would have asked additional questions regarding suicide if she had been aware. SW#2 stated she was not told at any time the resident had made statements of wanting to die. She stated nursing was responsible for the BMIs and they must have been initiated 9/2014 as none were found for 8/2014 documenting the suicidal statements on 8/21/14 or 8/26/14. SW#2 stated the resident should have been assessed for the suicidal statements and the care plan should have included interventions for statements of wanting to die.	F 250		chg per facility request 10/30/14 10/22/14
F 252 SS=E	Refer to F329 for additional details. 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the floors were clean in resident common areas and living spaces. This was true for 4 of 6 hallways in the facility (hall #'s 100, 300, 400 & 500), as well as resident rooms #306 and #312. The deficient practice had the potential for psychosocial harm if residents became embarrassed or depressed from living in a dirty environment. Findings	F	Compliance date: 10/~~15~~/14 17 F252 E 1: Residents in room 306 and room 312 were assessed by the licensed Social Worker on 09/30/14 to ensure that had no negative psychosocial effect related to unclean floors. No negative adverse effects were identified. Residents on the 100, 300, 400, and 500 units will be assessed by the licensed social worker or designee on or before 10/14/14 related to any adverse effects related to an unclean environment. Findings will be identified as indicated.	chg per facility request 10/14/14

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F 252	Continued From page 36 included: 1. On 9/2/14 between 9:20 and 9:45 AM, the following observations were made in the hallways/resident rooms: *Between the dining room and the entrance to the 500 hall, there were multiple black grainy splotches on the floor, each approximately the size of a quarter. *The floor outside the laundry room had black, worn wheel-type tracks, extending approximately 15 feet. A similar pattern, lighter in color, extended for approximately 20 feet beyond, between the laundry room and the kitchen. *Stains on the carpet in the hallway outside resident room #s 503, 509, 512, 514, 515, and 513, as well as the MDS office. *The carpet in front of the 500 hall nurse's station was worn. *Bleach spots on the carpet outside resident room #s 502, 504, 505, and 518, and by the doorway leading to the long-term care dining room. *A yellowed stain, approximately 2 feet by 10 inches long, along the baseboard by the entrance to the dining room nearest the long-term care nurse's station. *Black with gray dirt build-up around the toilet area covering approximately 1 foot x 2 feet in size was noted on the floor in the bathroom of resident room #306. *Resident room #312 was observed to have black and gray dirt build-up near the bed by the window. In front of the toilet in the bathroom were 3 strips with build-up of black and gray dirt around all three strips and the toilet.	F 252	The area between the entrance to the 500 hall with black grainy splotches were cleaned by Housekeeping Services on 09/29/14. The floor between the laundry room and the kitchen was cleaned by Housekeeping Services on 09/30/14. The carpet on the 500 unit will be replaced with new flooring by a contracted service provider the purchase order will be obtained on or before 10/15/14 and the project will be immediately scheduled The replaced carpets will address the noted bleach spots outside of rooms 502,504,505, and 518, the stains on the carpet outside of the MDS office, and the worn carpet on the 500 hall. The 500 hall carpet will be deep cleaned by housekeeping weekly and the administrator will review the plan for carpet replacement at resident council on or before 10/14/15. The yellow stain along the baseboard by the entrance to the dining room nearest to the long term care nurses station was cleaned by Housekeeping Services on 09/26/14,	

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F 252	Continued From page 37 *The floor in the 300 hall was dingy gray. The day room at the end of the hall had cobwebs in 2 of the corners with black specks in them. The room had areas of cracked tiles and black streaks with food stains. There were cracked tiles between resident rooms #309 and #311 and there was a build-up of black dirt where the baseboard met the flooring in that same area. On 9/3/14 at 4:45 PM, the Administrator, DNS, RVP, and RNC were informed of these findings. The RVP stated, "Did you see that yesterday? Because we saw that, too, and took care of it." The facility offered no further information. 2. On 9/2/14 at 2:35 PM, the following was observed in the 400 hall: *To the right of Resident room #409's door, in the hallway, was a brown liquid stain on the wall that had dripped onto the floor. *Areas of the hall where the baseboard met the flooring had various degrees of black and orange debris. There was a cobweb in 1 corner with 5 black specks in it. 3. On 9/2/14 at 3:00 PM, the following was observed on the 100 hall: *A staff member with a floor buffer finished buffing the floor and left the area. Areas of the hall where the baseboard met the flooring had various degrees of black, orange and brown debris. On 9/3/14 at 10:15 the 300 and 400 halls were observed to be the same as they were on 9/2/14.	F 252	The black gray dirt build-up around the toilet area of room #306 was re-waxed by Housekeeping Services on 09/22/14. Resident room #302 was cleaned by Housekeeping Services on 09/22/14. The floor of the 300 hall was cleaned on 09/22/14 by Housekeeping Services. The cracked tiles between resident room #309 and room #311 was repaired by Maintenance on 09/26/14. The resident room #409 and the door were cleaned by Housekeeping Services on 09/22/14. The 400 unit hallway and baseboard were cleaned by Housekeeping Services on 09/22/14. The 100 hall floor and baseboard were cleaned by Housekeeping Services on 09/26/14. Other Residents 2: A center environmental round for resident rooms and resident common areas and living spaces was completed by the Administrator, housekeeping supervisor and director of maintenance on 09/15/14 to identify	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING			

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F 309	Continued From page 38 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to follow physician orders or provide care and services in accordance with accepted standards of practice. This was true for 3 of 6 sampled residents (#s 2, 3, and 4), and resulted in harm to: *Resident #2, whose scrotum and penis were injured; *Resident #4, who required hosptialization for septic shock; and *Resident #3, who required hospitalization for weeping wounds and cellulitis. Findings included: 1. Resident #2 was admitted to the facility from an acute care hospital on 5/13/14 with multiple diagnoses which included left lower extremity cellulitis with MRSA colonization, bilateral heel decubitus ulcers, thoracic paraplegia with neurogenic bowel and bladder, and history of anoxic brain injury. Resident #2's admission MDS assessment, dated 5/20/14, coded: *Extensive assist of 2 for bed mobility, transfers, dressing, personal hygiene, and bathing;	F 309	any needed deep cleaning, or environmental modifications, repairs or cleaning that would need to be completed. Areas identified were cleaned/ repaired by the Director of maintenance or the housekeeping supervisors on or before 10/14/14. System Change: 3: The housekeeping, maintenance staff will be educated by the Administrator on or before 10/14/14 on the cleaning of resident rooms and public areas of the facility and the process for communicating and cleaning/ repairing stains that are not easily cleaned. Center staff will be educated by the Administrator on or before 10/14/14 on the reporting needed repairs to the maintenance log. Review 4: Beginning the week of 10/15/14 the Administrator or Designee will complete an environmental round of resident rooms and common areas to identify areas in the center that are in need of cleaning or repair. These audits will be completed weekly X4 weeks and then monthly X 2 months.	

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F 309	Continued From page 39 *Indwelling foley catheter present, incontinent of bowel, dependent on 2 persons for toileting; *Two Stage III pressure ulcers present, with treatments and medications ordered; *Had received injectable medications and anticoagulants each of the previous 7 days; and *Receiced IV medications while a resident. a. Scrotum and Penis Injuries. Resident #2's May 2014 Recapitulation orders, care plan, and TAR documented the resident had an indwelling catheter, that was to receive "catheter care" each shift, beginning the date of admission. However, the resident's May 2014 TAR documented this care was not completed on night shift on 5/13/14, 5/20/14, or 5/22/14. Resident #2's MAR for May 2014 documented the "catheter securement device" that was ordered be changed weekly and as needed, beginning 5/13/14, documented the device was changed on 5/15/14, but at no other time for the remainder of the month. A 5/19/14 Change of Condition Documentation in Resident #2's Nurse's Progress Notes (PNs) documented, "Was alerted by staff on end of shift res[ident] was noted to have a scab on his penis last Thursday (5/15/14) but forgot to tell anyone. On inspection res was found to have an irregular skin tear on his scrotum 4 X 2 cm (centimeters) approx(imately) 0.5 (cm) in depth, bleeding...Attempted to steri-strip would not hold. Abrasion to [left] shaft of penis, measures 1.2 X 0.2 cm...sent to ER [emergency room] for wound care to scrotum...returned from ER [at 3:30 AM]. No sutures..."	F 309	The results of these audits will be compiled by the Administrator and reported to the QA/PI committee for review monthly X3 months or until resolved. The Administrator is responsible for monitoring and follow-up. Compliance Date: 10/~~15~~ 17 14 chg per facility request 10/14/14 F309 G Residents Effected 1: Resident #2 discharged from the center on 06/27/2014. Resident #3 was discharged from the center on 05/25/2014. 10/22/14 Resident #4 was discharged from the center on 05/30/2014. chg per facility request 10/30 NC Other Residents 2: A review of risk management reports completed over the last 30 days will be completed by the Director of Nursing or designee on or before 10/14/14 to ensure that injuries of unknown origin are reported to the	

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F 309	Continued From page 40 On 5/19/14 at 10:45 PM, a facility Risk Management System (I/A) documented the resident had a "self-inflicted injury" of a skin tear and an abrasion. The form documented an LPN noted an abrasion to the resident's penis four days prior, which had not been reported, as well as the "torn" area to his scrotum, noted in the above entry on 5/19/14. The "root cause conclusion" was documented as, "The skin tear was not witnessed, but seems likely it was caused by extra tubing from the foley catheter catching the skin of the scrotum and tearing the skin. Catheter to be securely attached to leg with no extra tubing..." Missing from the I/A report was any investigation regarding the allegation the abrasion to the resident's penis had been noted four days prior, how the injuries were determined to be self-inflicted, and how the conclusion of the catheter causing the areas had been determined. Please see F 225 regarding the missing elements of the facility's investigation. On 5/19/14, a facility Skin Integrity Report for Resident #2 documented a wound to the resident's scrotum which was incontinence related. This wound was tracked weekly until the time of the resident's discharge, and was documented to decrease in size each week. On 5/20/14, a physician's order for Resident #2 documented the facility was to clean the wound to the left side of the resident's penis each shift (day, night, and evening). An additional order documented the facility was to monitor the abrasion to the resident's penis and skin tear to his scrotum on day shift and evening shift daily. This was not documented as completed on the evening of 5/31/14.	F 309	Department of Health per policy and regulatory requirement, incidents are fully investigated and include obtained witness statements, and staff who cared for the resident prior to noted occurrence are interviewed prior to the conclusion and ability to rule out abuse. A skin sweep will be completed on or before 10/14/14 by DON or designee for any previously unidentified skin impairment results of the skin sweep and follow up physician notification with care plan updates will be completed. A review of residents who require dialysis will be completed by DON or designee on 10/14/14 to ensure that pertinent information related to resident health status is identified and communicated with the dialysis clinic and the attending MD.	

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F 309	Continued From page 41 On 5/22/14, the physician ordered the facility's wound nurse to assess and treat the wound to the resident's scrotum. On 5/23/14, a physician's order documented a change in the dressing to the resident's scrotum. The order now directed the nurse to cleanse the wound with wound cleanser, apply triple antibiotic ointment, and cover with Telfa. This dressing change was not documented as completed on night shift for 5/26/14, 5/27/14, 6/1/14, 6/7/14-6/9/14, 6/19/14, 6/20/14, 6/22/14, 6/25/14, or 6/26/14. The dressing change was not documented as completed on day shift for 6/13/14, 6/14/14, or 6/26/14. Although the resident discharged from the facility on 6/27/14, several treatments, including the dressing change to the resident's scrotum, catheter care, and flushing the resident's PICC line, were all documented as completed on the night shift 6/28/14, more than 24 hours after the resident discharged from the facility. On 9/3/14 at 2:30 PM, the RNC and RVP were asked about the missing documentation on the resident's TARs. After reviewing the documentation, the RNC stated, "There's nothing I can say. It's not there." On 9/4/14 at 8:15 AM, the DNS and Wound Nurse (WN) stated the WN was asked to assess the area after the resident was found with a skin tear. Regarding the area on the resident's scrotum, the WN stated she felt the joint between the catheter tubing and drain bag tubing had become lodged under the resident's scrotum, and when it was removed the skin in that area was torn. The WN stated the tear was not "that bad,"	F 309	Residents who are currently receiving wound care will be reviewed by DON or designee on or before 10/14/14 to ensure that treatments are being implemented per physician order and that they were implemented in a timely manner. MD and resident responsible party will be updated of any omissions and follow-up will be completed by the nurse manager as ordered. Review of resident with Catheters will be completed on or before 10/14/15 to ensure that catheter securing devices are in place and follow up as indicated. Residents on a fluid restriction will be reviewed by DON or designee on 10/14/14 to ensure that fluid intakes are monitored and documented in CC's as ordered and that fluid intake is totaled every 24 hours and that resident totals do not exceed 24 hour fluid restriction. Follow up with physician and resident/ responsible party will be completed as indicated by review. A review of residents' weights will be completed by DON or designee on or before 10/14/14 to ensure that resident weights are completed on admission and per MD order. Addressing 5 lbs. weight gains or losses. Follow-up	

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F 309	Continued From page 42 but because of the delicacy and moisture in the area, the nurse was unable to approximate the wound so the resident was sent to the ER. Although the nurse originally thought the resident might receive stitches, the resident returned to the facility with only a dressing in place. Regarding the area to the resident's penis, the DNS stated she had not been aware until the previous day (9/3/14) that there had been a statement indicating the area may have been present but untreated for several days. The DNS stated, "I just asked [the RN on duty when the injury was discovered] about that last night, and we're investigating it now." The DNS could not explain why treatments had been documented as completed more than 24 hours after the resident discharged. On 9/4/14 at 4:30 PM, the Administrator, DNS, RNC, and RVP were informed of the concerns. The facility offered no further information. b. Other Orders Not Followed. Resident # 2's MAR for May 2014 documented the following medications were not administered as ordered by the physician: *Mupiroxin topical ointment, ordered to the nostrils for MRSA, afternoon dose on 5/28/14. *Ceftriaxone Sodium IV ordered daily for cellulitis, 5/18/14 or 5/29/14. *House dietary supplement, ordered twice daily at 3:00 PM and 8:00 PM beginning 5/16/14. 3:00 PM dose 5/17/14 or 5/19/14. 8:00 PM dose 5/17/14, 5/18/14, 5/24/14, or 5/26/14. Resident #2's TAR for May 2014 documented the following treatments not administered as ordered: *Monitor abrasion to the bottom of the right foot,	F 309	weights and MD and resident / responsible party notifications will be completed as indicated by review. A review of residents on pain medication will be completed by DON or designee on or before 10/14/14 to ensure that pain medication is administered as ordered. A pain assessment will be completed by DON or designee on or before 10/14/14 for residents who require pain medication to ensure that current pain regimen is effective and that residents are not experiencing adverse effects such as sedation. Follow up with physician and resident/ responsible party will be completed with the findings addressed. A review of resident physician orders will be completed by the DON or designee on or before 10/14/14 to ensure that medications that require parameters have physician ordered parameters in place, and are followed as ordered and clarifications obtained as required. Follow-up with the MD will be completed by a licensed nurse on or before 10/14/14 for any identified issues.	

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F 309	Continued From page 43 night shift for 5/22/14. *PICC line flushed night shift 5/22/14. *PICC site observed before and after IV medications administered on the day shift for 5/14/14, or the night shift on 5/20/14 or 5/22/14. *Catheter site dressing changed weekly, the date of admission on 5/13/14, through 5/31/14. *Abrasion to knee and blister to top of right foot not monitored on the night shift of 5/22/14. *Emollient lotion the morning of 5/28/14. *Output from the foley catheter documented twice daily day shift 5/16/14 - 5/18/14, 5/20/14, 5/23/14, 5/24/14, or 5/29/14. Night shift on 5/22/14, 5/24/14 - 5/26/14, 5/29/14, or 5/30/14. *Daily shin check from the waist down 5/29/14.	F 309	A review of residents who have admitted in the last 90 days will be completed by medical records manager or designee on 10/14/14 to ensure that provider visits are completed per regulation, and that resident's and their responsible parties have their questions for the provider answered in a timely manner. Follow-up communication with the resident's provider will be completed as indicated.	
	Resident #2's TAR for June 2014 failed to document the following treatments as administered: *Emollient lotion, 6/16/14, 6/24/14, 6/26/14. *Foley output day shift of 6/1/14, 6/2/14, 6/6/14, 6/10/14, 6/16/14, 6/22/14, 6/24/14, or 6/26/14. Night shift on 6/1/14, 6/8/14, 6/9/14, 6/14/14 - 6/16/14, or 6/21/14 - 6/23/14. *House supplement at 8:00 PM on 6/4/14 - 6/8/14, 6/11/14 or 6/12/14. *PICC line flush on the day shift 6/13/14 - 6/16/14, 6/23/14, or 6/25/14 - 6/27/14. Night shift 6/5/14 - 6/9/14, 6/14/14, 6/16/14, 6/19/14, or 6/22/14. *Observation of the PICC site before and after the administration of IV medications for day shift 6/13/14 and 6/14/14. Night shift 6/1/14, 6/6/14 - 6/10/14, 6/12/14, 6/14/14, 6/16/14, 6/22/14, 6/24/14, or 6/26/14. *Oxygen administration for day shift 6/15/14 - 6/17/14, or 6/26/14. Night shift 6/14/14 - 6/17/14, 6/22/14, 6/24/14 or 6/26/14.		A review of resident's progress notes for last 30 days will be completed by the director of nursing or designee on or before 10/14/14 for any unidentified changes of condition. System Change 3. licensed nurses will be re-educated by nurse educator on or before 10/14/14 related to identifying and communicating changes of condition including wound, following physicians orders for medication administration and treatment administration including following parameters, and obtaining order clarifications as needed and implementing orders for medications	

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F 309	Continued From page 44 According to the Idaho Administrative Code for Skilled Nursing Facilities (IDAPA), medications and treatments must be documented in the resident's medical record by the person administering them at the time they are given, in order to be considered as given or completed. On 9/4/14 at 8:15 AM, the DNS was asked about the missing documentation for the above medications and treatments. The DNS stated she was confident all medications and treatments had been administered as ordered, but had simply not been documented. The DNS stated, "We are planning to look at documentation as part of our Quality Improvement plan." On 9/4/14 at 4:30 PM, the Administrator, DNS, RNC, and RVP were informed of the findings. The facility offered no further information. 2. Resident #4 was admitted to the facility on 5/6/14 with multiple diagnoses, including aftercare healing traumatic fracture of the pelvis, End Stage Renal Disease (ESRD), and diarrhea, and joint pain in the shoulder region, pelvic region, and thigh. On 5/30/14, the resident was transferred from the Dialysis Center to a local hospital where she was admitted with septic shock secondary to Clostridium Difficile, hypotension, and persistent diarrhea. * The resident's Admission MDS, dated 5/13/14, coded the following: - Extensive assistance of two people for bed mobility, transfers, and toileting. * The resident's Hydration care plan dated 5/8/14, Bowel Elimination/Diarrhea care plan dated	F 309	and treatments timely ensuring documentation of administration. Education will include to ensure that catheter securing devices are in place, the weight monitoring system, dialysis communication, pain assessment including assessment for side effects of medication including sedation, and expectations related to MD visits and provider communication, and completing event/ incident investigations timely and completely. Also on addressing returning calls to ER and dialysis and answering phone, labs as ordered with documentation reason behind delay if applicable, need to assess with findings and then notify the MD. A care conference for resident's who require dialysis treatment will be scheduled by Social Service on or before 10/14/14 to include the center IDT, patient and or responsible party, to communicate current health status, plan of care, and goals. The resident's MD and dialysis physician will be updated by the nurse manager on or before 10/14/14. Monitoring 4. Beginning the week of 10/15/14 an audit of 5 residents will be completed by the Director of Nursing or designee	

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F 309	Continued From page 45 5/15/14, and Dialysis care plan dated 5/16/14 documented the following interventions: - Limit fluids to 1500 ml/day. Dietary to provide 1080 mls. Nursing to provide approximately 420 ml. Nursing to monitor and document all fluids consumed from all sources. - Encourage fluids. - Observe resident for signs of dehydration (tenting skin, dry mouth etc.) - Evaluate for medications that cause diarrhea. - Weekly weights x 4 weeks - started 5/12/14. - Daily weights started on 5/15/14 (Daily weights were d/c'd on 5/21/14.) - Notify MD of weight gain of 3 or more pounds since last weight. The resident's Weights and Vitals Summary documented the following three weights: - 5/14/14 at 2:34 PM, 129.6. - 5/25/14 at 2:06 PM, 124.6. - 5/28/14 at 2:34 PM, 121.8. The resident's discharge weight from the hospital on 5/6/14 was 116.6 pounds. The first weight taken by the facility for Resident #4 was on 5/14/14 and the resident weighed 129.6 pounds. There was no documentation in the resident's record to indicate the physician had been notified of the resident's weight gain of more than three pounds. Addtionally, there were no daily weights documented for 6 days, from 5/16/14 to 5/21/14. The resident's labs, Facility Faxes (FF), Interdisciplinary Progress Notes (IPN), Nutrition Note (NN), Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (SP), Physician Notes (PN), ADL Record, Dialysis Notes (DN), Hospital History and Physical (HH&P), Hospital discharge summary (HDS), Dialysis Communication Record (DCR), Dialysis Patients	F 309	to ensure changes of condition are noted with adequate follow up, physicians orders are followed and implemented in a timely manner including clarification of orders and parameters for medications as indicated, weights are completed on admission and per order. 3 residents who require dialysis will be reviewed by the Director of Nursing or designee to ensure that resident health status is communicated with the dialysis providers. A review of 5 residents with pain medication will be reviewed by the Director of Nursing or designee to ensure that pain is controlled with current regimen without adverse effect such as sedation. Additional audits for catheter securing device placement, wound audits, completing labs timely and as ordered and care plan update audits. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be compiled by the Director of Nursing and will be reported to the QA/PI committee for review and remedial intervention monthly X3 months or until resolved. The Director of Nursing is responsible for monitoring and follow-up.	

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F 309	Continued From page 46 Notes (DPN), and Emergency Room Report (ER) were reviewed and documented the following: The resident's Interagency/Interfacility Physician's Orders dated 5/6/14 documented the following orders: - Low Potassium diet. - Less than 1.5 Liters of fluid every day. - Metoprolol XL 25 mg by mouth once daily. Do not take if systolic blood pressure is less than 110 [mm Hg]. Do not take on dialysis days. The resident's All Active facility Orders for May 2014 and the MAR documented: - Metoprolol Succinate ER 12.5 mg tablet by mouth on Tuesday, Thursday, Saturday, and Sunday. Do not give if systolic blood pressure is less than 100, Heart Rate (HR) less than 55. Do not give on dialysis days. Note: The All Active Orders for May 2014 signed by the resident's physician did not include low potassium diet or the fluid restriction of less than 1.5 Liters of fluid every day. In addition, The Interagency/Interfacility Physician's order and the All Active Order for the Metoprolol were not the same and the resident's record did not document the physician was notified to clarify the Metoprolol order for the less than 1.5 Liters of fluid a day. Additionally, the MAR documented the resident received 13 doses of Metoprolol but only 1 of 13 doses had blood pressure taken prior to administration, the resident's heart rate was not assessed prior to 13 of 13 doses, and there were 2 of 13 days with no documented vital signs. - HDS dated 5/6/14 documented, "She [Resident #4] has chronic diarrhea that was C. Difficile negative, so we continued her Imodium that she	F 309		

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F 309	Continued From page 47 takes outpatient." - FF dated 5/7/14 at 2:45 PM documented, "New Admit, Noted to have loose, mucousy (sic) stool with foul odor. Collected sample would you like to send for C&S?" - IPN dated 5/7/14 at 3:00 PM documented, stool sample sent to the lab with orders to culture stool, O&P, and C. Diff. will follow-up with results. - IPN dated 5/8/14 at 5:00 PM documented, resident noted to have blood in toilet x 2 this day. MD notified possible hemorrhoids resident with multiple episodes of loose stool/diarrhea. Pending C. Diff. test. - IPN dated 5/9/14 at 7:30 PM documented, Patient continues with loose stools. Stool sample sent via taxi this AM. Hemorrhoids present with mild frank blood in AM. Note: The IPN note dated 5/7/14 documented the stool sample was sent to the lab on 5/7/14, however the IPN note dated 5/9/14 documented the stool sample was sent on 5/9/14 via taxi. The Communication record dated 5/9/14 sent with the resident to dialysis documented the stool sample was sent to the lab on 5/9/14. It could not be determined why the stool sample that was ordered on 5/7/14 was not collected and sent until 5/9/14. The RNC was asked about the discrepancy of the dates and she stated the sample was collected and sent via taxi on 5/9/14. -Lab results dated 5/9/14 documented, stool negative for Clostridium Difficile antigen and toxin and no OVA or Parasites seen. Stool culture pending. - PO dated 5/12/14 documented, "Obtain appt. [appointment with] Pt's GI MD ASAP r/t [related to] GI bleed." - Lab results dated 5/13/14 documented, "Stool	F 309		

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F 309	Continued From page 48 culture positive with many Staphylococcus Aureus present." - IPN dated 5/12/14 documented, bloody stools noted per rectum. appt. scheduled with GI physician. Note: The resident's medical record did not include the GI Physician's report for Resident #4. On 9/2/14 at 10:00 AM the DNS and RNC were asked to provide a copy of the GI report. The RNC at 3:00 PM said the report was not in the resident's chart and she could not obtain a copy from the physician's office because there was no documentation an appointment had ever been scheduled. The DNS stated she didn't know whether the resident had been seen by a gatroenterologist during her stay at the facility. The DNS and RNC could not explain why the appointment was not scheduled. - The facility portion of the DCR dated 5/14/14 documented, "... continues to have bleeding with bowel movements," however the facility failed to document the resident had been diagnosed with Staphylococcus Aureus in her stool and had been prescribed an antibiotic. Note: The DCR (Dialysis Communication Record) is completed by the facility and was to be sent with the resident to every dialysis appointment. The Dialysis Center completed the bottom portion of the form and sent it back to the facility with the resident. The facility and Dialysis Center were responsible for documenting the resident's general condition, special instructions, change in condition and/or other pertinent information on this form. - The DCR dated 5/14/14 from the facility to the	F 309		

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F 309	Continued From page 49 dialyis center did not communicate the resident had been diagnosed with Staphylococcus Aureus in her stool, therefore blood cultures were ordered by the HD related to, "[Resident #4] has fever with chills post treatment, temperature 99.1 F, and incontinent of stool (diarrhea-foul smelling). HD notified and orders given for Blood Cultures x 2 and Tylenol. Orders faxed to facility and report given to [Nurse]." - IPN dated 5/14/14 at 6:00 PM documented, "Dialysis requesting blood cultures x 2 and for resident to be assessed by medical doctor. Nurse Practitioner in facility and resident placed on alert charting." - MAR dated 5/15/14 documented the first set of blood cultures were drawn at 5:00 AM. - MAR dated 5/15/14 at 8:00 AM documented the resident received her first dose of the antibiotic for her Staphylococcus Aureus. She missed her second dose at 4:00 PM, and received what was documented as a "third" dose at 12:00 AM. The MAR documented the resident missed 4 of 18 doses of the antibiotic. There was nothing documented in the resident's record that the physician was notified of the missed doses. - IPN dated 5/15/14 at 3:00 PM documented, "Resident currently going out of facility for single lumen PICC placement for IV antibiotic." Note: The results of the Staphylococcus Aureus with the sensitivities for antibiotic treatment were received by the facility on 5/13/14; however the antibiotic was not started until 5/15/14 at 8:00 AM, two days after the infection was detected. There was nothing documented in the resident's record to indicate why there was a delay in treatment.	F 309		

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F 309	Continued From page 50 - MAR dated 5/16/14 documented the second set of blood cultures were drawn at 3:00 AM. Note: It is unclear why the facility was drawing blood cultures on a resident who had already been diagnosed with infection and had antibiotic treatment initiated. The DNS was asked why the Dialysis Center was not notified reletated to the Staphylococcyus Aureus in the resident's stool. The DNS stated, "I don't know." The DNS and RNC were asked if it is standard practice to draw blood cultures after an antibiotic is started. The RNC stated blood cultures are typically drawn before antibiotic treatement is started, unless the physician specifies otherwise.	F 309		
	- DPN dated 5/16/14 at 3:52 PM documented, "The [residen't interested party] stated [Resident #4] went to the hospital yesterday to have a PICC line placed due to need for abx [antibiotic]... Patient's BP down into the 70's on the way to the hospital so [the] EMT stopped and gave [the] Patient fluids. [Resident #4] is now 4 kg [8.8 pounds] over her EDW today. Trying for 3.0 kg [6.6 pounds]. Call to care center about the abx patient is on. Left a message, no return call." Note: There was nothing documented in the resident's record that the facility had followed up with the resident's interested party to ensure her questions about the antibiotics had been answered. Furthermore, the Dialysis Center documented it had attempted to contact the facility with questions about the resident's antibiotic and left a message, but the facility had not returned the Dialysis Center's call. - PN dated 5/16/14 documented, "The patient			

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F 309	Continued From page 51 was admitted to the facility on May 6, 2014 but I have not been able to evaluate her secondary to her typically being at dialysis during my visit day. The patient's [interested party] also informs me today that the patient was very hypotensive yesterday. She informs me that [Resident #4's] blood pressure had gone down to 77/46 the ambulance contacted the emergency department and they informed the crew to bring the patient in if they felt it was needed. Apparently the patient's blood pressure stabilized after a fluid bolus yesterday. Currently, [Resident #4] appears to be very anxious and nervous and is very uncertain on her answers it appears. The patient's [interested party] states that this is not a very common thing for [this resident] and states that she has had episodes like this in the past where she has had a urinary tract infection. Uncertain as to what is going on with this patient at this time but we will obtain a urinalysis with CNS [sic] if indicated." The UA was ordered that day at 7:00 PM. Note: There was nothing documented in the resident's medical record on 5/15/14 or 5/16/14 that the resident had a hypotensive crisis while en-route to the hospital for PICC line placement and that the ambulance crew had to contact the Emergency Room to obtain orders for a fluid bolus. Furthermore, there was nothing documented in the resident's medical record that the facility had informed the resident's physician or the Dialysis Center related to the above incident on the day it occurred. The HD and the NP documented they were notified by the resident's interested party on 5/16/14, one day after the crisis occurred. - DPN dated 5/19/14 from 5:01- 5:09 PM	F 309		

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F 309	Continued From page 52 documented, "Pt arrived to treatment 5.7 kg [12.5 pounds] over EDW. Pt tolerated a 1.5 L (3.3 pounds) fluid removal over a 3.00 hr [hour] treatment. Pt left 4.5 kg [9.9 pounds] over EDW. The RD at the Dialysis Center reviewed the nutrition report with patient's interested party and RD at the Extended Care Facility. Albumin continues to trend down. Patient to increase intake of protein as reviewed with [interested party] and RD at ECF. Patient was on liberalized renal diet. RD to change to regular NAS diet. Pt to receive Health Shakes 4 ounces [120 mls] twice a day." Note: There were no daily/24 hr fluid intake totals in the resident's record to ensure the resident did not exceed the daily 1500 ml fluid restriction. - FF dated 5/19/14 written by the RD to the physician documented, "Please change diet to NAS d/t decreased potassium per dialysis and start health shakes BID for increased protein intake. Nursing to document percent of intake." The order was not consistent with the dialysis RD's order of, "Health Shakes 4 ounces twice a day." - MAR dated 5/19/14 did not document the resident was to receive only 4 ounces twice a day or 120 ml's. Additionally, the order was written for the percentage of intake instead of the amount in ml's which was necessary to ensure resident did not receive more than 1500 ml's of fluid a day. - FF dated 5/20/14 written by the RD to the physician documented, "May we d/c 1500 ml fluid restriction? [Resident] now receiving supplements which adds to fluid intake." The physician responded, "OK." - Weight Report from dialysis documented the	F 309		

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F 309	Continued From page 53 following: * 5/19/14 pre-dialysis weight = 59.2 kg and post dialysis weight = 58 kg, 4.5 kg over DW. * 5/21/14 pre-dialysis weight = 59.6 kg and post dialysis weight = 57.9 kg, 4.4 kg over DW. * 5/23/14 pre-dialysis weight = 57.8 kg and post dialysis weight = 56.3 kg, 2.8 kg over DW. - Lab results dated 5/20/14 and 5/21/14 related to the two blood cultures documented, "No growth 5 days." However, there was nothing documented in the resident's record related to the results of the blood cultures or that the HD or primary care physician had been notified. - DPN dated 5/26/14 documented, "Pt in a lot of pain today. Brought over by non-emergent transport at 12:00[PM] on a gurney. She was sent back to care center due to we did not have a chair or anywhere to put her for one hour to wait. Came back at scheduled time of 1:15 [PM]. Did not tolerate fluid goal well today. Lots of pain, generalized, but mostly in neck. She was taken of [sic] 16 minutes early at her request due to pain. Care center ... reports that patient was given a pain pill before she left for treatment. Patient is very anxious and is clearly in a lot of pain." Note: There was nothing documented in the resident's record based on the above note that the primary care physician was notified related to the resident having increased pain or being transferred to dialysis on a gurney. -IPN dated 5/27/14 documented: * 12:00 PM, Pt with complaints of loose stool. * 5:00 PM, C-Diff. stool sample and UA sent to lab. Note: The UA collected on 5/27/14 was ordered	F 309		

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F 309	Continued From page 54 to be collected on 5/16/14 by the facility NP related to the resident experiencing increased confusion. It could not be determined why the UA was not collected until eleven days after it was ordered. Additionally, it could not be determined why a stool sample was sent to the lab to check for C. Diff. The resident completed the antibiotic treatment of 5/20/14 and there was nothing documented in the nurses notes from 5/19/14 to 5/26/14 related to diarrhea/loose stools. The resident missed 4 doses of the antibiotic prescribed for the stool infection. - IPN dated 5/27/14 at 8:00 PM, "Called into patient's room. Patient's guest stated, 'Pt wasn't feeling well.' Pt was asked what was wrong, she stated, 'she was just sleepy she thinks.' Patient's pulse was 71, temperature was 99.8 F, and her oxygen saturation was 92% on room air." There was no blood pressure documented. "The patient's [interested party] asked if we could give her [resident] something for the fever and I explained there was Tylenol in the pain medication she got at 1930 [7:30 PM] so the temp. would be monitored. The [interested party] had concerns about the resident's 'confusion.' I told her that she had just had pain medication and that it could be from the meds. [Interested party] stated, 'She [resident] has been taking this medication for years and has never had this confusion/sleepiness from them.'" There was no documentation in the IPN that the nurse had done a complete assessment on the resident or notified the physician. Note: The resident received 61 doses of narcotic pain medication from 5/7/14 to 5/24/14 without showing signs of sedation per the resident's MAR. Starting on 5/25/14 the facility started	F 309		

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F 309	Continued From page 55 documenting the resident was showing signs of sedation. There was no documentation in the resident's medical record that the physician had been notified of the resident's change in condition. - IPN dated 5/27/14 at 10:40 PM, "[Interested party] called concerned about why we were testing the pt's stool. She would like the NP to call her tomorrow while he is here after seeing [the resident]." Note: The resident's medical record did not include the NP's dictated note from 5/28/14 or documentation as to whether the resident was seen by the NP on 5/27/14. Additionally, there was no documentation that the NP contacted the interested party to discuss concerns. When asked on 5/3/14 to provide a copy of the Physician's note for 5/27/14, the RCN stated there was no note. - Lab results dated 5/28/14, at 11:51 PM, reported positive for C-Diff, as well as positive for the presence of blood, protein, and yeast in the resident's urine. Hand written, but not initialed or dated, on the bottom of the lab result was, "Obtain C&S." - DPN dated 5/28/14 documented: * "Pt dropped off in lobby by transportation from [facility] at approximately 12:45 PM and brought back to treatment floor around 1:20 PM. * Pt oriented to self only, answers with yes/no and follows simple commands. * Unable to verbalize where pain is located, states, 'everywhere.' * Weakness notedly more-so on right side of body. * Patient's blood pressure 93/55 pre-dialysis	F 309		

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F 309	Continued From page 56 weight = 53.5 kg, the resident's post dialysis weight = 53.6 kg after the resident received a fluid bolus for low blood pressure." Note: The resident's record did not document the resident's primary physician had been notified about the significant change in the resident's condition as identified by the dialysis center. - NN dated 5/29/14 at 12:00 PM, "Res[idents] family at bedside, it was requested for res to have some 'pain pills' per [family] present. This nurse approached charge med[ication] nurse regarding request it was stated res received APAP as ordered [with] [family] present. Charge nurse and this nurse approached res and family, re-educated/informed of already medicated. Res had [no] s/sx of pain when asked where her pain was res stating, 'I don't know.' Res noted to have increased sedation, diff[iculty] keeping eyes open during assessment." Note: The resident's pain MAR was reviewed for 5/28/14 and 5/29/14 and documented the facility held the resident's routine Norco on 5/28/14 at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. The resident received no narcotic or non-narcotic pain medications from 5/27/14 at 7:00 PM until 5/29/14 at 6:00 AM. - Lab results dated 5/30/14 at 6:21 AM, final report, documented, greater than 100,000 Candida Albicans [bacteria] present in the resident's urine. - DPN dated 5/30/14 documented, "Treatment initiated, pt placed on 15 min B/P checks. O2 [oxygen] placed for hypotension prophylaxis. Pt reclined at 1433 [2:43 PM] for comfort. At approximately 1500 [3:00 PM] pt appeared to be	F 309		

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less oriented. [Dialysis staff] was unable to get pt to respond to her name. This LN was notified. Pt unresponsive to verbal stimuli, but grimaces with sternal rub. Orders received to transport pt to ER for decreased LOC."
- IPN dated 5/30/14 documented:
* 12:30 PM, "At approximately 12:30 PM this nurse received a call from a physician at a medical network. This nurse explained MD/Pt interactions per facility protocol. It was addressed that pt was often absent from center (at dialysis) at times when NP rounds, but NP/MD were still following pt and were involved [with] all cares as well as kept up to date on pt status."
* 4:00 PM, "I explained to [interested party] I spoke [with] NP and asked him to call her. I also called the [Physician's] office and left a message for him to call her in case the NP did not. [Interested Party] stated neither [the Physician or the NP] had called her... Sent an e-mail to [Physician] at that time, today NP informed me he was planning to call [interested party]." The [interested party] had requested a call from the NP on 5/27/14 and on 5/30/14 the NP had still not contacted the resident's [interested party].
- ER report dated 5/30/14 at 5:26 PM documented, "I spoke with the dialysis nurses who confirmed that she [the resident] has been slightly below her ideal dry weight on her last two visits and her blood pressures have been trending down from the 150's to the low 100s over the last several weeks. Her [interested party] also confirmed that her blood pressures have been very difficult to control and that her normal routine is to hold off on blood pressure medicines on the days that she dialyzes. We made several attempts to contact the nursing facility where she is staying, but no one would answer the phone. I do not have any further information available at

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F 309	Continued From page 58 this time." The resident was admitted to the ICU at a local hospital on 5/30/14 and expired on 6/8/14 with multiple diagnoses, including septic shock secondary to Clostridium difficile with refractory hypotension requiring multiple vasopressors, congestive heart failure, and pleural effusions. On 9/3/14 at 10:00 AM the DNS was asked why the NP had not been notified about the resident's rapid and significant decline, why the NP had not seen the resident until 10 days after admission (the facility identified the NP rounded on residents at the facility three times a week), and why the facility had not communicated with the Hemodialysis Doctor about the resident's stool infection.The DNS answered, "I don't know." Additionally, the DNS was asked why the facility's RD did not follow the Hemodialyis Doctor's order for health shakes and why the resident's daily fluid intake was not documented. The DNS stated, "I don't know." The DNS was asked why was there a delay in treatment for the administration of the antibiotic and why the physician wasn't notified related to the missing doses. The DNS stated, "I don't know." The DNS was asked why the resident's order for the Metoprolol was not clarified and why the resident's blood pressure and pulse were not taken prior to administration. The DNS stated, "I don't know." The RNC stated she and the DNS would review the resident's record for answers to the above questions/concerns. On 9/4/14 at 1:20 PM, the RNC stated she was not able to provide the documentation to answer the above questions.	F 309		

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F 309	Continued From page 59 3. Resident #3 was admitted to the facility on 5/10/14 with diagnoses that included atrial fibrillation, Coronary Artery Disease, Diabetes Mellitus (DM), and pneumonia. The resident's 5/10/14 Transfer Order/Instructions from the hospital, documented: -Notify Physician: "If you gain 2-3 pounds overnight or 4-5 pounds in 5 days, notify your physician. ..." -Patient Care: "Daily Weight. ..." The resident's admission Physician orders, dated 5/10/14, documented: -"Weight weekly x 4 weeks post admission then monthly." -"Daily weight x 3 days-Day Shift for 3 days." End date: 5/13/14. -"Daily weight. Notify MD of 3 lb. (pound) weight gain overnight or 5 lbs. in a week - Day Shift Everyday." -"Is there any swelling noted? If yes, document in shift note. - Night Shift, Day Shift Everyday." The resident's Admit Nursing Assessment, dated 5/10/14, documented: -Weight: "229" -Edema: "No." -Integumentary/Feet: "Other" was documented on the diagram on the lateral aspect, upper portion of the right lower leg, and medial aspect of the left ankle area. There was no description of what "other" was. -Skin Description: "Pink." The resident's Admission MDS dated 5/17/14 documented: cognition was intact, did not reject cares, was at high risk for developing pressure	F 309		

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F 309	Continued From page 60 ulcers, had no unhealed pressure ulcers, no venous and arterial ulcer, or other ulcers, wounds or skin problems. The resident's May 2014 TAR documented: *Is there any swelling noted? If yes, document in shift note. Start date: 5/10/14 Night shift, Day shift everyday. -"Y"(es) was documented on Day shift 4 times, Night shift 7 time. Day shift had 4 days with no documentation, and Night shift had 2 nights with no documentation. Nurses notes related to skin were documented on 5/20, 5/22, and 5/24. NOTE: There were a total of 11 opportunities to document on swelling and there were only 3 notes that documented the resident's swelling. *Daily weight x 3 days - Weight was documented on 5/10 but not on 5/11, 5/12 or 5/13. *Daily weight. Notify MD of 3 lb. weight gain overnight or 5 lbs. in a week -Weights were documented on 5/14, 5/15, 5/16 5/19 /and 5/20. Weights were not documented on 5/17, 5/18, and 5/21 through discharge on 5/25. The resident's Care plan documented: * Interventions for "Alteration in Cardiac Status...," initiated on 5/12/14, included to observe for edema and report increased edema to the MD as well as to weigh the resident and notify the MD as ordered. *Interventions for "Potential for skin breakdown..., initiated and revised on 5/10/14, included to observe skin every shift for sign and symptom of potential skin breakdown (e.g. redness /discoloration or open areas) and to alert the charge nurse if observed for notification of physician as needed for treatment orders.	F 309		

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F 309	Continued From page 61 The resident's May 2014 TAR documented: "Weekly skin checks on Saturday" -Completed on 5/10 and 5/17. It was blank for 5/24/14. NOTE: The care plan documented to observe skin every shift; however there was no documentation that this had occurred. The resident's MD progress notes, NP's (Nurse Practitioner) progress notes, LN progress notes, COCD (Change of Condition Documentation), SIR (Skin Integrity Report) and PFC (Physician Fax Communication), documented: 5/12/14 NP Progress note: -Skin- Warm and dry to the touch. -Extremities- Reveal 1-2+ edema to the bilateral lower extremities. 5/13/14 MD Progress note: -Extremities- Has +2 edema bilaterally. PFC with no date by LN, signed by Physician 5/16/14, -"Res(ident (with) (increase) wt 4 lbs in 6 days." LN -"Nurses please monitor for edema." Physician. 5/19/14 NP Discharge Summary note: -Skin-Warm and dry to the touch. -Extremities-Reveal no significant edema to the periphery. 5/20/14 8:00 PM, LN progress note: "...Skin pink and warm to touch. ..." The note did not include whether or not the resident had edema. 5/22/14 9:00 PM, LN progress note:	F 309		

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F 309	Continued From page 62 "... C/O [complaint of] watery diarrhea x 7 today. Dr. notified... 1+ edema BLE [bilateral lower extremities. elevation encouraged." The note did not document if the physician was notified of the edema or any description of the skin. 5/24/14 at 2:00 PM, COCD, -Reason you are calling the Physician: "Skin blister, top of R [right] foot." -Assessment: Skin Concern-Location of skin concern: "[R marked over with an L for Left] foot [top]." -Nursing Progress note: "CNA notified nurse on 700 [hall] of "water on floor" and discovered ruptured blister to top of [R marked over with an L] foot measuring 6.5 cm x 5 cm. Clear fluid noted. Pt. [patient] states had not noticed it. Dressing to shin directly above last [changed] on 5/16. [Changed] dressing. Dressed new blister. Round nurse, Physician, floor nurse, adon [Assistant director of nurse's] notified. Staff knows to keep dry. Dressing [changes] daily. Will cont[inue] to monitor. No s/sx of infection. No pain." NOTE: There was no documentation of the skin or edema on 5/23/14. - This was the first and only note in the record that documented a dressing to the shin of the left leg. - There was no description of the left shin and the reason why there was a dressing on it. -There was no documentation the Physician had been notified of the need for a dressing to the left shin, or orders to treat the shin with a dressing. -This was the first documentation of the 6.5 cm x 5 cm blister, to the left foot, that caused there to be "water on floor" when it ruptured.	F 309		

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F 309	Continued From page 63 5/24/14 SIR: -Other: "Blister" "Not incontinence related." -Appearance: SB (blister/ serous). -Length: 6.5 cm. Width: 5.0 cm Depth: 0 cm. -Drainage: Serous -Surrounding Tissue: Healthy. -Wound edges: Healthy. -Care plan updated: Yes. The resident's updated Care Plan related to the "Potential for skin breakdown..." included the following additional goal: -"Monitor blister to top of foot (left) daily. Change dressing daily and PRN." Date Initiated: 5/24/14. NOTE: This was the only change in the resident's care plan for skin. There were no new interventions to protect the resident from further skin breakdown. 5/24/14 9:30 PM, LN progress note: "... Did note RLE [right lower extremity] to be edematous 2-3+ pitting edema and calf has area where is reddened and [unable to read] to the touch, encouraged to elevate BLE [left] foot has an Border gauze dressing that is intact & dry." 5/25/14 2:45 PM, LN progress note: "Family member approached this nurse and asked about getting a copy of the resident's medical record. When asked about relationship to resident she mentioned she was his daughter. She stated she was concerned about the blister on his feet, his blood sugars, and overall well being. She stated she wanted to take him to the hospital for further evaluation. Called Dr. [physician's name] on call doctor, for order to send to St. Luke's Meridian Medical Center.	F 309		

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F 309	Continued From page 64 Family transported resident." PFC with no date by LN and Physician signed it on 5/27/14: -"Discovered blister [ruptured] to top of [left] foot 5/24. Dressed, measured. Skin sheet done. Please [illegible]!" LN -"Wound care to eval[uate] & TX [treat]" Physician. The Physician orders were received 3 days after the blister had been discovered and had ruptured. The resident was discharged to the hospital on 5/25/14, which was 2 days prior to the physician's evaluation and to treat order.	F 309		
	An ER physician's report from the hospital report, dated 5/25/14, documented: *History of Present Illness: -"...presents with his children for evaluation of areas of redness, swelling and blistering to bilateral legs. The symptoms are moderate in severity." *Physical Exam: -"No focal areas of crepitus or pain. Strength 5/5 throughout. He has pretibial edema which is bilateral and pitting. He has evidence of a cellulitis that is nearly circumferential of his right lower extremity and on portions of the dorsal aspect of his left foot and anterior aspect of his left shin." The admission to the hospital, Physician History and Physical report, dated 5/25/14, documented: *History of Present Illness: -"...Please note that all of these information was provided to me by the patient. ...Patient stated that he went to [the facility]. He was "neglected."			

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F 309	Continued From page 65 He developed lower extremity swelling, then the swelling was so bad that his leg started to blisters and those blisters opened. The staff tried to take care of it with putting bandages; however, when the symptoms was not improved, he was subsequently transferred to our ER for further evaluation. ...Patient stated he has pain in his lower extremity, complained of swelling blister on the lower leg with clear fluid discharge...." *Physical Examination: -Extremities:"Negative for clubbing. Positive for +3 edema of the lower extremity. Edema extended up to mid thigh. There is a blister in the midportion of the lower part of the legs on the right side. It was positive for erythema blister that covered the entire front and back of the lower legs. There were blister but the lesion were not opened. There was no purulent discharge. On the left side he has erythema with multiple blisters in the front midportion of the lower part of the legs. On his left foot here is a big blister that was already burst. The lesion is dry. No purulent drainage. Patient has clear fluid weeping from all those blisters. The area of erythema on the lower portion of the lower extremity is around 8 cm circumferential all the way on the right and only mostly anterior on the left. Positive for pain upon palpation." *Plan: -"...For his cellulitis due to recent hospitalization as well as rehab stay, I will place patient on Unasyn and vancomycin with the plan to taper down rapidly. ...We will obtain wound care, check daily weights, strict in-and-outs. ...anticipate patient will require longer than two midnight stays due to his cellulitis and acute and renal failure. If these issues are not treated appropriately it can be worsened and become life-threatening."	F 309		

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F 309	Continued From page 66 On 9/3/14 at 9:40 AM, the surveyor asked the DON and Corporate Consultant for an assessment of the wound that had a dressing to the left shin, when the physician was notified and the treatment plan. They were asked to provide nursing assessment of the resident's skin, to include the lower extremities and edema, daily weights, and an updated care plan related to skin. No comments were offered or further information provided.		Compliance Date F311 D Residents effected 1: Resident #2 was discharged from the center on 06/27/2014. Other residents 2: A review of residents' ADL records will be completed by DON or designee on or before 10/14/14 to ensure that resident showers/bathing where completed as scheduled. Residents with missed shower/baths will be assessed for any adverse effect by the Director of Nursing or designee on or before 10/14/14. The residents shower/ bath schedule and plan of care will be reviewed with the resident/ and responsible party as indicated and changes will be made to the schedule per resident preference. Systemic Change Center staff were re-educated on or before 10/14/14 by nursing educator related to completing residents shower/ baths per the care planned schedule, including re-approaching resident and if resident refuses or factors occur that require alternate schedule.	10/~~15~~ 17/14 chg per facility request 10/14/14 M 10/22/14 chg per facility request 10/30/14
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents had adequate assistance for bathing. This was true for 1 of 6 residents (#2) sampled for bathing. The deficient practice had the potential to cause harm if the resident's wound healing was hampered by dirty skin. Findings included: Resident #2 was admitted to the facility on 5/13/14 with multiple medical conditions which included paraplegia and Stage III pressure ulcers to both heels. Resident #2's admission MDS assessment, dated 5/20/14, coded the resident required extensive assistance of 2 for bathing.			

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F 311	Continued From page 67 Resident #2's ADL flow record documented the resident did not receive a shower from the time of his admission on 5/13/14, until 5/21/14, a period of 8 days. The resident did not receive a shower again between 6/20/14 until 6/26/14, a period of 6 days. The resident's ADL correction form documented on 6/24/14 evening shift, the resident was due to have a shower but did not, "due to catheter problems and IV hooked up." There was no documentation of what, specifically, the "catheter issues" were, nor if the resident was offered the opportunity to shower once those issues had been resolved and the IV medications finished. On 9/4/14 at 8:15 AM, the DNS reviewed Resident #2's ADL flow record, and confirmed the gaps in resident bathing activities. The DNS stated residents were normally scheduled for at least 2 baths or showers per week, but had no explanation for why this resident did not receive baths as scheduled. On 9/4/14 at 4:30 PM, the Administrator, DNS, RVP, and RNC were informed of these findings. The facility offered no further information.		The ADL's records will be reviewed by a nurse manager at the morning clinical meeting beginning the week of 10/15/14 to ensure that showers/ baths are completed per schedule. Review: Beginning the week of 10/15/14, 5 residents ADL records will be reviewed by the Director of Nursing or designee to ensure that showers/ baths are being offered and completed per resident schedule and that follow up related to refusals or missed showers are completed. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be compiled by the Director of Nursing and reported to the QA/PI committee for review and remedial intervention X3 months or until resolved. The Director of Nursing is responsible for monitoring and follow-up.	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and		Compliance Date F314 G Residents effected Resident #5 skin was assessed by RN to include wound on 9/24/14.	10/~~15~~17/14 Chg per facility request/IR 10/22/14 Chg per facility request/IR

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F 314	Continued From page 68 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to prevent pressure sores, and document pressure sore treatment for 2 of 2 (#2 & #5) sampled residents. The deficient practice caused harm to Resident #5 when the resident developed a Stage III pressure sore to the left heel, and a Suspected Deep Tissue Injury [STDI] to the right buttocks, while in the facility. Resident #2 was harmed when the resident developed an STDI to his buttocks and treatments were not consistently documented for Stage III pressure sores to the resident's bilateral heels. Findings include: 1. Resident # 5 was admitted to the facility on 10/1/01 with current diagnoses of heart failure, hypertension, non-Alzheimers Dementia, depression, muscular wasting & disuse atrophy, and chronic kidney disease (CKD). The resident's Annual MDS, dated 12/11/13, and Quarterly MDS, dated 3/13/14, documented the resident had long and short term memory problems and a decline in bed mobility, dressing, eating, toilet use, and personal hygiene from extensive assistance to total dependence on staff for cares on 3/13/14. The quarterly MDS dated 6/12/14, documented the same levels of need as the 3/13/14 MDS, except bed mobility increased from a 1 person assist to 2 person assist. All three MDS's documented the resident was high risk for pressure sores and had no pressure sores.	F 314	Resident #5's current skin and wound status and treatment was reviewed by RN with the MD on 9/30/14 with no new orders as the wound is continuing to show improvement as evidenced by the wound measurements decreed with no signs or symptoms of infection. A Braden pressure ulcer risk assessment was completed for resident #5 on 09/12/14 by DON, and the residents care plan and cardex were reviewed and updated to include new interventions including preventative measures by the Director of Nursing on 09/30/14. Resident #5 was evaluated by the Occupational therapist on 09/05/14 for wheelchair positioning. Changes were implemented as suggested. CNA #3 was re-educated by nurse educator on 09/05/15 related to pressure ulcer prevention measures for resident #5 including every hour repositioning, and infection control measures including hand-washing and changing gloves after providing peri-care and before application of barrier cream to avoid wound contamination. Resident #2 was discharged from Meridian Center on 06/27/14.	

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F 314	Continued From page 69 The resident's Braden scale, dated 4/17/14, placed the resident at severe risk for developing pressure sores. The next Braden Scale completed on 6/30/14, placed the resident at High risk. The resident's Care plan documented: *Interventions for potential for skin breakdown related to: immobility, incontinence, advanced age and general debility... revision on: 3/14/14, included air mattress, Broda chair, Calmoseptine: to buttocks and coccyx, encourage to lay down between meals, float heels in bed, Quarterly and [as needed] Braden assessments, skin assessments per facility protocol, turn and reposition frequently to relieve pressure [every] 2 hrs [hours], keep skin clean and dry, pressure reducing/relieving devices to bed and w/c [wheelchair], observe skin every shift for s/sx [sign and symptoms] of potential skin breakdown. Alert charge nurse if observed for notification of physician as needed for tx orders, and skin breakdown unavoidable d/t [due to]terminal dx of dementia & immobility. The resident's Nurse Interdisciplinary Progress Note (NIPN), Skin Integrity Report (SIR), Physician progress note (PPN), Physician's notification of Change of Condition Documentation (COCD), SBAR Communication Form (SBARCF), Treatment Administration Record (TAR) and Care Plan (CP) documented: -6/7/14, NIPN with similar documentation on 6/8, 6/9, 6/13 documented: -"...Resident's skin warm dry, and pink. Skin is very fragile on arms & legs." -6/16/14 SIR Left heel:	F 314	Other residents A skin inspection of residents will be completed by nurse mangers or designee on or before 10/14/14. MD and family will be notified of findings with orders and care plan updates as indicated by DON or designee upon initiation of any new orders. A Braden pressure ulcer risk assessment will be completed by a licensed nurse for current residents on or before 10/14/14. Residents identified to be at risk for skin breakdown will have their care plans and cardex's reviewed and updated by the Director of Nursing or designee on or before 10/14/14 to ensure that resident risk factors are addressed to prevent avoidable skin breakdown including positioning and offloading, pressure reducing cushions to wheelchairs, pressure relieving mattresses, and positioning devices. A center round was completed by the Director of Nursing or designee on or before 10/14/14 to ensure that care planned interventions to prevent pressure ulcers are in place.	

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F 314	Continued From page 70 *Primary Type of Wound: "Pressure." *Pressure Ulcer Stage: "III" *Appearance: (Granulation) 100% *Length: 0.5 cm (centimeter), Width: 0.5 cm, Depth: (less than) 1 mm (millimeter). *Care Plan Updated. -6/16/14 COCD: -"Res. was found to have a pressure sore to the left heel... Prevalon boots applied." NOTE: The Prevalon boots were applied to resident's feet after the development of a Stage III pressure sore to the left heel on 6/16/14. - 6/16/14, Initial CP: *Prevalon boots to bilateral feet at all times; weekly wound measurements documented on flow sheet to include intact, reddened, and/or opened areas of skin; daily monitoring for s/s of infection; report abnormalities to MD, treatment as ordered. -6/17/14 PPN: *Subjective: "(Resident's name) is seen again today for evaluation of a wound she has developed on the left posterior heel...." *Objective: "The patient is nonverbal, sitting up in a reclining wheelchair. she has a stage 2 ulcerated area on the posterior aspect of the left heel which, unfortunately, appears to be exactly at a site of pressure on the firm ridge of her wheelchair steps or foot rest. .." *Assessment and Plan: "Stage 2 pressure sore left posterior heel secondary to foot rest on wheelchair. The wound has been appropriately dressed, just with protection. Staff will address the presence of her foot rest and ensure that it is either removed or at least padded when she is in the supine position..."	F 314	Resident's with BRODA wheelchair's or other specialty wheelchairs will be reviewed by the Director of Nursing or designee and the therapy manager or designee on or before 10/14/14 to ensure that the wheelchairs have been assessed for individual resident use and risk benefit analysis for continued use has been completed. A review of treatment administration records will be completed by a nurse manager on or before 10/14/14 for missed treatments. Residents identified as having missed treatments will be assessed by a licensed nurse on or before 10/14/14 for any adverse effect. MD will be notified as indicated. Review to ensure weekly skin assessments completed, orders transcribed on TAR per MD order, accurate care plan and kardex updates as indicated. System Change Licensed nurses will be re-educated by DON or designee on or before 10/14/14 related to pressure ulcer prevention measures, treatment, interventions to include care plan and kardex updates, and documentation requirements, required assessments for specialty chairs, timely	

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F 314	Continued From page 71 -6/19/14 NIPN: -"IDT [Interdisciplinary Team] f/u [follow up] for PU [pressure ulcer] [left] heel. Environment & equipment assessed, Res. on air mattress, turn schedule, float heels, padded broda chair & has foot cushion. When assessing chair if cushion on foot pedals fall down to[sic] much back of ankle area would rest on foot pedal where site of PU was found. Foot pedals were extended out further by maint[enance] to prevent this from occurring. Prevalons placed to BLE [bilateral lower extremities] [at] all times..." -6/19/14 CP updated: *...foot pedals were extended out further by maintenance. -6/23/14 SIR Left heel: *Primary Type of Wound: "Pressure." *Pressure Ulcer Stage: "III" *Appearance: (Necrotic) 100% *Length: 1.6 cm, Width: 1.8 cm, Depth: "UTD" (Unable to Determine). *Care plan not updated. NOTE: The Pressure sore to the resident's left heel had more than doubled in size in the week after it was discovered, and the "granulated" tissue was now necrotic. -6/25/14 NIPN: -"...Skin checks changed to 2x/wk." -The resident's June 2014 TAR, did not include the following documentation: *Pillow in between legs at all times to keep legs from crossing. Start Date 6/23/14. Four times on night shift. *Prevalon boots to bilateral feet at all times. Start	F 314	implementation of treatments, infection control measures related to incontinence and wound care, and ensuring that care planned interventions are in place at the bedside. The MD and family will be notified. CNA's will be educated on wound basics the nurse educator or designee on or before 10/14/14. Course includes prevention identification and infection control principles. CNA staff will have a peri-care competency completed by nurse educator on or before 10/14/14. Review Beginning the week of 10/15/14 an audit of 5 residents at risk for pressure ulcer development will be reviewed to ensure that resident pressure ulcer risk factors are identified, that physician orders for treatment, and preventative measures are followed, Interventions are in place on the plan of care and cardex and followed and updated, documentation including assessments, wound status, and treatments are complete. A review of 3 residents with wounds will be completed by the Director of Nursing or designee to	

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F 314	Continued From page 72 date 6/16/14. Two times on night shift. -7/25/14 NIPN: -"Cares- Res [with] endstage dementia & has had slow, steady decline & is on pallative care. Res. [with] multiple co-morbities CKD, PVD [peripheral Vascular disease], periphral neuropathy, immobility, poor circulation BLE [with] delayed cap[illary] refill & skin to BLE pale, cool, tight shiny [with] no hair growth... Further interventions implemented, prevalons BLE, & foot pedals extended. Res. potential to heal is poor & additional wounds are unavoidable d/t co morbities & disease process despite skin care & pressure relief interventions." -The residents July 2014 TAR, did not include the following documentation: *Skin at risk: Check 2x weekly. Start Date: 6/25/14. Three times on day shift. NOTE: The resident was "high" risk for skin breakdown, had developed a pressure sore on the left heel on 6/16/14, had 2 x a week skin assessments ordered and the assessments were not documented as completed. -8/6/14 SIR left heel: *Primary Type of Wound: "Pressure." *Pressure Ulcer Stage: "III" *Appearance: Granulation 100% *Length: 0.9 cm, Width: 1 cm, Depth: "0.1" cm. *Care plan not updated. -8/20/14 NIPN with similar notes documented on 8/1, and 8/6: -"Will cont(inue) (with) prevalon boots at all times, air mattress, and turning Q (every) 2 (hours) as res. allows."	F 314	ensure that wounds improving and physician orders for treatments are being followed, and assessments, interventions, and care plan and cardex are up to date. A review of 3 CNA's completing peri-care will be completed by the Director of Nursing or designee to ensure that infection control measures are followed and residents with wounds do not have wound contamination and that residents are checked for repositioning. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be compiled by the Director of Nursing and reported to the QA/PI committee for review and remedial intervention monthly X3 months or until resolved. The Director of Nursing is responsible for monitoring and follow-up.	

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MERIDIAN CENTER GENESIS HEALTHCARE	1351 WEST PINE AVENUE MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 73 -8/23/14 SBARCF, signed by the physician 8/26/14: -Started on: 8/23/14 -Assessment: "Alert, has a blanchable, red peeling area on (right) buttocks r/t moisture exposure. Requesting Calazime cream after each incontinent episode." -8/25/14 at 9:30 AM, NIPN: -"Moisture associated excoriation noted to (right) buttocks surrounding tissue is blanching. ...res. on air mattress. Turned Q 2 (hours) as res. allows. Calazeme cream applied..." -8/26/14 SBARCF, not signed by Physician: -Situation: "Worsening excoriation to (right) buttock." -Started on: 8/25/14 -Request: "Upon assessment of excoriation to (Right) buttock, skin noted to have a deep purple area surrounded by excoriated skin. (No) s/sx of pain, (no) s/sx of infection. See SIR for measurements MD in and notified of skin issues. N. O. (new order) received for cream and OT to eval(uate) and treat." NOTE: The physician was sent a SBARCF on 8/23/14 to notify him of the new skin condition, and request of new orders, which was not signed until 8/26/14. On 8/26/14 the MD was "in" and notified by staff a second time of the resident's skin condition, which had developed an area that was "deep purple." -8/26/14 at 11:45 AM, NIPN: -" N.O. (new order) received for nightly heel and coccyx checks, turn Q 1 (hour) as tolerated, and OT eval and treat for wc positioning and eval wc cushion..." NOTE: The new orders written on 8/26/14, which	F 314		

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F 314	Continued From page 74 increased skin checks to include nightly heel and coccyx checks, and increase the resident's turn and reposition schedule to every 1 hour were written 3 days after the resident had a change in her skin condition, and a "deep purple" area had developed. 8/26/14 SIR Buttocks: *Primary Type of Wound: "Incontinence related." *Pressure Ulcer Stage: "-" *Appearance: Epithelial 100% *Length: 1.5 cm, Width: 1 cm, Depth: "<0.1" cm. *Care plan updated. The resident's TAR for August 2014 did not include the following documentation: *Check placement and function of air mattress: One time on day shift. *Prevalon boots: One time on day shift. *Skin checks 2x weekly: Two times on day shift. *Monitor excoriation to right buttocks every shift: One time on day shift. *Ensure resident is turned every 1 hour: One time on day shift and one time on night shift. NOTE: The resident not turned every 1 hour on day shift and night shift occurred on the same day. *Monitor SDTI (Suspected Deep Tissue Injury) to right buttock every shift: One time on day shift and one time on night shift. NOTE: This occurred on the same day. -9/3/14 SIR Buttocks: *Primary Type of Wound: "Incontinence related." *Pressure Ulcer Stage: "SDTI (Suspected Deep Tissue Injury)" *Appearance: Epithelial 100% *Length: 1.5 cm, Width: 1.5 cm, Depth: "<0.1" cm. *Care plan not updated.	F 314		

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F 314	Continued From page 75 -9/3/14 SIR left heel: *Primary Type of Wound: "Pressure." *Pressure Ulcer Stage: "III" *Appearance: Granulation 100% *Length: "0.5" cm, Width: "0.9" cm, Depth: "0.1" cm. *Care plan not updated: -The resident's September 2014 TAR did not document the following 9/1- 9/3/14: *Foot cradle: Two times on night shift. *Excoriation to right buttocks: Two times on night shift. *Monitor SDTI to right buttocks: Two times on night shift. *Nightly heel and coccyx check: Two times on night shift. *Pillow in between legs: One time on night shift. *Prevalon boots in place: Two times on night shift. *Check placement and function of air mattress: Two times on night shift. *Resident turned Q hour: Two times on night shift. On 9/4/14 at 8:25 AM, the surveyor observed the resident sitting in the Broda chair by the nurses station. At 8:29 AM, the resident remained in the Broda and was taken to the dining room. At 9:00 AM, the resident was taken from the dining room to her room. The resident was set beside her bed in the Broda chair with the Television on. On 9/4/14 at 9:15 AM, CNA#3 and CNA# 4 assisted the resident to bed. The resident was positioned on her left side, prevalon boots were in place with the left leg/foot directly on the bed with a pillow on top of it and the right leg on top of the pillow. A foot cradle was in place at the foot of the bed. When asked when the resident got out of	F 314		

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F 314	Continued From page 76 bed, CNA#3 stated, "She was one of our last ones up so probably close to 8:00 AM." CNA #3 identified herself as the resident's caregiver for the day. On 9/4/14 at 10:20 AM, the surveyor observed the resident in the same position as that described for 9:15 AM. On 9/4/14 at 10:40 AM, the surveyor observed CNA# 3 with CNA # 5 reposition the resident. The resident was incontinent of bowel and bladder. CNA # 3 provided pericare. The dressing to the right buttocks was loose and CNA # 3 pulled it up and tucked under the corners. The surveyor observed a dime size open area with red granulation tissue to the buttocks. CNA# 3 applied Calamazine cream with soiled gloves to the buttocks and the wound. The resident was positioned on the right side with a pillow between her legs. The surveyor asked CNA # 3 what skin prevention measures were provided for the resident and CNA # 3 stated, "She is last up and first down, and we turn her about every hour and a half." On 9/4/14 at 11:00 AM, the surveyor met with the DON and Corporate Consultant, and asked if repositioning the resident every hour and a half was too long, to which the DON gestured "Yes" with a nod of her head. The surveyor asked when the Broda chair was implemented, whether an assessment had been completed prior to the Stage III pressure sore that developed on the heel from the Broda chair, and to provide the skin care plan that was in place prior to the skin issues now present. The Corporate Consultant stated, "I know they had a lot in place, she has been here a while. I am looking for it now."	F 314		

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F 314	Continued From page 77 On 9/4/14 at 11:45 AM, the Occupational Therapy [OT] Supervisor stated that typically her department would get a referral and do the assessment for a Broda chair. The OT Supervisor stated she did not know whether this procedure was followed for Resident #5. On 9/4/14 at 2:20 PM, CNA # 3 approached the surveyor and stated she had talked with the other CNAs on the floor and was told the resident was supposed to be turned every hour, and she should have turned her sooner. On 9/4/14 at 4:30 PM the Adminstrator, DON and Corporate Consultant were notified of the findings. Additional information provided did not resolve the concerns. On 9/8/14 the facility faxed 2 documents to the surveyor which documented: *5/22/13 Interdisciplinary Progress note: The Broda chair had been placed for positioning and comfort. An assessment of the chair at placement and when the resident had declined was not provided. *4/29/14 Podiatry Care Center Note: Assessment documented the resident had a diagnosis of peripheral neuropathy and peripheral vascular disease. The resident had a decline in ADL's with new diagnoses that placed her feet and heels at risk for breakdown. New interventions to protect the resident's feet and heels were not implemented until after the resident had developed the left heel pressure sore on 6/16/14. The additional information provided by the facility did not resolve the	F 314		

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F 314	Continued From page 78 concerns. 2. Resident #2 was admitted to the facility on 5/13/14 with multiple diagnoses which included paraplegia, stage III pressure ulcers to both heels, blisters to the top of his feet, and cellulitis. a. Development of an SDTI: A 5/13/14 Braden Scale for Predicting Pressure Sore Risk (Braden) scored a 13, indicating the resident was at high risk of developing pressure ulcers. On 5/13/14, Resident #2's Discharge Instructions from the acute care hospital documented, "...Keep your leg elevated at the level of your heart while you are sitting" and contained a diagram for positioning of a person in a hospital-type bed, with the head and feet elevated and heels floated on pillows, with a dip in elevation at the person's mid-section. As diagramed, the person's feet were pictured as level with the person's heart, and the bulk of body weight on the person's buttock area. A 5/14/14 nurse's progress note (PN) for Resident #2 documented the resident was admitted with stage III pressure ulcers to both heels. The resident was documented to have no deep tissue injuries or other pressure ulcers. On 5/14/14, Resident #2's care plan documented pressure ulcer interventions of offloading boots, heels floated on pillows while in bed, an air bed, assistance with turning and repositioning every 2 hours, and observing skin each shift for skin breakdown. Although the resident was paraplegic and had already developed pressure ulcers on	F 314		

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F 314	Continued From page 79 each heel, the care plan did not include special considerations to protect the resident's skin to his coccyx, either when in bed or in the wheelchair, and did not include repositioning more frequently than once every 2 hours or identify how he could be repositioned in the bed if the bed was positioned as identified in the 5/13/14 Discharge Instructions. The care plan did not specify whether the resident's wheelchair had any kind of a pressure relieving cushion. A 5/20/14 Braden scored deteriorated 11, indicating increased risk for pressure ulcer development since the time of admission, with a decline in the resident's mobility and an increase in the moisture on his skin noted. Resident #2's 5/20/14 admission MDS assessment coded: *Two stage III pressure ulcers were present on admission, with no other pressure ulcers present. No deep tissue injuries were coded. *BIMS of 11, indicating moderately impaired cognition; *Extensive assist of 2 for bed mobility, transfers, dressing, personal hygiene, and bathing; and *Did not ambulate and needed extensive assistance of 1 for wheelchair mobility. On 5/27/14, Resident #2's care plan documented a new focus area related to impaired memory, judgment, and decision making. One intervention documented, "Provide cueing & prompting to ensure resident makes attempts at own care before offering assistance." On 5/28/14, a progress note from the infectious disease clinic documented, "Elevate legs above heart [for four hours] mid day every day."	F 314		

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F 314	Continued From page 80	F 314		

On 6/10/14 at 6:30 PM, a Change of Condition Documentation form for Resident #2 documented, "Noted open area to lower back above sacrum. Area measures 3 cm X 1.5 cm X 0 cm. Wound covered with macerated tissue [with] 2 [small] areas open that reveal pink moist wound base. [No] drainage, [no] odor [no complaints of] pain. Suspect wound origin from perspiring when [up] in [wheelchair with] back against [wheelchair] padding..."

On 6/11/14 at 5:00 PM, Resident #2's PNs documented, "[Patient] noted to have SDTI to coccyx [with] denuded skin...educated [patient] to turn and reposition [every 2 hours] while in bed and to offload [every hour] while in [wheelchair]. Voiced understanding of education. Cont[inue with] current [plan of care]." NOTE: There is no evidence that the coccyx wound identified here is a different one than is described as a sacrum wound the previous day.

On 6/11/14, Resident #2's care plan was updated to include encouraging the resident to change positions every hour while in his wheelchair as a result of the development of the SDTI. No other new positioning interventions were added to direct staff to assist the resident with repositioning in his wheelchair, to reposition the resident more frequently in his bed, or how to protect both his heels and his coccyx from further damage from skin breakdown. There was no documentation as to whether or not the facility had ensured the resident had a pressure relieving cushion in his wheelchair, even with the development of the SDTI.

Resident #2's Skin Integrity Reports for his

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F 314	Continued From page 81 coccyx documented: *6/11/14 & 6/17/14, SDTI 2 cm long X 2 cm wide, unable to determine depth, intact and deep purple. *6/24/14, SDTI 2 cm X 2.5 cm (0.5 cm wider than the previous week), unable to determine depth, 100 percent epithelial tissue. Please see example b. below regarding missed treatments for the SDTI to Resident #2's coccyx. The RAI manual for MDS version 3.0, section M Skin Conditions, documented, "...A pressure ulcer with intact skin that is a suspected deep tissue injury should....be coded as unstageable..."	F 314		
	On 9/3/14 at 2:30 PM, the RNC stated it was her understanding the resident could move himself "pretty well," and it may have been possible for him to follow the command to reposition himself. The RNC was not sure how the facility was assuring the resident did not create additional shearing on his coccyx when repositioning himself, but would have facility staff research the matter. The RNC was unable to explain how direct care staff would know when, how, and how much to help the resident with repositioning, given the care plan put in place on 5/14/14 and the update on 5/27/14. On 9/4/14 at 8:15 AM, the DNS and WN stated the interventions in place prior to the development of the SDTI were an air mattress and positioning every 2 hours. They were unable to explain the care plan update from 5/27/14, in light of the resident's MDS assessment, although the WN stated, "He could do quite a bit for himself. I think cueing him was appropriate." The WN stated when she first assessed the area to			

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F 314	Continued From page 82 the resident's coccyx on 6/11/14, she determined it was an SDTI with excoriation. The WN stated since the resident liked to spend a great deal of time in his wheelchair, and had doctor's appointments outside the facility where no one was available to help him reposition, she felt educating the resident on repositioning was appropriate. No explanation was offered as to why the staff would not have been directed to help the resident to reposition more frequently when he was in the facility, or why, if the resident needed help to reposition while out for a doctor's appointment, the facility did not ensure an appropriately trained person was sent with the resident to ensure his safety. The WN did not know why the facility had not identified the resident was at risk for skin breakdown on his coccyx, but thought an air mattress and repositioning every two hours would have been sufficient interventions even if that assessment had been made. Resident #2 was harmed when the facility failed to identify a resident at high risk for skin breakdown, who had already developed pressure ulcers, needed additional interventions to prevent development of further pressure ulcers. The facility did not implement care plans to provide relief to his coccyx while the resident was in his wheelchair, and to relieve added pressure to his coccyx caused by the positioning required to protect the wounds to his heels. Additionally, even though the facility had assessed the resident required extensive assistance of 2 for bed mobility and extensive assistance of 1 for wheelchair mobility, his care plan was updated to direct staff not to assist the resident unless he had first attempted to care for himself. These failures culminated in the resident developing an	F 314		

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F 314	Continued From page 83 unstageable SDTI to his coccyx, which then grew in size prior to his discharge. On 9/4/14 at 4:30 PM, the Administrator, DNS, RVP, and RNC were informed of these findings. The facility offered no further information, b. Treatments not done: Resident #2's TAR for May 2014 documented the following treatments not administered: *Cleanse and treat the wound to the left heel, ordered twice daily. Day shift 5/18/14. Night shift 5/18/14 and 5/20/14. *Cleanse and treat wound to right heel, ordered twice daily. Day shift 5/17/14 and 5/18/14. Night shift 5/17/14, 5/18/14, and 5/20/14. *Monitor opened blister to top of right foot, ordered twice daily. Night shift 5/27/14. *Cleanse and treat opened blister to top of right foot, ordered daily, 5/28/14. *Offloading boots to both feet, to be checked twice daily. Night shift 5/13/14 and 5/22/14. Day shift 5/14/14. Resident #2's TAR for June 2014 documented the following treatments not administered: *Change dressing to heels daily. 6/6/14, 6/16/14, 6/24/14. and 6/26/14. *Float heels with pillows, to be checked twice daily. Day shift 6/16/14 and 6/26/14. Night shift 6/1/14, 6/7/14, 6/9/14, 6/19/14, 6/22/14, 6/23/14, 6/25/14, and 6/26/14. *Monitor opened blister to top of right foot, ordered twice daily. Day shift 6/14/14 and 6/25/14. Night shift 6/1/14, 6/7/14 - 6/9/14, 6/14/14, 6/17/14, 6/19/14, and 6/25/14. *Offloading boots to both heels, to be checked twice daily. Day shift 6/14/14, 6/16/14, and	F 314		

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F 314	Continued From page 84 6/23/14. Night shift 6/7/14 - 6/9/14, 6/14/14, 6/18/14, 6/19/14, and 6/26/14. *Apply skin prep to area surrounding SDTI, cover with foam daily. 6/13/14 - 6/17/14, and 6/26/14. *Monitor SDTI, ordered twice daily. Day shift 6/13/14, 6/16/14, 6/22/14, and 6/26/14. Night shift 6/12/14, 6/14/14, 6/18/14, 6/19/14, 6/22/14, 6/25/14, and 6/26/14. *Ensure resident is offloading every hour while in wheelchair, to be confirmed twice daily. Day shift 6/13/14, 6/16/14, and 6/26/14. Night shift 6/11/14, 6/12/14, 6/14/14, 6/22/14, 6/25/14, and 6/26/14. On 9/3/14 at 2:30 PM, the RNC stated, "There's nothing I can say. It's not there." On 9/4/14 at 4:30 PM, the Administrator, DNS, RVP, and RNC were informed of the surveyor's findings. The facility offered no further information.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it		Compliance date F315 D Residents effected 1: Resident #1 was discharged from the center on 9/22/14.	10/~~15~~ ~~17~~/14 Chg per facility request M 10/27/14 Chg per facility request M

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F 315	Continued From page 85 was determined the facility failed to ensure residents who were incontinent of urine were thoroughly assessed prior to discontinuing their toileting program. This was true for 1 of 6 sampled residents (#1). Failure to assess voiding patterns placed Resident #1 at risk for skin breakdown, further decline of urinary function, and urinary tract infections. Findings included: Resident #1 was admitted to the facility on 7/10/14 with diagnoses which included muscular wasting, hip fracture, type II diabetes, and neuralgia. The resident's admission 7/11/14 Bladder Incontinence Evaluation (72 hour voiding diary) documented the resident was incontinent twice on 7/13/14 and 3 times on 7/14/14. The diary had nothing documented for 7/12/14 and 7/13/14 from 7:00 a.m. through 2:00 p.m. The resident's 7/13/14 ADL record documented the resident was incontinent twice between 3:00-11:00 p.m. The diary documented the only incident of incontinence was at 9:00 p.m. The diary for 7/14/14 documented the resident was incontinent at 8:00 p.m., however, the ADL record documented 3 incidents of incontinence between 3:00-11:00 p.m. The voiding diary included areas to document the reason for the assessment, type of incontinence, type of care plan (bladder retraining, prompted voiding etc.), and the interventions to be implemented. All of the areas were blank. The resident's 7/14/14 (revised 8/18/14) Care Plan (CP) identified urinary incontinence related to medications and impaired mobility. The initial	F 315	Other residents Residents with incontinence will be reviewed to ensure that bladder assessment is current and toileting plan is indicated for assessment. Residents care plans and care cards will be updated by DON or designee on or before 10/14/14. System Change Nursing staff will be re-educated by the nurse practice educator on bladder assessments proper documentation, ensure completion and documentation per direction on form/policy and development of individualized toileting plans on or before 10/14/14. Review Beginning the week of 10/15/14, 5 residents with incontinence will be audited by the Director of Nursing or designee to ensure that bladder assessments and toileting plans are completed and care plans and care cards reflect resident plan. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be compiled by the Director of Nursing	

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	135125		C 09/04/2014

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F 315	Continued From page 86 goal was for continence to be maintained, but on 8/18/14 that was revised to "clean and dry." The interventions were: 7/14/14 -Keep bedpan/urinal in easy reach - discontinued 8/18/14 7/14/14 - Offer to assist to toilet before/after meals and prior to activities 7/14/14 - Peri care after incontinence 7/14/14 - Observe for symptoms urinary tract infection 8/18/14 - Check and change 8/18/14 - Briefs for incontinence protection On 9/3/14 at 9:40 a.m. LN#7 stated Resident #1 was continent and could "tell" when he needed to use the toilet. CNA #8 stated the resident was dependent on staff and sometimes used his call light. The CNA stated the resident would sometimes "go" if toileted. On 9/3/14 at 1:50 p.m., the DON stated the voiding assessment was incomplete and that staff should have documented the type of incontinence and interventions identified. When asked if another bladder assessment had been completed for the CP revision on 8/18/14, the DON stated she would check. On 9/5/14 the DON stated the ADL documentation initiated the 8/18/14 revision to the CP but did not explain why the initial Bladder Assessment documentation conflicted with the 7/14 ADL information. When asked why another assessment was not completed prior to the revision to ensure accuracy, the DON again stated the ADL information was used. When informed that a nurse and a CNA had stated the resident was often aware when he needed to be toileted, the DON provided no further information.	F 315	and reported to the QA/PI committee for review and remedial intervention monthly X3 months or until resolved. The Director of Nursing is responsible for monitoring and follow-up.	

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F 328	Continued From page 87		Compliance date	10/~~15~~/14 17
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.		F 328 D Residents effected Resident #2 was discharged from Meridian Center on 06/27/2014. Other Residents Residents with ordered CPAP and/or oxygen will be reviewed by DON or designee on or before 10/14/14 to ensure that orders, indication for use, parameters, and equipment is in place at the bedside, is clean and is in working order. If resident refusal is noted, resident will be assessed and MD notified of findings as indicated. A review of provider orders for the last 30 days will be reviewed by DON or designee on 10/14/14 to ensure that any discontinued oxygen or CPAP was completed with adequate justification and assessment of resident. Findings will be reported to MD as indicated.	Chg per facility request 10/14/14 10/22/14 Chg per facility request 10/31/14
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure resident CPAP machines and oxygen were used per physician's orders. This was true for 1 of 6 residents (#2) sampled for respiratory care. The deficient practice had the potential to cause harm if the resident experienced respiratory distress when treatments were not administered as ordered. Findings included: Resident #2 was admitted to the facility on 5/13/14, with multiple diagnoses including a history of an anoxic brain injury. On 5/13/14 Resident #2's transfer orders from the acute care hospital documented, "[Oxygen] delivery device details: CPAP-auto-titrating with 2 [liters] oxygen. Durable Medical Equipment - Discharge: CPAP..." Resident #2's May 2014 TAR contained an area			

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F 328	Continued From page 88 to document the use of the CPAP as ordered. The CPAP was documented as not administered on 5/14/14, 5/15/14, 5/19/14 - 5/21/14, and 5/26/14. The TAR was blank on 5/18/14 and 5/22/14 - 5/25/14. On 5/15/14 Resident #2's care plan documented, "[Resident #2] chooses not to use CPAP." There was no documentation as to how the facility arrived at the conclusion this was the resident's choice, or that the resident or his family had been educated as to the potential risks and benefits of making this choice. Resident #2's 5/20/14 admission MDS assessment documented the resident did not receive oxygen or CPAP therapy, either prior to or since admission to the facility. On 5/23/14, Resident #2's Social History and Initial Assessment form documented, "CPAP machine is at home. He has been without it. Patient acknowledges family can bring in CPAP machine and was encouraged to bring it in." There was no documentation as to who had "encouraged" the resident's family to bring in the CPAP machine. There was no documentation the facility attempted to provide a machine for the resident, in light of the fact there were barriers to obtaining his own machine from home. On 5/26/14, the facility faxed the physician requesting, "Currently has order for CPAP [with 2 liters of oxygen]. States that his machine is at home and seems to be doing well without it, Can we [discontinue] his CPAP order." The physician responded, "yes," and signed the order on 5/28/14. There was no documentation from the	F 328	Systemic Change Licensed nurses will be re-educated by the nurse educator on or before 10/14/14 related to indications for CPAP, the process for obtaining machines including contacting the family and following up with an alternate agency and physician if arrangements cannot be made within 24 hours, following physicians orders for CPAP and oxygen administration and discontinuation with appropriate indication. Including proper assessment of resident in absence of unit or resident refusals. Review Beginning the week of 10/15/14 a Review of 3 residents who require CPAP will be completed by the Director of Nursing or designee to ensure that physician orders for administration are followed, and machine was obtained and implemented timely is at the bedside clean and functioning. A review of 5 residents with oxygen orders will be reviewed by the Director of Nursing or designee to ensure that oxygen is administered per MD order, and that it has been implemented timely. The results of these audits will be compiled by the Director of Nursing	

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F 328	Continued From page 89 facility as to how they had assessed the resident "seemed" to be doing well without the machine, i.e., no oxygen saturations or respirations documented while he was sleeping, no monitoring of how frequently he wakened or how much he slept during daytime hours. There was no documentation regarding the resident's history of using the CPAP, such as how long he had been using it, what his symptoms were that prompted its use, and whether or not the resident would like the physician contacted to discontinue the use of the machine. There was no documentation the facility had contacted the resident's father at this time to request the machine be brought in, or documentation the resident's father was informed the machine had been discontinued.	F 328	and reported to the QA/PI committee for review and remedial intervention monthly X3 months or until resolved. The Director of Nursing is responsible for monitoring and follow-up.	
	On 6/12/14 at 9:30 PM, Resident #2's nurse's progress notes (PNs) documented, "...Father set up [CPAP] for [patient without oxygen]. [Patient] stated he used 3 liters [of oxygen]. [Physician] asked for order of [oxygen]." A corresponding fax documented, "[Patient] states he uses [illegible] to 3 [liters oxygen] per [CPAP]. No [oxygen] ordered." The physician's response was documented as, "[Oxygen 3 liters per minute] to keep [saturations above 90 percent]." The order did not include orders for the resident to use his CPAP machine, only to have oxygen. When transposed onto the resident's TAR, the facility was documenting the use of oxygen only on the day and evening shift, but not on night shift when a CPAP machine would typically be used. The facility was not documenting what the resident's oxygen saturations were on room air, nor after the oxygen was started. Therefore, it was not possible to tell when the resident required the oxygen as stipulated in the physician's order, nor			

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F 328	Continued From page 90 whether the amount of oxygen was effective when used. On 9/4/14 at 8:15 AM, the DNS stated in general, if a resident was admitted with orders for a CPAP machine, the facility would expect the resident would bring their own machine from home. Regarding Resident #2, the DNS stated she recalled the nurse managers trying to contact the resident's father to bring in the machine, but did not know the outcome of those requests. The DNS stated these conversations were not something which would typically be documented in the resident's record. The DNS stated in a case where the facility could not obtain a resident's own machine, they did have an arrangement with a local durable medical equipment company so the facility could provide one if needed. The DNS stated there was no specific time frame for the facility to take these actions, as, "It would just depend on the patient's situation." On 9/4/14 at 4:30 PM, the Administrator, DNS, RVP, and RNC were informed of these findings. The facility offered no futher information.	F 328	Compliance date 10/15/14 ~~11~~ chg per facility request 10/14/14 F329 D Residents affected 1: Resident #1 was discharged from the center on 9/22/14. 10/22/14 Other residents A review of residents with antidepressant therapy will be completed by social worker on or before 10/14/14 to ensure that antidepressant therapy is indicated, that target behaviors are included on the behavior monitor, that side effects of medication are monitored. chg per facility request 10/30/14 M A review of care plans for residents with depression will be reviewed by the director of nursing or designee and licensed social on or before 10/14/14 to ensure that care plan problems, interventions, and goals are clarified to include resident identified risk factors, and clarifications including definitions for isolation, current health	
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.			

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F 329	Continued From page 91 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	status, family involvement, and instructions for hearing aid use as indicated. Monitoring Beginning the week of 10/15/14 an audit of 5 residents with depression will be completed by the Director of Nursing or designee to ensure that statements of wanting to die are followed up on and that there are indications for use for antidepressant including behavior monitoring, and side effect monitoring, and that care plans are updated, complete, and have clear instructions for staff. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be compiled by the Director of Nursing and the results will be reported to the QA/PI committee for review and remedial intervention monthly X3 months. The Director of Nursing is responsible for monitoring and follow-up.	
	This REQUIREMENT is not met as evidenced by: Based on staff interview and record review it, was determined the facility failed to identify specific indications for use, and target behaviors prior to administering an anti-depressant medication. This was true for 1 of 3 (#1) residents reviewed for medication use. This failed practice had the potential to cause harm if the resident experienced side effects of migraine headaches, insomnia and/or suicidal behavior from the use of an unnecessary antidepressant. Findings included: Resident #1 was admitted to the facility on 7/10/14 with diagnoses which included muscular wasting, hip fracture, type II diabetes, and neuralgia. The resident's 9/14 recapitulation Physician Orders included an order for Escitalopram Oxalate (antidepressant) 10 mg daily with a start date of 8/26/14.			

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F 329	Continued From page 92 An 8/21/14 "Daily Therapy Note" documented the therapist had informed the unit manager the resident stated he "just wants to go to the grave." An 8/26/14 "Nursing Home Visit" from the physician documented the resident stated he did not want to be at the facility and "is wondering if there is anyone around [who] would be willing to euthanize him." The resident's 8/26/14 Care Plan (CP) with documented behaviors of sadness/depression as exhibited by isolation and tearfulness "related to current health status." The CP did not define isolation, such as staying in bed, not participating in activities, or refusing to go to the dining room etc. Additionally, the care plan did not include any definition of "current health status," such as frequent-or fear of frequent pain, unable to be independent in self-care or fear of not being able to return to home. The CP did not address the resident's verbalizations of wanting to die. Identified CP interventions included: Administer medication, encourage family involvement and encourage verbalization of feelings. All interventions were dated 8/26/14. The interventions did not include a definition for family involvement. Social Service was identified as being responsible for encouraging family to be involved however the CPt did not include whether "involved" meant eating meals with the resident, participating in activities, bringing familiar items from home, etc. Additionally, social services and nursing were to encourage the resident to verbalize his feelings. The resident was hard of	F 329		

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F 329	Continued From page 93 hearing and there was no instructions on how to encourage (such as ensure hearing aide in, speak directly in ear, etc.) or if staff were to redirect, validate or reassure when the resident verbalized feelings of sadness. The resident's medical record included 2, undated, "Behavior Monitoring and Intervention" (BMI) forms-one for tearfulness and another for statements of wanting to die and/or self isolation, which were handwritten on the forms as behavior symptoms. The BMIs did not document any behaviors for the month. On 9/4/14 at 10:45 a.m., Social Worker #2 (SW#2) was asked if the resident's behavior for depression had been monitored prior to the antidepressant being administered. SW#2 stated the resident had been assessed on 8/27/14 as having minimal depression [indicating depression was not present]. SW#2 stated she had not been informed of the resident stating he wanted to be euthanized on 8/26/14, but she would have asked additional questions regarding suicide if she had been aware. SW#2 stated she thought the physician must have ordered the antidepressant after the visit when the resident asked about being euthanized. SW#2 stated she had not been told the resident had made statements of wanting to die. She stated nursing was responsible for the BMIs and they must have been initiated 9/14 as none were found for 8/14 (medication ordered 8/26/14). SW#2 stated the CP should have addressed statements of wanting to die and identified specific interventions to address the depression. On 9/4/14 at 4:15 p.m., the Administrator, DON	F 329		

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F 329	Continued From page 94 and Regional Consultant were informed of the above concern. The facility provided no further information.		Compliance date 10/~~15~~/14 17 Change per facility request 10/14/14 KR	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and		F441 D Residents affected 1: Resident #3 was discharged from the center on 05/25/2014. Resident #4 was discharged from the center on 05/30/14. CNA #3 was re-educated on 09/05/14 by nurse educator related to infection control measures when completing peri-care. CNA #3 had a competency for peri-care completed on 09/04/14 by Nurse Educator. A review of in house residents with CDiff or requiring isolation precautions was made by DON or designee on or before 10/14/14 to ensure that isolation precautions were implemented per policy. No concerns identified. System change Nursing staff will be re-educated on infection control measures including hand washing and glove changes with	10/30/14 Chg per facility request 10/30/14 KR

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F 441	Continued From page 95 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview it was determined the facility failed to ensure adequate handwashing and failed to institute isolation precautions in the provision of care for a resident with infectious diarrhea. This was true for 2 of 2 sampled residents (# 3 & 4). This practice placed residents at risk for infections or the spread of infections. Findings included: 1. On 9/4/14 at 10:40 AM, the surveyor observed CNA #3 and CNA #5 provide peri care to resident #3. Both CNA's put gloves on and assisted to pull down the resident's pants and remove the incontinence brief. The resident was incontinent of bowel and bladder. CNA #3 performed pericare by wiping the front of the resident first then the buttocks, cleaning the stool from the area. The resident had a dressing on the right buttocks. With the soiled gloves the CNA lifted the loose dressing and applied Calamazine to the wound and the buttocks. The surveyor asked CNA #3 if she had changed her gloves and the CNA stated, "No," and continued to perform cares for the resident with the soiled gloves. CNA #3 assisted to pull up the resident's pants, position the resident on her side, and position pillows to support the resident. CNA #3 then removed the soiled gloves. On 9/4/14 at 4:30 PM, the Administrator, DON and Corporate Consultant were notified of the	F 441	peri-care and the indications and process for implementing isolation precautions on or before 10/14/14 by nurse educator. Competencies for peri-care will be completed for CNA staff by nurse educator on or before 10/14/14. Observations of CNA's providing care will be completed by DON or designee on or before 10/14/14 to ensure hand washing performed as indicated and proper infection control practices are being used. Review Beginning the week of 10/15/14 observations of 5 CNA's completing peri-care will be completed by the Director of Nursing or designee to ensure that infection control measures are followed to include handwashing. An audit of 5 residents on antibiotics will be completed by the Director of Nursing or designee to ensure that isolation precautions are implemented as indicated. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be compiled by the Director of Nursing or designee and	

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F 441	Continued From page 96 findings. No additional information was provided. 2. Resident #4 was admitted to the facility on 5/6/14 with multiple diagnoses to include aftercare healing traumatic fracture of the pelvis, End Stage Renal Disease (ESRD), and diarrhea. A facility fax dated 5/7/14 at 2:45 PM documented, "New Admit, noted to have loose, mucousy stool with foul odor." A physician's order dated 5/7/14 documented, "[Collect a] stool sample, for stool culture, O&P, and C. Diff. toxin tests." An IPN dated 5/8/14 at 5:00 PM documented, "Resident noted to have blood in toilet x 2 this day. MD notified possible hemorrhoids resident with multiple episodes of loose stool/diarrhea. Pending C. Diff. test. Lab results dated 5/13/14 documented, "...stool culture positive with, 'many Staphylococcus Aureus' present." There was no documented evidence the resident was placed on isolation precautions at the time of admit or after she was diagnosed with Staphylococcus Aureus in her stool. On 9/3/14 at 10:00 AM the DNS was asked if the resident had been placed on isolation precautions for the Staphylococcus Aureus. The DNS stated, "I don't know." When asked if the resident should have been placed on isolation upon admission based on her condition, the RNC stated it was the facility's policy to place a resident on isolation precautions based on the above information. The RNC stated she would have to review the	F 441	reported to the QA/PI committee for review and remedial intervention monthly X3 months or until resolved. The Director of Nursing is responsible for monitoring and follow-up.	

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	135125		C 09/04/2014

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F 441	Continued From page 97 resident's record. On 9/4/14 at 1:20 PM the RNC stated she was unable to provide documentation that the resident was placed on isolation related to the infectious diarrhea.		Compliance date F490 E 1: Resident #4 was discharged from the center on 05/30/2014. Resident #6 was assessed on 10/01/14 by administrator with no adverse effect to related to the notice of discharge. Resident #6's responsible party was notified of the withdrawal of the notice of discharge by the administrator. The resident's responsible party voiced no concerns and had no additional questions. LN#6 was educated by nurse educator on or before 10/14/14 related to the phone system. And the need for timely response to calls. Other residents 2: A resident council meeting will be held on or before 10/14/15 by the activities director to discuss staff	10/~~15~~17/14 Chg per facility request 10/14/14 DR 10/22/14 Chg per facility request 10/22/14 DR
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 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. This REQUIREMENT is not met as evidenced by: Based on observation, resident/family/staff interviews, and medical record review, it was determined the Administrator and management team failed to manage the facility to ensure the safety and well-being of each resident. This affected 2 of 6 (#'s 4 & 6) sampled residents and any resident in the facility whose family member or physician may attempt to contact them via telephone. This failed practice had the potential for harm if residents were discharged without documented reason and if outside medical providers attempted to contact the facility without response. 1. Resident #4's Dialysis Note dated 5/16/14 at 3:52 PM documented, "Call to care center about the abx [antibiotic] patient is on. LM [Left Message], no return call." Resident #4's Emergency Room note dated			

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F 490	Continued From page 98 5/30/14 at 5:26 PM documented, "We made several attempts to contact the nursing facility where she is staying, but no one would answer the phone. I do not have any further information available at this time." On 9/2/14 at 8:33 PM, LN #6 was asked about the facility's phone system. The LN stated the phone system is automated and after hours if no selection is made it rings to the Long Term Care nurses station. Nurses usually answer the phone then transfer the call to wherever it needs to go. He identified at peak times (meals, after meals etc.) staff is too busy to answer the phone. The automated system offers the caller the option to leave a message. The survey team asked the LN if the nurses can listen to a message if one is left. The LN stated he had never had anyone leave a message. On 9/2/14 at 8:39 PM the following was observed: After approximately 15 rings from a phone at the nurse's station, a nurse was observed to walk past the nurse's station and ringing phone, and down the 200 hall where she asked another nurse to answer the phone. The phone rang 19 times before it was answered. On 9/2/14 at 8:45 PM the RNC was informed the phone at the nurse's station rang 19 times before it was answered. The RNC stated, "It shouldn't do that; it should go to the option to leave a message." The survey team asked what if a physician called. The RNC stated, "I guess they would just have to do what any of us would do, call back until someone answered." The RNC acknowledged that practice was not acceptable. 2: Resident #6 received a NOD from the facility on 8/15/14, which was signed by the facility's	F 490	timely phone response. The plan of correction for telephone response and system change will be explained. The resident's response will be documented. 3: Center staff was educated by the nurse educator on or before 10/14/14 on the phone system, including answering the phone in a timely manner. An employee will be hired by the administrator on or before 10/14/15 to answer the phones as a receptionist, as their main responsibility from 5pm to 9pm, Mondays through Fridays. Review Beginning the week of 10/15/14 an audit of the phone answering times will be completed on various shifts by the Administrator of designee to ensure that phones are answered in a timely manner to meet resident needs. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be compiled by the Administrator and reported to the QA/PI committee for review and remedial intervention monthly X3 months or until resolved.	

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F 490	Continued From page 99 Administrator. The NOD contained no documentation as to the reason the resident was being discharged. When interviewed on 9/3/14, the Administrator stated the NOD was issued due to resident behaviors. However, the facility did not involve social services, either in addressing behavioral changes prompting the NOD, nor in advocating for the resident once the NOD had been issued. Additionally, the facility did not involve the resident's physician before determining the resident could not be cared for in the facility. Please see F 201, F 202, and F 250 for details. On 9/4/14 at 4:30 PM, the Administrator, DNS, RVP, and RNC were informed of these findings. The facility offered no further information.	F 490	The Administrator is responsible for monitoring and follow-up. Compliance date 10/~~15~~ 14, 17 F514 E Residents affected 1: Resident #1 was discharged from the center on 09/22/2014 Resident #2 was discharged from the center on 06/27/2014 Resident #3 was discharged from the center on 05/25/2014 Resident #4 was discharged from the center on 05/30/2014 Resident #5's was assessment on 10/01/14 by RN with no negative affects related to lack of documentation of physician ordered interventions. Other residents 2: A review of residents who require physician ordered snacks will be completed by DON or designee on or before 10/14/14 to ensure that	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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. This REQUIREMENT is not met as evidenced			

Chg per facility request 10/14/14 M

10/30/14 Chg per facility request 10/30/14

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F 514	Continued From page 100 by: Based on record review and staff interview, it was determined the facility failed to accurately document information in residents' medical records. This was true for 5 of 6 residents sampled (#s 1, 2, 3, 4, & 5) for clinical records. This created the potential for medical decisions to be on based on inaccurate information. Findings included: 1. Resident #1 was admitted to the facility on 7/10/14 with diagnoses which included muscular wasting, hip fracture, type II diabetes, and neuralgia. a. Resident #1's 7/21/14 Care Plan for "Nutrition" had a goal was to not have a change in weight of 5% for 30 days or 10% in 180 days. Interventions included snacks 2 times a day with a start date of 8/28/14 and for the family to provide nutritional supplements with a start date of 9/2/14. An order for Health Shakes 3 times a day was signed by the physician on 7/25/14 and a TAR documented the supplement was started on 7/26/14. An order for Health Shakes was signed by the physician on 7/25/14. A FAX, dated 8/29/14, was sent by the dietitian stating the family was requesting to provide the nutritional shake. On 9/2/14 an order was signed for the family to provide the nutritional shake. A fax received by the BFS on 9/8/14 documented snacks were initiated on 7/21/14, not 8/28/14, and house supplements were initiated on 7/25/14, updated on 8/25/14 (not 9/2/14).	F 514	percentage of snacks intake is documented on the MAR. The MAR's were updated by DON or designee on 10/14/14 to reflect the intake percentage of snacks. DON or designee will conduct a review on or before 10/14/15 of all current residents MAR and TAR for the last 30 days to ensure all medications and treatments are documented. Review will include confirmation of accurate transcription of provider orders. A review of resident provider logs for the last 90 days will be completed by DON or designee on or before 10/14/14 to ensure that provider progress notes are available in the medical record. No additional concerns were identified. A review of discharged records for the last 30 days will be completed by DON or designee on or before 10/14/14 to ensure that there is no documentation entered post discharge, or omitted discharge notes. No other concerns were identified. A review of resident care plans will be completed by DON or designee on or before 10/14/14 to ensure that care	

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F 514	Continued From page 101 The Care Plan did not reflect the actual start dates of the Health Shakes or the snacks.	F 514	plan interventions include a date of implementation. Identified interventions were updated by DON or designee on 10/14/14 with the current date.	
	b. The resident's medical record included daily documentation of the percentage of the nutritional supplement consumed by the resident; however, there was no documentation regarding consumption of the snacks. On 9/3/14 at 11:30 a.m. the Dietitian stated the amount eaten of the snack was not documented; however, the CNA would write on the snack if it was refused and return the snack to the kitchen who documented the refusals. The surveyor stated because the snack was an intervention to address weight change the amount eaten (0% to 100%) needed to be documented to evaluate the effectiveness of the intervention. On 9/4/14 at 4:10 p.m. the Administrator, DON, Regional Nurse Consultant and Regional Dietary Consultant were informed of the above concern. A fax regarding weight loss was received by BFS on 9/8/14, however, documentation of the percentage of the snack was not included. c. Resident #1's 7/14/14 Interdisciplinary Progress Notes (IPN) documented a laboratory critical blood glucose level of 42, the resident felt he was going "crazy" and was hallucinating. A 7/20/14 IPN documented the family was concerned with the resident's "increased confusion" and the Physician Assistant (PA) was called. A "Physician Visit Log" documented a physician assistant (PA) saw the resident on 7/23/14. There		System change 3: A new dictation system will be implemented by the health information manager on or before 10/14/14 for a more efficient process for handling of physician progress notes. Licensed nurses will be re-educated by the nurse educator on or before 10/14/14 related to timely and complete documentation of medications, treatments, nutritional supplement administration in CC's and snack administration in percentages, TAR and MAR accuracy, discharge documentation requirements, and care plan documentation. Review Beginning the week of 10/15/14 an audit of 5 medical records will be completed by the medical records manager or designee to ensure that	

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F 514	Continued From page 102 were no physician progress notes in the resident's medical record for 7/23/14. On 9/4/114 at 1:00 p.m. the DON stated the PA had seen the resident on 7/23/14 but the physician notes were deleted and the only documentation was the visit log signed by the PA. 2. Resident #2's record documented blank spaces for physician ordered medications and treatments for May and June 2014: *Cleanse and dress wound to left heel, 5/18/14 and 5/20/14; *Cleanse and dress wound to right heel, 5/17/14, 5/18/14, and 5/20/14; *Monitor abrasion to bottom of right foot, 5/21/14, ~~6/7/14 - 6/9/14, 6/11/14, 6/13/14,~~ 6/14/14, 6/16/14, 6/19/14, and 6/23/14; *Mupirocin antibiotic ointment, 5/28/14; *Flush PICC line, 5/22/14, 6/4/14 - 6/9/14, 6/14/14, 6/16/14, 6/19/14, 6/22/14, 6/23/14, and 6/25/14 - 6/27/14; *Monitor PICC site before and after IV medications, 5/14/14, 5/20/14, 5/22/14, 6/1/14, 6/6/14 - 6/10/14, 6/12/14 - 6/14/14, 6/16/14, 6/22/14, 6/24/14, 6/26/14, or 6/27/14; *Ceftriaxone Sodium (IV Rocephin), 5/18/14 and 5/29/14; *House Dietary supplement, 5/17/14, 5/18/14, 5/24/14, 5/26/14, 5/29/14, 6/4/14 - 6/8/14, 6/11/14, and 6/12/14; *Monitor Abrasion to left foot, 5/22/14; *Monitor blister to top of right foot, 5/22/14; *Emollient lotion to skin, 5/28/14, 6/16/14, 6/24/14, and 6/26/14; *Output from foley catheter, 5/16/14 - 5/18/14, 5/20/14, 5/22/14 - 5/26/14, 5/29/14, and 5/30/14; *Daily skin checks, 5/29/14; *Cleanse opened blister to top of right foot,	F 514	medication and treatment administration documentation is complete, physician ordered snacks intake is documented, care plan interventions include dates for implementation of interventions, provider visits are included in the medical record findings brought to the DON for correction and follow up. Including MAR, TAR and physician orders. These audits will be completed weekly X4 weeks and then monthly X2 month. The results of these audits will be compiled by the Director of Nursing or designee and reported to the QA/PI meeting for review and remedial intervention monthly X3 months or until resolved. The Director of Nursing is responsible for monitoring and follow-up.	

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F 514	Continued From page 103 5/28/14, 6/5/14, 6/6/14, 6/8/14, 6/9/14, 6/14/14, and 6/16/14; *Monitor opened blister to top of right foot, 5/27/14, 6/1/14, 6/7/14 - 6/9/14, 6/14/14, 6/17/14, 6/19/14, and 6/25/14; *CPAP use, 5/18/14 and 5/22/14 - 5/25/14; *Float heels, 5/14/14, 5/20/14, 5/22/14, 6/1/14, 6/7/14, 6/9/14, 6/16/14, 6/19/14, 6/22/14, 6/23/14, and 6/25/14 - 6/27/14; *Foley Catheter care, 5/13/14, 5/20/14, 5/22/14, 6/1/14, 6/2/14, 6/6/14, 6/8/14 - 6/11/14, 6/14/14 - 6/16/14, 6/21/14 - 6/23/14, and 6/27/14; *Offloading boots, 5/13/14, 5/14/14, 5/22/14, 6/7/14 - 6/9/14, 6/14/14, 6/16/14, 6/18/14, 6/19/14, 6/23/14, 6/26/14, and 6/27/14; *Cleanse skin tear to scrotum, 5/26/14, 5/27/14 6/1/14, 6/7/14 - 6/9/14, 6/13/14, 6/14/14, 6/19/14, 6/20/14, 6/22/14, and 6/25/14 - 6/27/14; *Notify family for update on scrotal wound, 5/23/14; *Change dressing to left heel daily, 6/6/14, 6/16/14, 6/24/14, and 6/26/14; *Indwelling foley catheter present, 6/7/14 - 6/9/14, 6/22/14, 6/23/14, and 6/27/14; *Elevate legs above heart 4 hours per day, 6/24/14 and 6/26/14; *Elevate legs as much as possible, 6/14/14, 6/15/14, 6/17/14, 6/19/14, and 6/22/14 - 6/27/14; *Jock strap for scrotal support, 6/1/14, 6/7/14 - 6/9/14, 6/14/14, 6/19/14, 6/26/14, and 6/27/14; *Monitor skin tear to scrotum and abrasion to penis, 6/1/14, 6/2/14, 6/7/14, 6/8/14, 6/12/14, 6/14/14, 6/16/14, 6/17/14, 6/24/14, and 6/27/14; *Monitor abrasion to left foot second toe, 9/7/14 - 6/9/14, 6/14/14, 6/16/14, 6/23/14, and 6/26/14; *Cleanse abrasion to left calf, 6/24/14 - 6/26/14; *Cleanse wound to left heel, 6/24/14 - 6/26/14; *Apply skin prep to tissue surrounding SDTI to coccyx, 6/13/14 - 6/17/14, and 6/26/14;	F 514		

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F 514	Continued From page 104 *Monitor SDTI to coccyx, 6/12/14 - 6/14/14, 6/16/14, 6/18/14, 6/19/14, 6/22/14, and 6/25/14 - 6/27/14; *Ensure offloading every hour while in wheelchair, 6/11/14 - 6/14/14, 6/16/14, 6/22/14, and 6/25/14 - 6/27/14; and *Oxygen administration, 6/14/14 - 6/17/14, 6/22/14, 6/24/14, or 6/26/14. Additionally, even though the resident discharged from the facility on 6/27/14, several treatments were documented as completed on the night shift on 6/28/14, including cleansing the skin tear to the resident's scrotum, floating his heels, checking his foley catheter, elevating his legs, monitoring the abrasion to his toe, placing offloading boots, ensuring the resident was offloading while in his wheelchair, monitoring the SDTI to his coccyx, flushing his PICC line, and placing his jock strap. On 9/4/14 at 8:15 AM, the DNS stated she was confident the medications and treatments had either been provided and not documented, or refused by the resident. The DNS stated any time a medication or treatment was not given as ordered, it should be documented by the nurse's initials on the MAR or TAR with a circle around them, and an explanation written on the back of the document. The DNS was unable to explain how it could be determined what, specifically, had happened for the blank spaces on the resident's MAR or TAR without further explanation documented. The DNS could not explain why there was documentation on the resident's TAR for the day after he discharged. On 9/4/14 at 4:30 PM, the Administrator, DNS, RVP, and RNC were informed of these findings.	F 514		

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F 514	Continued From page 105 The facility offered no further information.	F 514		
	3. 4. Resident #5 was admitted to the facility on 10/1/01 with diagnoses of heart failure, hypertension, non-Alzheimer's Dementia, depression, muscular wasting & disuse atrophy, and chronic kidney disease (CKD). The resident's June 2014 TAR did not include the following physician ordered interventions documentation: *Pillow in between legs at all times to keep legs from crossing. Four times on night shift. Start Date 6/23/14. *Prevalon boots to bilateral feet at all times. Two times on night shift. Start date 6/16/14. The resident's July 2014 TAR did not include the following physician ordered intervention documentation: *Skin at risk: Check 2x weekly. Three times on day shift. Start date: 6/25/14. The resident's TAR for August 2014 did not include the following physician ordered interventions documentation: *Check placement and function of air mattress: One time on day shift. *Prevalon boots: One time on day shift. *Skin checks 2x weekly: Two times on day shift. *Monitor excoriation to right buttocks every shift: One time on day shift. *Ensure resident is turned every 1 hour: One time on day shift and one time on night shift. *Monitor SDTI (Suspected Deep Tissue Injury) to right buttock every shift: One time on day shift and one time on night shift.			

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F 514	Continued From page 106 The resident's September 2014 TAR did not include the following physician ordered interventions documentation, 9/1- 9/3/14: *Foot cradle: Two times on night shift. *Excoriation to right buttocks: Two times on night shift. *Monitor SDTI to right buttocks: Two times on night shift. *Nightly heel and coccyx check: Two times on night shift. *Pillow in between legs: One time on night shift. *Prevalon boots in place: Two times on night shift. *Check placement and function of air mattress: Two times on night shift. *Resident turned Q hour: Two times on night shift. 5. Resident # 3 was admitted to the facility on 5/10/14 with diagnoses that included atrial fibrillation, Coronary Artery Disease, Diabetes Mellitus (DM), and pneumonia. The resident's Recapitualtion of Resident's Stay documented: The resident was discharged on 5/21/14 with final summary of resident status completed by social services, nursing services, nutrition services, activites, and rehabilitation services. The resident signed the form on 5/21/14 and the physician signed the form on 6/4/14. An IDT LN note, dated 5/21/14 at 11:00 AM, documented the resident had been discharged to home this day and time, and the resident was assisted to the vehicle in good spirits. NOTE: A line had been crossed through the entire note and "error" was written beside the documentation; however, when interviewed on 9/4/14 at 11:35 AM, LSW #1 stated the resident	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135125		C 09/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER GENESIS HEALTHCARE	1351 WEST PINE AVENUE MERIDIAN, ID 83642

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F 514	Continued From page 107 had gone home on the 5/21 and had returned to the facility the same day. Refer to F250 for additional details. The next note was an IDT LN note, dated 5/21/14 at 9:30 PM, which documented the resident's vital signs and that the resident had been moved to a different room. On 9/4/14 at 4:30 PM, the Administrator, DON, and Corporate Consultant were notified of the findings. No additional information was provided.	F 514		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MDS001850		C 09/04/2014

NAME OF PROVIDER OR SUPPLIER: MERIDIAN CENTER GENESIS HEALTHCARE

STREET ADDRESS, CITY, STATE, ZIP CODE: 1351 WEST PINE AVENUE, MERIDIAN, ID 83642

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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 a complaint survey of your facility. The survey team included: Amy Barkley, RN, BSN, Team Coordinator Sherri Case, QMRP, LSW Susan Gollobit, RN Nina Sanderson, LSW The survey team entered the facility on 9/2/14 and exited the facility on 9/4/14.	C 000		
C 105	02.100,02 ADMINISTRATOR 02. Administrator. The governing body, owner or partnership shall appoint a licensed nursing home administrator for each facility who shall be responsible and accountable for carrying out the policies determined by the governing body. In combined hospital and nursing home facilities, the administrator may serve both the hospital and nursing home provided he is currently licensed as a nursing home administrator. This Rule is not met as evidenced by: Refer to F490 as it relates to administration of the facility.	C 105	Refer to F490 in the 2567 document RECEIVED OCT - 2 2014 FACILITY STANDARDS	
C 120	02.100,03,c,iv Appropriate Cause for Transfer/Discharge	C 120	Refer F201, 202 in the 2567 document	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Richard Administrator TITLE (X6) DATE 10/1/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER: MERIDIAN CENTER GENESIS HEALTHCARE

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C 120	Continued From page 1 iv. Is transferred or discharged only for medical reasons, or for his welfare or that of other patients/ residents, or for nonpayment for his stay (except as prohibited by Titles XVIII or XIX of the Social Security Act), and is given reasonable advance notice to ensure orderly transfer or discharge, and such actions are documented in his medical record; This Rule is not met as evidenced by: Please see F 201 and F 202 as they pertain to involuntary Notice of Discharge.	C 120		
C 155	02.100,08 NOTIFICATION OF CHGE PTNT/RSDNT STATUS 08. Notification of Change in Patient/Resident Status. There shall be written policies and procedures relating to notification of next of kin, or sponsor, in the event of a significant change in a patient's/resident's status. This Rule is not met as evidenced by: Please see F157 as it pertains to family notification of change in the resident's condition..	C 155	Refer to F157 in the 2567 document	
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: Please see F 225 as it pertains to incident investigations.	C 175	Refer to F225 in the 2567 document	

Bureau of Facility Standards

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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 facility cleanliness.	C 361	Refer to F252 in the 2567 document	
C 669	02.150,03 PATIENT/RESIDENT PROTECTION 03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Refer to F441 as it relates to infection control.	C 669	Refer to F441 in the 2567 document	
C 696	02.152 SOCIAL SERVICES 152. SOCIAL SERVICES. The facility shall provide for the identification of the social and emotional needs of the patients/residents either directly or through arrangements with an outside resource and shall provide means to meet the needs identified. The program shall be accomplished by: This Rule is not met as evidenced by: Please see F 250 as it pertains to the provision of social services.	C 696	Refer to F250 in the 2567 document	

Bureau of Facility Standards

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C 784	Continued From page 3	C 784		
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Refer to F309 and F328 as they relate to the provision of resident care.	C 784	Refer F309,328 in the 2567 document	
C 785	02.200,03,b,i Grooming Needs i. Good grooming and cleanliness of body, skin, nails, hair, eyes, ears, and face, including the removal or shaving of hair in accordance with patient/resident wishes or as necessitated to prevent infection; This Rule is not met as evidenced by: Please see F 311 as it pertains to resident bathing.	C 785	Refer to F311 in the 2567 document	
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F329 as it relates to medication.	C 788	Refer to F329 in the 2567 document	
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers	C 789	Refer to F314 in the 2567 document	

Bureau of Facility Standards

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C 789	Continued From page 4 or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 as it relates to pressure ulcer prevention.	C 789		
C 795	02.200,03,b,xi Bowel/Bladder Evacuation/Retraining xi. Bowel and bladder evacuation and bowel and bladder retraining programs as indicated; This Rule is not met as evidenced by: Refer to F315 as it related to incontinence.	C 795	Refer to F315 in the 2567 document	
C 879	02.203 PATIENT/RESIDENT RECORDS 203. PATIENT/RESIDENT RECORDS. The facility maintains medical records for all patients/residents in accordance with accepted professional standards and practices. This Rule is not met as evidenced by: Refer to F 514 as it related to medical records.	C 879	Refer to F514 in the 2567 document	
C 903	02.203,05 CONFIDENTIALITY 05. Confidentiality. The facility shall safeguard medical record information against loss, destruction, and unauthorized use. This Rule is not met as evidenced by: Refer to F164 as it related to confidentiality of records.	C 903	Refer to F164 in the 2567 document	

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER

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STREET ADDRESS, CITY, STATE, ZIP CODE

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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
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PHONE 208-334-6626
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November 3, 2014

FILE COPY

Richard M. Ord, Administrator
Meridian Center Genesis Healthcare
1351 West Pine Avenue
Meridian, ID 83642-5031

Provider #: 135125

Dear Mr. Ord:

On **September 4, 2014**, a Complaint Investigation survey was conducted at Meridian Center Genesis Healthcare. Sherri Case, L.S.W., Q.I.D.P., Nina Sanderson, L.S.W., Amy Barkley, R.N., Susan Gollobit, R.N. and Linda Hukill-Neil, R.N. conducted the complaint investigation.

The following information was reviewed in the context of the complaint investigation as a whole:

- The record of the identified resident as well as five other residents.

  For the identified resident; the physician's progress notes, physician's orders, nurses' progress notes, physical and occupational therapy's notes, social services' progress notes, medication and treatment administration records, nurse aide's flow sheets, Minimum Data Set assessment, care plan, wound tracking forms and pressure ulcer risk assessments were reviewed;

- Observations of the physical environment of the facility;
- Staff, residents, family and resident group interviews;
- Resident council meeting minutes;
- Facility's grievance file;
- Staffing records;

- Facility's policies and procedures regarding bathing, family notifications, grievances, respiratory care, discharge planning and wound management;
- Facility's incident reports;
- Observations of the care in the facility during the day and into the evening as residents were getting ready for bed; and
- Records of the visits from the residents' physicians.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006513

ALLEGATION #1:

The complainant stated an identified resident was not having his/her clothing changed at night.

FINDINGS #1:

The identified resident had discharged from the facility prior to the survey being conducted.

Residents were asked at the resident group interview if they received a choice in their sleeping attire. The group unanimously stated they did. The group was asked if they received timely assistance to change from their day clothes into their preferred sleeping attire. Again, the group unanimously stated they did.

Individual residents interviewed stated they were offered a choice of sleeping attire and assistance to change into that attire.

Observations were conducted in the facility, as many residents were getting ready for bed. The residents were being offered a choice of sleeping attire and assistance to change into that attire.

Evening shift nurses and nurse aides were interviewed regarding the facility's process for determining sleepwear for the residents. Staff interviewed reported residents chose their own sleepwear and received assistance from staff to change if needed. Staff stated the only circumstance that may result in a resident sleeping in their street clothes would be if the resident chose to do so.

The identified resident's record documented he received assistance with dressing daily during the day and evening shift.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the identified resident did not receive regular baths while in the facility.

FINDINGS #2:

The identified resident's record documented two gaps in his bathing schedule, one for eight days and another for six days.

This allegation was substantiated and cited at F311.

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

ALLEGATION #3:

The complainant stated an identified resident had sores on both heels.

FINDINGS #3:

The identified resident's record documented pressure ulcers on both heels at the time of admission to the facility; however, the treatments as ordered by the resident's physician were not documented consistently as being completed. Additionally, the resident developed a pressure-related injury to his/her coccyx while residing in the facility.

Discrepancies with wound development and care for another resident were discovered as well.

This allegation was substantiated and cited at F314.

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

ALLEGATION #4:

The complainant stated an identified resident developed a sore on his scrotum while in the facility, which grew in size. The complainant also stated the resident's responsible party was not notified of the status of the injury.

FINDINGS #4:

The identified resident's record documented two questionable injuries to the resident's genital area. The facility did not thoroughly investigate the timing of when these injuries developed, nor the exact cause of the injuries.

The facility documented the resident's responsible party was notified that the resident was being sent to the emergency room for evaluation for one of the injuries; but, there was no documentation from the facility that any further updates were provided. In addition, at least one of the injuries was still present and required daily dressing changes when the resident was discharged from the facility into the care of the responsible party.

The facility did not document the responsible party was informed of the status of the injury at the time of discharge, demonstrate the responsible party had been trained to perform the necessary dressing changes or arrange for the responsible party to have the necessary supplies.

This allegation was substantiated and cited at F157, F225 and F309.

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

ALLEGATION #5:

The complainant stated there was only one nurse on duty at night in the facility.

FINDINGS #5:

The survey team reviewed the facility's staffing records for a three-week period. Observations were made at the time night shift was coming on duty and staff were interviewed. All of these sources indicated that staff-to-resident ratios more than exceeded minimal staffing requirements.

A Resident Group interview was conducted. The unanimous consensus of the residents present was that there was sufficient nursing staff at night.

Individual residents were interviewed; no concerns were voiced about nighttime staffing in the facility.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated the facility provided an identified resident's responsible party with misinformation regarding physician's visits.

FINDINGS #6:

The survey team reviewed the physicians' visits for the identified resident. The identified resident had frequent visits to a local clinic with medication and/or treatment changes at each appointment. The facility documented the responsible party was notified of some but not all of the medication and treatment changes.

This allegation was substantiated and cited at F157.

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

ALLEGATION #7:

The complainant stated an identified resident was missing clothing in the facility.

FINDINGS #7:

The survey team reviewed the facility's grievance log. The facility had a record of the identified missing clothing items, which were located and returned to the identified resident.

The regulatory requirement is that residents should be able to file a grievance with the facility, and the facility is required to make attempts to resolve those grievances. In this case, the resident filed a grievance with the facility, which the facility was able to resolve.

While the allegation from the complainant was determined to be true, the facility acted according to the regulatory requirement.

CONCLUSIONS:
Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #8:

The complainant stated an identified resident used a Continuous Positive Airway Pressure (CPAP) machine at home. The complainant stated the facility documented they requested the

resident's responsible party to bring the machine in for the resident's use; but in fact, the request was never made.

FINDINGS #8:

The identified resident's record documented the resident had a CPAP machine at home but did not document a request to the resident's responsible party for the machine to be brought to the facility.

A CPAP machine was ordered for the resident, but documented that it was not used for the resident. After documenting in the record the machine had not been used for thirteen days, the facility requested a physician's order to discontinue the machine. The facility did not document the resident's responsible party was notified of the non-use of the machine nor its discontinuation.

This allegation was substantiated and cited at F328 and F157.

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

ALLEGATION #9:

The complainant stated an identified resident did not make progress over a period of 22 days of a rehabilitation stay in the facility.

FINDINGS #9:

The identified resident received skilled physical and occupational therapy services in the facility and made progress towards his baseline functional status. The resident also received daily skilled nursing services for wound care and intravenous antibiotics for infections in the wounds.

It was established that on several occasions the facility did not document that one of the antibiotics and several of the wound treatments had been completed as ordered.

Of note, a concern was raised while the resident was in the acute care hospital prior to his nursing home admission, that the resident needed referrals for additional services at home once he was discharged. This information was passed on to the nursing home, but the nursing home did not act on it. Furthermore, the physician ordered that the resident should receive home health nursing visits for wound care after the resident was discharged home. At the time of discharge, the resident was receiving daily wound care, dressing changes and injections in the facility. The

facility was aware of the home health nursing order but did not ensure those services were arranged until the resident had been at home for six days.

This allegation was substantiated and cited at F250, F309 and F314.

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

ALLEGATION #10:

The complainant stated the floors in the facility were stained and not swept.

FINDINGS #10:

The survey team observed dirty floors in several areas of the facility.

This allegation was substantiated and cited at F252.

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

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

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor
Long Term Care

LKK/dmj

IDAHO DEPARTMENT OF HEALTH & WELFARE

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PHONE 208-334-6626
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November 3, 2014

Richard M. Ord, Administrator
Meridian Center Genesis Healthcare
1351 West Pine Avenue
Meridian, ID 83642-5031

Provider #: 135125

Dear Mr. Ord:

On **September 4, 2014**, a Complaint Investigation survey was conducted at Meridian Center Genesis Healthcare. Amy Barkley, R.N., Susan Gollobit, R.N., Linda Hukill-Neil, R.N., Nina Sanderson, L.S.W. and Sherri Case, L.S.W., Q.I.D.P. conducted the complaint investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006545

ALLEGATION #1:

The complainant stated the resident was left in clothes that were saturated from weeping ulcers, had fecal matter on the clothing, clothes were not changed since admission and the resident's left shoe smelled of urine.

FINDINGS #1:

The surveyors were in the building from September 2, 2014 through September 4, 2014. During the investigation, residents' cares were observed and numerous residents throughout the facility were observed for cleanliness.

The residents' clothes were clean and in good repair. A resident was observed for cares; the resident was not saturated with urine and the resident's clothes were clean. The resident was dressed in clothes for daytime. The facility did not smell of urine.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the resident had not been bathed.

FINDINGS #2:

During the investigation, the resident's bath record and care plan were reviewed.

The care plan documented the resident was to get baths and showers per schedule and as needed. The bath record for the month of May 2014 documented the resident received a bath five days after the resident was admitted and refused a bath two other times; once during the day shift and once during the afternoon shift.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant reported the resident had bubbling blisters and ulcers to the right leg, with a large wound to the top of the left foot and lower leg.

FINDINGS #3:

During the investigation, the resident's facility and hospital records were reviewed, and the DoN was interviewed.

The resident's facility record documented on May 24, 2014, the resident had a dressing in place on the left lower leg and a blister to the top of the left foot had burst.

The hospital's admission history and physical dated May 25, 2014, for the resident documented the resident had 3+ edema to lower extremity with blistering and erythema. The left foot had a blister that already burst. All the blisters had clear weeping fluid. The resident was admitted for cellulitis and for antibiotic therapy.

On September 3, 2014, the surveyor requested the DoN and corporate consultant provide documentation that the physician had been notified of the wound on the lower leg. The facility was also asked to provide orders for treatment, assessments of the resident's skin (to include lower extremities and edema), daily weights and an updated care plan related to the skin. The facility was unable to provide the information requested.

The resident was harmed when the facility failed to ensure the physician was notified when the resident's skin had a change in condition, to document daily weights, skin assessments and assessments of edema. The facility was cited at F157 and at F309 for harm to the resident.

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

ALLEGATION #4:

The complainant reported the resident had a diagnosis of cellulitis and C-Diff.

FINDINGS #4:

During the investigation, the resident's facility and hospital records were reviewed.

The facility record documented a stool sample was collected on May 23, 2014, and was positive for C-difficile toxin. The resident was started on an antibiotic the same day.

The hospital record was reviewed, and the resident was admitted to the hospital on May 25, 2014, for treatment of Cellulitis to his lower legs.

The allegation was substantiated and the facility was cited for the cellulitis of the lower legs at F309 and F157.

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

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

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor
Long Term Care

LKK/dmj

IDAHO DEPARTMENT OF
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PHONE 208-334-6626
FAX 208-364-1888

November 10, 2014

Richard M. Ord, Administrator
Meridian Center Genesis Healthcare
1351 West Pine Avenue
Meridian, ID 83642-5031

FILE COPY

Provider #: 135125

Dear Mr. Ord:

On **September 4, 2014**, a Complaint Investigation survey was conducted at Meridian Center Genesis Healthcare. Amy Barkley, R.N., Susan Gollobit, R.N., Linda Hukill-Neil, R.N., Nina Sanderson, L.S.W. and Sherri Case, L.S.W., Q.I.D.P. conducted the complaint investigation.

A total of 30 hours were required to complete this complaint investigation.

During this investigation, the Director of Nursing (DNS), Regional Nurse Consultant (RNC), Registered Dietitian (RD) and Physical Therapy staff (PT) were interviewed.

Observations of residents' care were provided and the following documents were reviewed:

- The records of nine sample residents, including the closed record of the identified resident;
- Incident and Accident Reports from April 2014 to September 2014;
- Grievances from April 2014 to September 2014; and
- Infection Control Policy and Procedures.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006579

ALLEGATION #1:

The complainant reported the resident had a physician's order for restricted fluids and a low sodium diet

due to dialysis. The facility provided the resident with large amounts of water and a regular diet.

FINDINGS #1:

The resident's Hydration and Nutrition Care Plan dated May 8, 2014, documented "Limit fluids to 1500 ml/day. Dietary to provide 1080 mls (milliliters). Nursing to provide approximately 420 mls. Nursing to monitor and document all fluids consumed from all sources."

The identified resident's record did not contain documentation that the facility had monitored or documented resident's daily total fluid intake for May 2014.

Dialysis Physician's Notes dated May 19, 2014, documented "Pt (Patient) arrived to treatment 5.7 kg (12.5 pounds) over Estimated Dry Weight (EDW). Pt tolerated a 1.5 L (3.3 pounds) fluid removal over a 3.00 hr (hour) treatment. Pt left 4.5 kg (9.9 pounds) over EDW. The RD at the Dialysis Center reviewed the nutrition report with patient's interested party and RD at the Extended Care Facility (ECF). Albumin continues to trend down. Patient to increase intake of protein as reviewed with (interested party) and RD at ECF. Patient was on liberalized renal diet. RD to change to regular NAS (no added salt) diet. Pt to receive Health Shakes 4 ounces (120 mls) twice a day."

A facility's fax dated May 20, 2014, faxed to the resident's physician by the facility dietician documented, "May we d/c (discontinue) 1500 ml fluid restriction? Now receiving supplements which adds to fluid intake." The physician responded, "OK." There was nothing documented in the resident's record to indicated the facility's dietician had discussed discontinuing the fluid restriction with the physician from the dialysis center.

On September 4, 2014, the RD stated she spoke with the physician who had initiated the fluid restriction and he indicated it would be appropriate to discontinue it related to adding supplements. The RD was asked to provide documentation related to the discussion she had with the physician; however, she was unable to provide the information requested.

On September 9, 2014, the RNC and DNS when asked where nursing staff documented the daily fluid totals for a resident on a fluid restriction. The DNS stated the information is documented on the resident's Medication Administration Record (MAR). The DNS was asked to provide documentation for the identified resident's May 2014 daily fluid intake totals. The facility was unable to provide the information requested.

The above information was included and cited as part of F309 as it relates to the provision of care for residents.

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

ALLEGATION #2:

The complainant reported he/she told the facility the resident's neighbor and friend could visit and receive health information related to the resident. The facility did not provide health information to this person.

FINDINGS #2:

The Interdisciplinary Progress (Nurses') Note dated May 27, 2014, documented "This nurse kindly explained to the family friend that her name was not on the form to have information released to her, and the (concerned party) would have to contact the (nurse) directly for any concerns."

The resident's release of information form was reviewed and it did not include the identified friend's name.

On September 9, 2014, the DNS and RNC confirmed the identified resident's friend was not included on the facility's release of information form.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant reported that a dialysis center's nurse called and stated the resident was transported to dialysis on a gurney at noon. The resident traditionally showed up in a wheelchair for appointment. The resident was sent back to the facility due to no room for the resident to wait for an hour for an appointment while on the gurney. The resident returned at 1:00 p.m. in wheelchair and received dialysis but was in "distress and pain."

FINDINGS #3:

A Dialysis' Progress Note dated May 26, 2014, documented "Patient in a lot of pain today. Brought over by non-emergent transport at 12:00 (noon) on a gurney. She was sent back to care center due to we did not have a chair or anywhere to put her for one hour to wait. Came back at scheduled time of 1:15 (p.m.) Did not tolerate fluid goal well today. Lots of pain, generalized, but mostly in neck. She was taken off (the dialysis machine) 16 minutes early at her request due to pain. Care center reports patient was given a pain pill before she left for treatment. Patient is very anxious and is clearly in a lot of pain."

There was nothing documented in the resident's record based on the above note that the primary care physician was notified related to the resident having increased pain or being transferred to dialysis on a gurney.

On September 9, 2014, at 10:00 a.m. the DNS and RNC were asked to provide documentation the

physician had been notified related to the above event. The facility was unable to provide the information requested.

This deficient practice was cited at F309.

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

ALLEGATION #4:

The complainant reported the dialysis center ordered and drew labs on the resident on May 26, 2014, which were sent back to the facility with the resident. On May 28, 2014, the dialysis center identified the blood samples were still in the resident's personal bag.

FINDINGS #4:

The resident's medical record, dialysis' communication records and dialysis physician's patient notes were reviewed and none contained documentation that the resident had blood samples left in her bag.

During an interview on September 9, 2014, the DNS stated the dialysis center and nursing staff had not reported blood vials being found in the resident's bag.

It could not be determined that this event occurred.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant was concerned that the resident did not get regularly scheduled or as needed pain medication.

FINDINGS #5:

A Dialysis Physician's Patient note dated May 16, 2014, documented the concerned party "Did not feel like the resident was confused but had a problem with the pain management system she was receiving at the facility." The concerned party stated the resident was required to ask for pain medications, and she was told by Physical Therapy, "they don't like to medicate patients before therapy because it causes them to be more tired."

A Dialysis Physician's Patient note dated May 26, 2014, documented the resident did not tolerate her dialysis treatment very well and had to be taken off of the dialysis machine sixteen minutes early at her request due to pain. The Dialysis nurse stated, "Patient is very anxious and is clearly in a lot of pain."

A Nurse's Progress Note dated May 27, 2014, documented "(A family member) had concerns about pt 'confusion.' I told her that she (the resident) just had a pain medication and that it could be from the meds. The (family member) stated, 'she has been taking this medication for years and she has never had confusion/sleepiness from them."

The resident's MAR was reviewed and documented the resident did not start receiving routine pain medication until 6:00 p.m. on May 16, 2014. Additionally, from May 27, 2014, after 7:00 p.m. until May 29, 2014, at 6:00 a.m. the resident did not receive routine or as needed pain medication.

Nurse's Notes dated May 29, 2014, documented the concerned party requested pain medication for the resident. Nursing staff "Re-educated/informed" the concerned party that the resident had already been medicated. The Charge nurse told the concerned party that the resident had no signs and symptoms of pain and responded "'I don't know" when she was asked where her pain was.

A Dialysis Physician's Patient note dated May 30, 2014, documented the resident was dropped off at the Dialysis Center and was alert to self only and could answer yes/no questions and follow simple commands. The resident was unable to verbalize where the pain was located and stated, "everywhere."

On September 9, 2014, the DNS was asked why nursing staff held the resident's pain medication; the DNS said the pain medications were held related to the resident displaying increased confusion and sleepiness.

The facility was cited at F309 for failure to appropriately assess and monitor the resident through a significant change in condition.

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

ALLEGATION #6:

The complainant reported that when calling the facility, the phone would ring "20 times" with no answer. Messages were left, but facility staff never returned the call.

FINDINGS #6:

A Dialysis Note dated May 16, 2014, at 3:52 p.m. documented "Call to care center about the antibiotic the patient is on. Left Message, no return call."

The resident's Emergency Room note dated May 30, 2014, at 5:26 p.m. documented "We made several attempts to contact the nursing facility where she is staying, but no one would answer the phone. I do not have any further information available at this time."

On September 2, 2014, at 8:33 p.m. a licensed nurse (LN) was asked about the facility's phone system.

The LN stated the phone system is automated, and after hours if no selection is made it rings to the Long Term Care nurse's station. Nurses usually answer the phone and then transfer the call to wherever it needs to go. He identified that at peak times (meals, after meals etc.) staff is too busy to answer the phone. The automated system offers the caller the option to leave a message. The survey team asked the LN if nurses could listen to a message if one is left. The LN stated he had never had anyone leave a message.

On September 2, 2014, at 8:39 p.m., the following was observed: After approximately fifteen rings from a phone at the nurses' station, a nurse was observed to walk past the nurses' station and ringing phone, and down the 200 hall where she asked another nurse to answer the phone. The phone rang 19 times before it was answered.

On September 2, 2014, at 8:45 p.m., the RNC was informed the phone at the nurses' station rang 19 times before it was answered. The RNC stated, "It shouldn't do that; it should go to the option to leave a message." The survey team asked what would happen if a physician called. The RNC stated, "I guess they would just have to do what any of us would do, call back until someone answered." The RNC acknowledged that practice was not acceptable.

The facility was cited at F490.

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

ALLEGATION #7:

The complainant reported the resident had been tested for C-Diff upon admission to facility and found negative. On May 28, 2014, a family member was told the resident had "infectious diarrhea" and tested positive for C-Diff.

FINDINGS #7:

The Hospital Discharge Summary dated May 6, 2014, documented the resident had chronic diarrhea that was C. Difficile negative.

A Physician's Order dated May 7, 2014, documented "Collect a stool sample for stool culture, O&P and C. Diff. toxin tests."

Lab results dated May 13, 2014, documented "...stool culture positive with 'many Staphylococcus Aureus' present."

Lab results dated May 28, 2014, documented the resident was positive for C-Diff; as well as, positive for the presence of blood, protein and yeast in the resident's urine.

The resident was found to have C-Diff., and the concerned party was notified.

The resident's hospital and medical record documented the identified resident was tested for C-Diff. during her initial hospital admission and was negative. The resident was tested for C-Diff. upon admission to the facility and was negative; however, the resident was diagnosed with Staphyloccoccus Aureus upon admission to the facility.

The facility was cited at F441 related to the resident not being placed on isolation precautions with the Staphyloccoccus Aureus in her stool.

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

ALLEGATION #8:

The complainant stated facility staff was unresponsive to a concerned party throughout the resident's stay.

FINDINGS #8:

During the time the resident was in the facility, from May 6 through May 30, 2014, the resident's medical record documented several occasions when the staff and concerned party discussed the resident's medical condition.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #9:

The complainant stated on May 30, 2014, while out of town, she/he received a telephone call that the resident became unresponsive during dialysis. The resident was sent to a local hospital and admitted with "septic shock," which was present for two weeks.

FINDINGS #9:

The resident's labs, facility faxes (FF), Interdisciplinary Progress Notes (IPN), Nutrition Note (NN), Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (SP), Physicians' Notes (PN), ADL Record, Dialysis Notes (DN), Hospital History and Physical (HH&P), Hospital discharge summary (HDS), Dialysis Communication Record (DCR), Dialysis Patients Notes (DPN) and Emergency Room Report (ER) were reviewed.

Physician Orders dated May 12, 2014, documented "Obtain appt. (appointment with)] Pt's GI MD (patient's GI physician) ASAP (as soon as possible) r/t (related to) GI bleed." IPN (Interdisciplinary

Progress Notes) dated May 12, 2014, documented bloody stools noted per rectum appt. (appointment) scheduled with GI physician.

The resident's medical record was reviewed and did not include the GI physician's report for the identified resident. On September 2, 2014, the DNS and RNC were asked to provide a copy of the GI report; at 3:00 p.m., the RNC said the report was not in the resident's chart, and she could not obtain a copy from the physician's office because there was no documentation that an appointment had ever been scheduled.

Lab results dated May 13, 2014, documented "Stool culture positive with many Staphylococcus Aureus present," and an order was received to start antibiotic treatment on the resident.

The MAR documented the resident did not receive the first dose of the antibiotic until dated May 15, 2014, two days after the infection was detected; the resident missed her second dose at 4:00 p.m. and received what was documented as a "third" dose at 12:00 a.m. There was nothing documented in the resident's record to indicate why there was a delay in treatment. In addition, the resident missed four of eighteen doses of the antibiotic. There was nothing documented in the resident's record that the physician was notified of the missed doses.

A Physician's Note dated May 16, 2014, documented "The patient was admitted to the facility on May 6, 2014, but I have not been able to evaluate her secondary to her typically being at dialysis during my visit day. The patient's (interested party) also informs me today that the patient was very hypotensive yesterday. She informs me that the (identified resident's) blood pressure had gone down to 77/46 the ambulance contacted the emergency department, and they informed the crew to bring the patient in if they felt it was needed. Apparently, the patient's blood pressure stabilized after a fluid bolus yesterday. (The identified resident) appears to be very anxious and nervous and is very uncertain on her answers it appears. The patient's (interested party) states that this is not a very common thing for (this resident) and states that she has had episodes like this in the past where she has had a urinary tract infection. Uncertain as to what is going on with this patient at this time; but, we will obtain a urinalysis with Culture and Sensitivity if indicated." The UA was ordered that day at 7:00 p.m.

Dialysis Physician Notes dated May 26, 2014, documented "Pt (patient) in a lot of pain today. Brought over by non-emergent transport at 12:00 (p.m.) on a gurney..."

The UA collected on May 27, 2014, ordered to be collected on May 16, 2014, by the facility's Nurse Practitioner related to the resident experiencing increased confusion. It could not be determined why the UA was not collected until eleven days after it was ordered.

Dialysis Physician Notes dated May 28, 2014, documented the patient was dropped off in the dialysis lobby at approximately 12:45 p.m.; oriented to self only; answered with yes/no; followed simple commands; unable to verbalize where pain is located; stated, "everywhere;" and had noted weakness on right side her body.

The resident's record did not document that the resident's primary physician was notified about the significant change in the resident's condition, as identified by the dialysis center.

The Dialysis Physician Note dated May 30, 2014, documented "(Dialysis) treatment initiated, and patient was placed on 15 minute blood pressure checks. At approximately 1500 (3:00 p.m.,) patient appeared to be less oriented and (Dialysis staff) was unable to get the patient to respond to her name. Pt (patient) unresponsive to verbal stimuli but grimaces with sternal rub. Orders received to transport pt (patient) to ER (emergency room) for decreased Level of Consciousness."

The resident was admitted to a local hospital on May 30, 2014, and expired on June 8, 2014, with multiple diagnoses, including septic shock secondary to Clostridium difficile with refractory hypotension requiring multiple vasopressors, congestive heart failure and pleural effusions.

The facility was cited at F309 for failure to assess, monitor and notify the resident's physicians of significant changes in condition.

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

ALLEGATION #10:

The complainant reported the resident had a "terrible wound" on his/her "bottom" that was "as red as the hazardous waste garbage bins." The wound has been on the resident's "bottom" for days. The complainant was concerned it was from the resident "being left wet and not cleaned" from C-Diff.

FINDINGS #10:

The resident's medical record, weekly skin check sheets, hospital admission record and dialysis communication records were reviewed and none of these documented any concerns related the resident's skin.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #11:

The complainant said the facility charged twenty-five cents per page for copies of the resident's medical record, which was 281 pages. The community standard (library copier) is ten cents per copy.

FINDINGS #11:

Based on review of the facility's policy, admission pack and the community standard price for photocopies; it was determined the facility's charge for copies exceeded the community standard price.

The identified resident's Power of Attorney (POA) requested a paper copy of the resident's medical record. The facility copied 281 pages at 25 cents a copy for a total of 281 copies for which the POA was charged seventy-five dollars and twenty-five cents.

On September 4, 2014, at 3:30 p.m., the survey team contacted a local commercial copy center to determine the community's standard for copies. The employee identified for standard 8 1/2 x 11 black and white photocopies the price was thirteen cents a copy for staff to make the copies.

The facility was cited at F153 for failure to provide the copies at a cost in accordance with the community's standard.

CONCLUSIONS:
Substantiated. Federal deficiencies related to the allegation are cited.

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

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor
Long Term Care

LKK/dmj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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October 22, 2014

Richard M. Ord, Administrator
Meridian Center Genesis Healthcare
1351 West Pine Avenue
Meridian, ID 83642-5031

Provider #: 135125

Dear Mr. Ord:

On **September 4, 2014**, a Complaint Investigation survey was conducted at Meridian Center Genesis Healthcare. Amy Barkley, R.N., Susan Gollobit, R.N., Sherri Case, L.S.W., Q.M.R.P., Nina Sanderson, L.S.W. and Linda Hukill-Neil, R.N. conducted the complaint investigation.

A total of 36 survey hours were required to complete this and two (2) other complaint investigations.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006643

ALLEGATION #1:

The complainant stated the facility failed to notify the family when the resident's blood glucose was at a critical level, and the medication was stopped.

FINDINGS #1:

The following documents were reviewed:

- A total of six (6) residents' medical records, which included the identified resident's record.
- The facility's grievances and Resident Council minutes for March through August 2013.

The Director of Nursing was interviewed.

It was determined the facility failed to notify family members regarding changes in medication or current health status and the facility was cited at F157.

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

ALLEGATION #2:

The complainant stated the resident's medical record did not include physicians' progress notes.

FINDINGS #2:

A total of six (6) residents' medical records were reviewed for physicians' notes.

The Director of Nursing was interviewed.

The identified resident's medical record did not document a visit by the nurse practitioner. The Director of Nursing stated the physicians' notes had been deleted in the computer prior to when they should be placed in the resident's medical record.

The facility was cited for deficient practice at F514.

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

ALLEGATION #3:

The complainant stated the resident was not participating in therapy, as the facility would not medicate the resident prior to therapy.

FINDINGS #3:

Nursing notes, care plans, physicians' orders, medication administration records and treatment administration records for six (6) residents were reviewed. July through August 2014 occupational/physical therapy notes and pain assessments were reviewed for the identified resident.

Interviews were conducted with the physical therapy department, dietitian, social services, the Director of Nursing and residents.

The identified resident's Pain Screening and Evaluation Tool reports were reviewed from July 10, 2014 through August 31, 2014. The forms documented that on a scale of one (1) to ten (10) (ten (10) being severe pain) the resident had experienced pain that ranged as low as two (2) and as high as ten (10). One of the areas identified for increased pain was therapy.

The identified resident's current physician's orders documented the resident received Tylenol 650 milligrams for pain when needed, when the resident was admitted on July 10, 2014. The orders included Tramadol 50 milligrams, as needed, which was ordered on July 23, 2014.

The as needed pain management sheet for July 2014 documented the resident received the medication eleven (11) times and nine (9) times in August 2014. Each time it was received the medication was documented to be effective.

The physical/occupational therapy records for July 2014 documented the resident participated in therapy sixteen (16) days. The August 2014 record documented the resident participated eighteen (18) days. The September record documented the resident had participated for the current two (2) days available.

On September 4, 2014, at 8:45 a.m. the physical therapist and a physical therapist assistant were interviewed. The assistant stated the resident usually refused when initially asked to participate in therapy and often refused several more times. The physical therapist assistant stated the resident liked for his wife to be present when he participated in therapy. The assistant stated the resident was to participate in therapy three (3) days a week. The therapist stated the resident always participates at some time, but it would be difficult to give the resident pain medication in time to be effective as it would be almost impossible to predict the time the resident would participate.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated the resident stated he wanted to die.

FINDINGS #4:

Nursing notes, social services' notes, medication administration records, care plans and physicians' orders were reviewed for six (6) residents. Behavior monitors were reviewed for two (2) residents.

Interviews were conducted with the Director of Nursing, physical therapy and social services.

A physician's note for the identified resident documented the resident asked about being euthanized. A therapy note documented the resident had stated he "wanted to go to the grave." The resident's care plan did not address the resident's statements of wanting to die.

The facility was cited at F250 and F329 for deficient practices.

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

ALLEGATION #5:

The complainant stated the resident can verbalize the need to void, but staff has him/her in adult briefs.

FINDINGS #5:

The identified resident's bladder assessment, care plan and documentation of incontinence were reviewed for the months of July and August 2014.

Interviews were conducted with a certified nurse aide, a licensed nurse and the Director of Nursing.

The facility was cited for deficient practice at F315.

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

ALLEGATION #6:

The complainant stated the resident was having auditory and visual hallucinations that were not addressed by the facility.

FINDINGS #6:

Nursing notes, care plans, physicians' notes, physicians' orders and treatment and medication administration records for July and August 2014 were reviewed for the identified resident.

The Director of Nursing was interviewed.

Nursing notes on July 14, 2014, documented the resident stated he thought he was hallucinating. A fax communication was sent to the physician on that day that informed the physician of the

hallucinations. An order was signed on the same day to discontinue the resident's current pain medication.

On July 20, 2014, laboratory results documented the resident tested positive for a urinary tract infection. A treatment administration record documented the resident received an antibiotic the same day.

On September 4, 2014, the Director of Nursing stated, in addition to the above interventions for the hallucinations, the facility had administered eardrops to clean the resident's ears for possible inner ear problems.

The allegation was not substantiated as the facility implemented interventions to address the hallucinations.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The complainant stated the resident did not like the food and was losing weight.

FINDINGS #7:

Nursing notes, care plans, physicians' orders and nutritional assessments for four (4) residents were reviewed. July through August weights were reviewed for the identified resident.

Interviews were conducted with social services, the Dietitian, the Director of Nursing and residents.

The identified resident's initial weight on July 13, 2014, was 186.6 pounds. The July 17, 2014, initial nutrition assessment documented the resident's meal intake ranged from 85% to 100%. The resident's August 24, 2014, weight was documented to be 166.2 pounds.

A Medication Administration Record documented the resident began to take a fluid reduction medication on July 25, 2014.

The identified resident's July 21, 2014, Care Plan for "Nutrition" included interventions of snacks two (2) times a day and nutritional supplements three (3) times a day.

An order for Health Shakes three (3) times a day was signed by the physician on July 25, 2014, and a Treatment Administration Record documented the supplement was started the next day.

The dietitian stated on September 3, 2014, that the resident was eating well when he was first admitted but lost weight after thirty days. The dietitian stated the weight loss was due to a loss of fluids secondary to fluid administration in the hospital. The physician ordered fluid restriction on July 24, 2014. The facility notified the physician of the weight loss, which initiated the health shake. The dietitian stated the care plan was revised to include snacks two (2) times a day, which were started on July 21, 2014. The dietitian stated the resident had no weight loss in the preceding thirty days.

The identified resident was observed eating lunch on September 2, 2014. The resident consumed less than twenty-five (25) per cent of the meal but drank all of the nutritional supplement. A Certified Nurse Aide offered to bring the resident something else to eat, but the resident stated he did not want anything else.

Additionally, ten (10) of eleven (11) residents participating in a meeting with the surveyors stated the food was good, and if a resident did not like the meal the facility would offer to bring something else.

A resident interviewed privately stated the "food is good," and added, if a resident did not like the food "they will bring something else."

Although the resident had experienced weight loss, the facility implemented interventions to address the loss. The facility was determined to be in compliance for weight loss; however, the resident's record did not document the effectiveness of the interventions, and the facility was cited at F514 related to accurate documentation.

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

ALLEGATION #8:

The complainant stated the resident's physician ordered blood glucose checks for one (1) week. The facility failed to document the blood glucose checks.

FINDINGS #8:

Nursing notes, care plans, physicians' notes, physicians' orders and treatment and medication administration records for July and August 2014 were reviewed for the identified resident.

The Director of Nursing was interviewed.

A July 14, 2014, blood draw from the laboratory documented a critical low blood glucose of

forty-two (42) for the identified resident. The physician was notified and ordered blood glucose levels be checked three (3) times a day and a laboratory blood glucose check on July 16, 2014.

On July 16, 2014, the facility informed the physician that the resident's morning blood glucose level was forty-three (43). The physician signed an order to discontinue the resident's oral medication for diabetes.

A Treatment Administration Record dated July 15 and July 16, 2014, documented blood glucose levels were taken three (3) times each day. A second Treatment Administration Record for July 16 through July 21, 2014, documented blood glucose levels three (3) times each day.

On September 4, 2014, the Director of Nursing stated the reason for the two (2) Treatment Administration Records was the initial order did not specify that the order was for one (1) week.

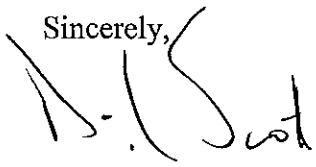
The allegation was not substantiated as the facility provided two Treatment Administration Records that documented the blood glucose levels were taken three (3) times a day for one (1) week.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

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

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj