



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
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CERTIFIED MAIL: 7012 3050 0001 2125 6126

September 23, 2014

Richard F. Cartney, Administrator
Monte Vista Hills Healthcare Center
1071 Renee Avenue
Pocatello, ID 83201-2508

Provider #: 135018

Dear Mr. Cartney:

On **September 12, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Monte Vista Hills Healthcare Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be 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) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form

CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 6, 2014**. Failure to submit an acceptable PoC by **October 6, 2014**, may result in the imposition of civil monetary penalties by **October 27, 2014**.

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

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring.
 - * It is important that the individual doing the monitoring have the appropriate experience and qualifications for the task.
 - * The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3.
 - * A plan for "random" audits will not be accepted.
 - * Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column (X5).

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **October 17, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 17, 2014**. A change in the seriousness of the deficiencies on **October 17, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 17, 2014** includes the following:

Denial of payment for new admissions effective **December 12, 2014**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 12, 2015**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **September 12, 2014** and continue until substantial

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compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **October 6, 2014**. If your request for informal dispute resolution is received after **October 6, 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 DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/12/2014
NAME OF PROVIDER OR SUPPLIER MONTE VISTA HILLS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVENUE POCATELLO, ID 83201	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification and complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Linda Hukill-Neil RN, BSN</p> <p>The survey team entered the facility on September 8 and exited on September 12, 2014</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligram ML = Milliliter PRN = As Needed</p>	F 000	<p style="text-align: center;"><i>RECEIVED</i></p> <p style="text-align: center;"><i>OCT - 8 2014</i></p> <p style="text-align: center;"><i>FACILITY STANDARDS</i></p> <p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Monte Vista Care Healthcare 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.”</p>	
F 154 SS=D	<p>483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS</p> <p>The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</p> <p>The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.</p>	F 154		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X8) DATE _____

Andy [Signature] ADMINISTRATOR 10/6/14

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 154	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility did not ensure a resident's representative was fully informed of the type of side rails used for the resident. This was true for 1 of 3 residents (#3) sampled for side rails. The deficient practice had the potential to cause harm when a resident's representative did not have the opportunity to make an informed decision regarding the potential risks and benefits, when the type of side rails agreed upon were not the type of side rails actually used for the resident. Findings included:</p> <p>Resident #3 was admitted to the facility on 12/5/02 with multiple diagnoses including muscle weakness, osteoporosis, infantile cerebral palsy, convulsions, and chronic pain.</p> <p>The resident's 7/30/14 annual MDS assessment, documented the following: *Required extensive assistance with two staff members for bed mobility; *Required total dependence with two staff members to transfer in/out of bed; and, *Was moderately cognitively impaired, BIMS=11.</p> <p>The resident's ADL care plan, dated 1/30/14, documented an intervention of: "Side Rails: 2 half rails up as per Dr.s [physician] order for safety while in bed due to seizure disorder, to assist with bed mobility..."</p> <p>The resident's September 2014 Order Summary Report documented an order dated 7/24/12, "2 1/2 Length Side Rails to Bed for safety, bed mobility R/T [related to] seizure disorder." Refer to F323 regarding the resident's fall from bed.</p>	F 154	<p>F154</p> <p>Corrective Actions: Facility updated the order and care plan to reflect four ¼ side rails with the full length bolsters. Family was notified and approved the decision. Education was provided to licensed staff that assistive devices match consents 10/2/14</p> <p>Identification of others affected and corrective actions: All residents that have side rails could have been affected. An audit of all side rails was done to ensure that the care plan and consents matched the side rails that are being utilized.</p> <p>Measures to ensure that the deficient practice does not happen again: Facility wide review of all side rails and consents was done by the maintenance director and D.N.S. The D.N.S. or designee will review all side rail orders and consent forms within 5 days of admissions for accuracy. D.N.S. or designee will audit all new side rail orders and consent forms daily during normal work days via PCC</p> <p>Monitor corrective actions: D.N.S. or designee will audit all new side rail orders and consent forms and 1 x week for 3 months. The audit results will be brought to QA monthly. Audits to begin 10/1/14</p> <p>Corrective Actions will be completed</p>	10/17/14	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 154	Continued From page 2 The resident's Physical Restraint/Enabler Consent signed by the Guardian via phone on 6/14/13, documented under Restraint/Enabler Type, Frequency, "2 1/2 length side rails in bed." Note: The Guardian lived in another state. The resident's Bed Side Rail Permission signed by the DON and Guardian on 8/15/14 and faxed back to the facility on 8/16/14, documented, "Having been so informed I choose the use of bed side rails as follows:" A blank check box was next to several options with a check mark in the box labeled, "All bed side rails used." The resident's Physician telephone order dated 9/9/14 documented, "4 1/4 length side rails to bed (2 on each side) with full length bilateral bolsters to promote comfort and safety due to immobility..." On 9/8/14 at 4:10 PM and throughout the survey, the resident's bed was observed to have four quarter length side rails with two rails to each side with full length bilateral bolsters. On 9/11/14 at 10:35 AM, the DON was interviewed with a Clinical Partner present. When asked about what type of side rails the resident had at the time of a fall on 9/6/14, he stated, "She had two quarter at the top." The DON was not sure why the resident did not have two half-length side rails as ordered. When asked about the side rail permission, which documented all side rails, he stated that was just to document the facility "can use all rails as needed." When asked if the Guardian knew two quarter rails were in use, despite the order and the previous consent which documented two half rails, he said he could not	F 154		

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F 154	Continued From page 3 remember if it was discussed with the Guardian. NOTE: Federal guidance at F 154 documented, "'Informed in advance' means that the resident receives information necessary to make a health care decision, including information about his/her medical condition and changes in medical condition, about the benefits and reasonable risks of the treatment, and about reasonable available alternatives." On 9/11/14 at 5:50 PM, the Administrator and DON were informed of the issue. No further information was provided.	F 154			
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident group interview and staff interview, it was determined the facility failed to provide residents with a variety of menu choices. This was true for 4 of 6 residents in the group interview and affected other residents who dined in the facility. The deficient practice had the potential to cause more than minimal harm if residents experienced weight loss when served food they did not like or were tired of receiving. Findings included:	F 242	Corrective Actions: Facility ED and dietary manager ordered new menus the will be instituted by 10/17/14. Identification of others affected and corrective actions: All residents that eat in the facility could have been affected. Measures to ensure that the deficient practice does not happen again: The dietary manager will interview residents upon admission and with the MDS schedule for food preferences. All staff were educated on 10/2/14 to notify the dietary manager of menu items that may not meet food preferences. Monitor corrective actions: Social services will audit resident response to new menus every other week for 6 weeks. The audit results will be brought to QA monthly. Audits to begin 10/17/14. Corrective Actions will be completed	10/17/14	

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F 242	Continued From page 4 Resident Council Meeting Notes dated 4/21/14, documented under the Other Comments area, "Kitchen is working on new menus." An email sent to the administrator and other staff on 4/24/14, documented a summary of the 4/21/14 Resident Council Meeting Notes, "Residents were informed the kitchen is working on implementing new menus." Resident Council Meeting Notes dated 5/30/14 and 6/16/14, documented the facility addressed listing menus for the day, but did not mention new menus. The facility's Menus were reviewed and Week 1-Week 4 menus documented, "Basic-Spring/Summer 2007." The menus were signed by a dietitian on 4/13/07. On 9/9/14 at 1:30 PM during the resident group interview, 4 out of 6 residents stated there was a lack of menu variety and the food was exactly the same every month. They said for example, the first Monday of the month was always the same food and the rest of the days of the week were also the same each month for that day. On 9/9/14 at 2:35 and 3:00 PM, the CDM was interviewed regarding the menus. He said the menus had not been updated significantly since 2007 and had tried several times to buy new menus, but had been turned down in the past. He said he had told the new administrator, who started working at the facility the week prior to survey, they needed new menus. He said the menus were on a four week cycle for the spring and summer and fall and winter menus and they	F 242			

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F 242	Continued From page 5 would occasionally switch a lunch for a dinner and vice versa. He also said residents could always order the alternative or a sandwich or soup if they did not like the menu choice. On 9/11/14 at 9:20 AM, the Clinical Resources Representative was interviewed regarding the Resident Council Notes. When asked if the note regarding new menus was ever readdressed in the Resident Council Notes, she said, she could not see where it had been resolved. On 9/11/14 at 5:50 PM, the Administrator and DON were informed of the issue. No other information was provided.	F 242		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure a resident's call light was accessible for 1 of 11 sampled residents (#8). The deficient practice had the potential to cause harm if the resident's needs were not met. Findings included: On 9/11/14 at 9:40 AM, Resident #8 was observed in her bed asleep. The call light was	F 246	F246 Corrective Actions: CNA placed the call light on the bed so that the resident could reach it. The facility ordered a pressure pad call light for the affected resident. Education was provided to all licensed staff and nursing aides regarding the call light policy & procedure 10/1/14 Identification of others affected and corrective actions: All residents with a call light could have been affected. The staff also checked and verified all call lights were within reach and appropriate for each resident needs. Measures to ensure that the deficient practice does not happen again: Proper call light placement will be part of the new hire orientation for all nursing staff. The Administrator or designee will review call light placement during rounds when on the floor. Monitor corrective actions: Activities Director or designee will audit proper call light for placement 1 x day for 5 days per week for 2 weeks. Then 2 x weeks for 1 month. Then 1 x week for 1 month. The audit results will be brought to QA monthly. Audits to begin 10/1/14. Corrective Actions will be completed	10/17/14

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F 246	Continued From page 6 clipped on the privacy curtain, which was out of the resident's reach. On 9/11/14 at 9:55 AM, CNA #1 was asked by the surveyor, if she could come to the resident's room and acknowledge where the call light was located. The CNA saw the call light on the curtain, unclipped it, and clipped it to the blanket that was covering the resident and stated, "No, it [call light] should be clipped on the bed where she can reach it." On 9/11/14 at 5:50 PM, the Administrator and the DON were informed of the issue and no additional documentation was provided.	F 246			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280 Corrective Actions: D.N.S. removed mats from the care plan for the resident that was affected. Identification of others affected and corrective actions: All residents that have mats at the bed side could have been affected. Measures to ensure that the deficient practice does not happen again: D.N.S. or designee did facility wide review of all care plans with mats to ensure they match and are consistent with what is used and required on 9/30/14. The M.D.S. or designee will validate mats are in use and update care plans as appropriate for all residents with their M.D.S. review. Monitor corrective actions: D.N.S. or designee will validate that care plans and mats are consistent 1 x week for 6 weeks. The audit results will be brought to QA monthly. Audits to begin 10/1/14 Corrective Actions will be completed	10/17/14	

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F 280	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to revise care plans for 1 of 9 sampled residents (#1). The care plan included an intervention for fall mats which were no longer used. This had the potential to result in harm if a resident did not receive appropriate care due to lack of direction in the care plan. Findings included: Resident #1 was readmitted to the facility on 8/4/08 with multiple diagnoses including abnormality of gait and history of falls. On 9/9/14 at 9:30 and 10:50 AM and on 9/10/14 at 9:40 AM, a fall mat was observed on the left side of the resident's bed between the bed and the window, but not on the right side of the bed. The resident's "At risk for falls..." care plan, dated 4/10/14, documented, "Floor mats to both sides of bed." On 9/10/14 at 3:15 PM, the MDS Coordinator said the resident had not been using the floor mats and, "it should have been taken off the care plan." On 9/11/14 at 5:50 PM, the Administrator and DON were informed of the issue. No other information was provided.	F 280			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281			

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F 281	<p>Continued From page 8 must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure staff utilized proper technique when medications were administered through a PEG (percutaneous endoscopic gastrostomy) tube. This affected 1 of 1 resident (#11) who received medications during medication pass observations through a PEG tube. This failure created the potential for less than optimal benefit and placed the resident at risk for adverse reactions. Findings included:</p> <p>On 9/9/14 at 10:25 AM, LN #2 was observed to crush 4 different medications together in 1 plastic crush bag, dispense 2 liquid medications and then mix them in 120 mL (milliliters) of water for Resident #11. LN #2 stated, "I crush all the tablets and mix the liquid medications in with about a 120 mL of water and then I follow that with another 120 mL of water. The resident has had her feeding turned off for a half hour."</p> <p>The 2 liquids and the 4 crushed medications were mixed together as follows: Omeprazole 20 mg (milligrams)/5 mL-10 mL of liquid Keppra 100 mg/mL-5 mL of liquid Abilify 10 mg-1 tablet Aspirin 81 mg-1 tablet Baclofen 10 mg-1/2 tablet Citalopram 20 mg-1 tablet</p> <p>On 9/9/14 at 10:35 AM, LN #2 administered the 6 medications with the 120 mL of water into the</p>	F 281	<p>F281 Corrective Actions: Pharmacy was contacted to ensure that no adverse effect was anticipated during this med pass. Identification of others affected and corrective actions: No other residents were effected as no other residents have enteral pumps. Measures to ensure that the deficient practice does not happen again: The employee that was observed during the med pass was immediately educated on facility policy & procedure regarding the proper method of administering enteral medication. Education was provided to licensed staff on proper enteral medication administration on 9/15/14. Monitor corrective actions: D.N.S. or designee will conduct an audit for proper enteral medication administration 3 x week for 4 weeks then 1 x week for 4 weeks. The audit results will be brought to QA monthly. Audits to begin 10/1/4 Corrective Actions will be completed</p>	10/17/14

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F 281	<p>Continued From page 9</p> <p>PEG tube and followed with flushing 120 mL of water.</p> <p>*The facility provided its policy and procedure, "Specific Medication Administration Procedures...Enteral Tube Medication Administration" on 9/11/14. The policy documented, "...Check the MAR to confirm the order: note the medication, dose, route (tube), volume of water for flushing...Crush...tablets into a fine powder, and dissolve in 5-10mL of warm water...Dilute liquid medications with 10-30mL...of warm water...Put 15-30mL of water in syringe and flush tubing...Pour dissolved/dilute medication in syringe...Flush with 5-10mL warm water between each medication...Flush tubing with 15-30mL of water, or prescribed amount. [If administering more than one medication, flush with 5mL of water, or prescribed amount, between each medication, or per physician's orders.]..."</p> <p>The resident's September 2014 Physician Order Summary Report and MAR included the orders, "Flush peg tube with 50cc [cubic centimeters]Free Water pre & post q [every] time peg tube accessed & 5mls between q med [medication] administration..."</p> <p>When the LN was interviewed after administration regarding the flushing between each medication and giving each medication separate, the LN stated, "I was not aware that each one should have been given separate with water." Note: The LN did not follow the Physician's orders for flushing pre and post access of the peg tube nor did she provide the 5 mLs between each medication administration.</p> <p>*Ref: S&C: 13-02-NH stated regarding medication</p>	F 281		

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F 281	Continued From page 10 administration via tube feeding, "For administering medications via tube feeding, the standard of practice is to administer each medication separately and flush the tubing between each medication. An exception would be if there is a physician's order that specifies a different flush schedule for an individual resident, for example because of a fluid restriction." On 9/10/14 at 4:45 PM, the Administrator and DON were informed of the issue. No other information or documentation was received from the facility.	F 281			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interviews, it was determined the facility failed to ensure physician's orders were followed for maintenance flushing of a port of cath. This affected 1 of 1 resident (#6) with a central venous catheter. This failure created the potential for more than minimal harm if the central venous catheter became occluded. Findings included: Resident #6 was admitted to the facility on 12/26/12 with multiple diagnoses including	F 309	F309 Corrective Actions: Physician orders were changed to have a flush completed monthly. The flush was completed on 10/3/14. Education was provided to licensed staff on following physician orders per policy and procedure on 10/1/14 Identification of others affected and corrective actions: Any residents with port-o-cath orders could have been affected. No other residents have a port-o-cath. Measures to ensure that the deficient practice does not happen again: The A.D.O.N. clarified and corrected the order. A revised procedure has been developed by pharmacy to include port-a-caths. D.N.S. or designee will review physician orders daily during normal work days. Monitor corrective actions: D.N.S. or RN designee will conduct an audit for physician orders for port-o-caths to ensure they are followed according to the facility policy & procedure administration 5 days per week for 2 weeks. Then 2 x week for 4 weeks. Then 1 x week for 4 weeks. The audit results will be brought to QA monthly. Audits to begin 10/3/14. Corrective Actions will be completed	10/17/14	

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F 309	Continued From page 11 chronic pain, Narcolepsy with Cataplexy, Epilepsy, Diabetes, Neurogenic Bladder, Chronic Airway Construction, and Depressive Disorder. The resident's 6/26/14 significant change MDS documented BIMS score of 15-cognitively intact. The resident's triggered medications were antidepressants, antibiotics, and diuretics. Resident #6's Physician Orders documented: -6/14/14, "...Normal Saline Flush Solution 0.9% (Sodium Chloride Flush) Use 10 ml intravenously one time a day every Sun [Sunday] for routine care to keep catheter line patent 0.9% Solution Intravenous (IV). Flush port-a-cath with 10cc every week and follow with heparin. DISCONTINUE 08/27/2014...REASON: NEW ORDER..." -6/14/14, "...Heparin Lock Flush Solution Use 5ml intravenously one time a day every Sun for routine cath care to keep line patent 100 UNIT/ML:5 ml Solution Intravenous (IV). Flush 5 ml through port-a-cath following 10cc normal saline flush weekly. USE 3/4 NEEDLE[.] DISCONTINUE 08/27/2014...REASON: NEW ORDER..." -8/27/2014, "...MAINTENANCE FLUSH-CENTRAL LINE/INPLANTED PORT: 10 ml NS then 5ml (10u/ml) Monthly every day shift every 30 day(s)..." -9/11/14, "...MAINTENANCE FLUSH-CENTRAL LINE/INPLANTED PORT: USE 10 ml NS [normal saline] then lock with 2.5ml normal saline mixed with 2.5ml of heparin 100units/ml for a 5ml total volume, every day shift every 30 day(s)."	F 309			

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F 309	<p>Continued From page 12</p> <p>Resident #6's MARs were documented as follows:</p> <p>-6/1 through 6/30/14, "...Heparin Lock Flush Solution Use 5 ml intravenously one time a day every Sun for routine cath care..." The MAR had no documentation the weekly flush was performed on 6/22 and 6/29/14.</p> <p>-7/1 through 7/31/14, "...Heparin Lock Flush...every Sun..." The MAR had no documentation the weekly flush was performed on 7/6, 7/20, and 7/27/14.</p> <p>-8/1 through 8/30/14, "...Heparin Lock Flush...every Sun..." The MAR had no documentation the weekly flush was performed on 8/3, 8/10, 8/17, 8/24, and 8/31/14. The MAR had a comment written twice, "Port not accessed".</p> <p>-9/1 through 9/30/2014, "...Maintenance Flush...every day shift every 30 day(s)...Order date 8/27/2014..." The MAR had no documentation reflecting a flush had been done in September and was not due until 9/27/14.</p> <p>Note: The facility provided Resident #6's records on 9/9/14 which contained August 2014 MAR with no initials on any day to reflect a flush had been performed in August. However on 9/11/14 at 4:00 PM, a second copy of the same page of the Resident's August MAR provided by the facility documented initials on 8/31/14, indicating the flush had been provided that day.</p> <p>On 9/9/14 at 2:15 PM, the resident stated that her central line had not been flushed for 3 months. Resident #6 stated, "I am missing most of my stomach so oral antibiotics don't work for me. I</p>	F 309			

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F 309	Continued From page 13 have had frequent UTIs [urinary tract infections] and the last few antibiotics have had to be IV antibiotics." The resident became very emotional and upset during the interview. She stated that she had previous catheters and they had stopped working, which resulted in having discomfort and the cost of having a replacement. On 9/11/14 at 12:15 PM, the DON was interviewed with the Clinical Partner present, regarding the August 2014 MAR. When asked whether the Heparin flush was provided per physician order, the DON stated, "Can't tell." On 9/11/14 at 4:00 PM, the ADON was interviewed about Resident #6's physician's order for weekly flushes on her port-a-cath. The ADON stated, "It should have been done weekly, until we changed it." On 9/11/14 at 5:50 PM, the Administrator and DON were informed of the issue. No further information was provided.	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced	F 314	F314 Corrective Actions: The D.O.N. updated the affected resident's care plan, assessment and documentation on current skin condition. Identification of others affected and corrective actions: All residents that are dependent for care could have been affected. A review of all skin assessments was conducted for timeliness and accuracy. Measures to ensure that the deficient practice does not happen again: Education was provided on 10/1/14 to licensed staff on assessing care plan interventions, how to complete skin assessments, and when to update interventions assessments and care plan intervention. Skin assessments and care plan interventions will be reviewed weekly during the skin committee for timeliness and accuracy. A wound nurse began work on 10/2/14. Monitor corrective actions: D.N.S. or designee will conduct an audit for timely, accurate skin assessments that corresponds with the additional care plan updates as needed 3 x week for 2 weeks. Then 2 x weeks for 4 weeks. Then 1 x week for 4 weeks. The audit results will be brought to QA monthly. Audits to begin 10/1/14 Corrective Actions will be completed	10/17/14	

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F 314	<p>Continued From page 14</p> <p>by: Based on record review and staff interview, it was determined the facility failed to ensure a resident's skin care plan interventions were effective, skin assessments were complete and interventions were updated after a resident developed a Stage II pressure ulcer on the coccyx. This was true for 1 of 10 (#8) sampled residents. This practice created the potential for more than minimal harm if a resident's pressure ulcer was not assessed correctly and interventions were not implemented and monitored. Findings included:</p> <p>Resident #8 was readmitted to the facility on 4/28/14 with multiple diagnoses including altered mental status, cardiovascular accident, congestive heart failure, peripheral vascular disease, and convulsions.</p> <p>Resident #8's 6/17/14 quarterly MDS documented: *Risk of pressure ulcers-Yes, *Unhealed pressure ulcer-No, *Other ulcers, wounds & skin problems-Moisture associated skin damage (MASD), *Required two-person assist with bed mobility, *Always incontinent of bladder and bowel.</p> <p>The facility's Skin Monitoring and Management - Ulcers Policy and Procedure documented, "...must assess/evaluate each wound...This assessment/evaluation should include but not be limited to...measuring the wound...staging the wound...describing the nature of the wound...describing the location of the wound...describing the progress with healing..."</p> <p>The Resident's Skin Care Plan documented on</p>	F 314			

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F 314	<p>Continued From page 15</p> <p>4/3/14: *Focus: "...History of pressure ulcers, scores high on Braden Scale." *Interventions: *Encourage fluid intake and assist to keep skin hydrated; *Monitor, document, and report to MD PRN changes in skin status: appearance, color, wound healing, s/sx (signs and symptoms) of infection, wound size and stage; *Turn and reposition frequently with cares. Up in wheelchair for meals, therapies, etc. Do not leave up in wheelchair for extended periods; *Requires pressure relieving/reducing device. Air mattress to bed. Sit straight coccyx cushion with checkerboard T layer in wheelchair; and, *Supplemental protein, vitamins, minerals as ordered to promote skin integrity.</p> <p>The Resident's Nursing Notes (NN), IDT Progress Notes (IDT) and LN Skin Assessment/Evaluation-PRN/Weekly (SA) documented:</p> <p>*6/30/14, SA, "Head to toe skin assessment...sacral and inguinal areas clear with no redness noted..."</p> <p>*7/1 through 7/27/14, no documentation was found in the NN and IDT regarding the coccyx.</p> <p>SA: *7/7/14-"Dressing to wound on Coccyx, clean dry and intact..." *7/14/14-"...Pressure ulcer to coccyx, has dressing...Did not visualize." *7/21/14-"Pt [patient] has stage II pressure ulcer to coccyx, dressing intact..." *7/28/14-"...Pressure ulcer to coccyx, cleansed</p>	F 314			

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F 314	<p>Continued From page 16</p> <p>with NS and applied sterile mepilex...Wound bed pink with no drainage." Note: The weekly assessments did not include, when the wound was discovered, measurements in order to monitor the wound, or staging until 7/21/14.</p> <p>-8/2/14, NN - "Assessed resident's superficial open area to vertical gluteal crease. Area measures 1.5 X [by] 0.3 X 0.1cm wound bed 100% pink, serosanguinous drainage with no foul odor...excoriation and maceration to area...due to incontinence. Staff educated to do prompt incontinent care..."</p> <p>-8/4/14 CP Interventions: Encourage good nutrition and hydration in order to promote healthier skin; Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD; Turn to sides frequently as tolerated by resident; and, Air mattress to bed to promote skin integrity. Note: There were no documented interventions from 7/7 until 8/4/14.</p> <p>The resident's SA, NN, IDT, and LN Skin Ulcer Non-Pressure Weekly notes, documented the resident's coccyx pressure ulcer had improved after the interventions on 8/4/14.</p> <p>On 9/11/14 at 5:30 PM, the DON with the Clinical Partner present was interviewed regarding Resident's #8 Stage II pressure ulcer. When the surveyor asked the DON, why there were no measurements taken until 8/2 when the wound was identified as a Stage II pressure ulcer on 7/21/14, the DON stated, "Can't explain why."</p>	F 314		

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F 314	Continued From page 17	F 314			
F 323 SS=G	<p>On 9/11/14 at 5:50 PM, the Administrator and DON were informed of the issue. No other information was provided.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility did not ensure a fall care plan and a physician order were followed for 1 of 5 residents (#3) sampled for falls. Resident #3 was harmed when she reached for a water bottle placed out of her reach, fell from bed which did not have the appropriate sized side rails as ordered by the physician, and the fall resulted in the resident sustaining femur fractures to both of her legs. Findings included:</p> <p>Resident #3 was admitted to the facility on 12/5/02 with multiple diagnoses including muscle weakness, osteoporosis, infantile cerebral palsy, convulsions, and chronic pain.</p> <p>The resident's 7/30/14 annual MDS assessment documented the following: *Required extensive assistance with two staff</p>	F 323	<p>F323</p> <p>Corrective Actions: Resident bed was changed to four ¼ rails with bolsters. Consents were obtained and the care plan was updated.</p> <p>Identification of others affected and corrective actions: All residents in the facility could have been affected. A sweep of the facility was conducted to ensure that all items were within all residents reach.</p> <p>Measures to ensure that the deficient practice does not happen again: The facility will add the "Take 5 Program" to our new hire orientation. DNS or designee will add to their list of duties to spot check rooms to validate care plan is being followed by aides on the floor. D.N.S. provided education for nursing staff, on our "Taking 5" program. And to remember to check rooms before leaving to ensure care plan is followed on 10/2/14.</p> <p>Monitor corrective actions: DNS or designee will audit resident rooms 3 x week for 2 weeks then 2 x week for 4 weeks. Then 1 x week for 4 weeks. The audit results will be brought to QA monthly. Audits to begin 10/1/29/14</p> <p>Corrective Actions will be completed</p>	10/17/14	

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F 323	<p>Continued From page 18</p> <p>members for bed mobility; *Required total dependence with two staff members to transfer in/out of bed; and, *Was moderately cognitively impaired, BIMS=11.</p> <p>The resident's September 2014 Order Summary Report documented an order dated 7/24/12, "2 1/2 Length Side Rails to Bed for safety, bed mobility R/T [related to] seizure disorder." Refer to F154 regarding informed health status regarding the use of side rails</p> <p>The resident's care plan dated 1/30/14, documented a focus of: "Has high risk for injury and fracture r/t severe Osteoporosis, osteopenia, Cerebral palsy and Seizure disorder with involuntary movement at times..." With an intervention of, "Protect from injury. Avoid sudden bumps..."</p> <p>The resident's ADL care plan, dated 1/30/14, documented an intervention of: "Side Rails: 2 half rails up as per Dr.s [physician] order for safety while in bed due to seizure disorder, to assist with bed mobility..."</p> <p>The resident's fall care plan, dated 1/30/14, documented a focus of: "At risk for falls r/t Poor communication/comprehension, Deconditioning, Psychoactive drug use, Incontinence." With interventions of, "Keep needed items, water, etc. in reach on bedside table/tray...Four 1/2 length side rails while in bed to provide safety r/t seizure disorder." Note: The care plan was not consistent on how many side rails were to be applied to the bed.</p> <p>The resident's Progress Notes dated 9/6/14 and</p>	F 323			

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F 323	<p>Continued From page 19</p> <p>9/7/14, documented the resident had fallen from bed, was found in the praying position, and was assessed , monitored, and given medication for pain. When leg pain was found, the facility transported the resident to a local Emergency Room (ER).</p> <p>A local hospital physician's note dated 9/7/14, documented, "Bilateral distal femur fractures...At this time, I believe nonoperative care is warranted. Our plan is a hinged knee brace for protection..."</p> <p>A facility "Fall Scene Investigation" dated 9/6/14 at 1:00 PM indicated the resident fell on 9/6/14 at 10:25 AM. The investigation documented the following: The "Fall Description Details" section documented, "Resident on knees beside bed with head on bed...reach for her pop [sic]." The "Root Cause of this Fall" section documented, "Resident was reaching for pop and table was out of reach...Staff educated on checking all before leaving."</p> <p>A facility investigation dated 9/10/14, documented the following: The "Investigation" section documented, "Res[ident] stated she was reaching for her drink when she fell...Interventions put in place immediately included floor mats on both sides and bed in lowered position. Two additional quarter rails were added as well as bilateral bolsters inside the rails." The "Summary" section documented, "Resident at high risk for fracture due to medical conditions...Resident did not complain of leg pain until later in the night. Upon return from hospital, has bilateral knee braces to prevent knee flexion;</p>	F 323			

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F 323	<p>Continued From page 20 as surgical intervention is not recommended."</p> <p>The resident's September 2014 MAR, documented the resident experienced no pain to mild pain from 9/1/14 to 9/5/14 and had not taken any PRN pain medications. However, after the fall from 9/6/14 to 9/8/14 the resident experienced moderate to severe pain and had taken PRN pain medications with effective results.</p> <p>After the fall, the resident's care plan was updated and contained the following interventions: -9/6/14, "Bed in lowest position." -9/8/14, "1/2 Side Rails x[times] 4 for bed mobility and padded bolster mattress for seizure precautions." -9/8/14, "Mats at bedside." -9/8/14, "Keep bedside table close to bed."</p> <p>The following observations were made of the resident's room: -On 9/8/14 at 4:10 PM, the bed had four quarter rails attached to the bed (two upper and two lower on each side of the bed) with the padding extending the length of the bed. The pads had bed bolsters attached to the inside portion. The resident was in bed watching a movie and had a pink water bottle in the bed with her. There was also a water mug on the over bed tray table. The tray table was one and a half feet away from the bed and was resting partially on top of one of the padded fall mats placed on each side of the bed. The bed was raised in the normal position. -On 9/9/14 at 7:35 AM, the resident was asleep in bed with a pink water bottle at her side. The bed was in the low position. The tray table was one and a half feet away from the bed, raised above the bed level and was resting partially on top of</p>	F 323			

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F 323	<p>Continued From page 21</p> <p>one of the padded fall mats with a water mug and Sprite bottle on top of the table. A staff member was seen going into the room, took the water mug away and walked out of the room with the mug.</p> <p>-At 7:43 AM, a CNA was observed in the room. She adjusted the tray table down to the level of the bed and moved it closer to the bed. The table was still 6 to 8 inches away from the edge of the bed.</p> <p>-At 9:53 AM, the tray table was observed sitting directly on the fall mat with the table top overlapping the bed by 2 inches.</p> <p>On 9/11/14 at 8:12 AM, CNA #3 was interviewed regarding the resident's fall. She stated she found the resident half on and half off the bed with her face and head looking over the bed. She stated the bed had a quarter side rail to each side of the bed toward the top half.</p> <p>On 9/11/14 at 8:40 AM, LPN #4 was interviewed regarding the fall. She stated the resident was found in the 'praying position' with her knees toward the ground and her head facing the bed. She stated she interviewed the resident who told her she was reaching for her pop which was in the pink water bottle, when she fell out of bed. When LPN #4 asked the resident where the pop was located, the resident said it was on the bedside table next to the head her bed. Note: The bedside table was located 18 inches diagonally away from the head of the resident's bed.</p> <p>On 9/11/14 at 9:00 AM, Resident #3 was interviewed regarding the fall. Holding up her pink water bottle she said she was reaching for it. When asked which side of the bed it was located at the time of the fall, she pointed to her left</p>	F 323		

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F 323	Continued From page 22 (window side). When asked where on that side, she stated, "table." When asked if it was the tray table (to her right) or the bedside table (to her left), she motioned her head left and said, "There." On the table were stuffed animals and the surveyor asked, "With the animals?" and she stated, "Yeah." On 9/11/14 at 9:40 AM, CNA #5 was interviewed regarding the fall. She stated the resident was found on her knees with her upper body on the bed right next to the lower portion of the quarter side rail. She said there were no lower side rails attached to the bed at the time. On 9/11/14 at 10:35 AM, the DON was interviewed with a Clinical Partner present. When asked for the conclusion of the investigation he stated, "The patient was reaching for a pop and fell off the bed." When asked to review the care plan regarding keeping items within reach, he reviewed and stated, "I understand." When asked about what type of side rails the resident had at the time of the fall he stated, "She had two quarter at the top." The DON was not sure why the resident did not have two half-length side rails as ordered. He was also informed of the surveyor's observations of the bed in the normal position and the tray table out of reach of the resident, where upon he stated, "I did not know about that."	F 323			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431			

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F 431	<p>Continued From page 23</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined the facility failed to ensure a medication was labeled with a correct</p>	F 431	<p>F431</p> <p>Corrective Actions: Pre-filled, unlabeled syringes and expired meds were immediately pulled from med cart and medication room. All medications and supplies without expiration dates were returned to pharmacy. Medication label for oral medication on NPO resident were corrected.</p> <p>Identification of others affected and corrective actions: All residents that receive medications could have been affected.</p> <p>Measures to ensure that the deficient practice does not happen again: Education was provided on 10/2/14 to licensed staff on expired medication and supplies, proper labeling of individual syringes and having Five Rights to be reviewed with med pass. Medication orders will be reviewed by D.N.S. or designee daily during normal work days in PCC.</p> <p>Monitor corrective actions: D.N.S. or designee will conduct an audit for med rooms and carts for expired meds, proper labels and proper route 3 x week for 4 weeks. Then 1 x week for 4 weeks. The audit results will be brought to QA monthly. Audits to begin 10/2/14</p> <p>Corrective Actions will be completed</p>	10/17/14	

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F 431	<p>Continued From page 24</p> <p>administration route, prefilled syringes were individually labeled, prescription medications had an expiration date, and outdated medical supplies were removed from the medication room. This failure created the potential for more than minimal harm if an incorrect medication was administered, diminished efficacy for medications administered via the incorrect route and/or after the expiration date, and the utilization of expired medical supplies. This had the potential to affect 1 of 9 residents (#2), 3 random residents (#11-#13), and any other resident who could receive incorrect or expired medication and/or biologicals and medication administered via the wrong route. Findings included:</p> <p>1. On 9/9/14 at 10:25 AM, during medication pass observation, Resident #11's medication label for Citalopram 20 mg (dispensed 8/9/14) documented to administer, "1 tablet by mouth daily." Resident #11's 9/2014 Physician Orders documented resident as being "...NPO (nothing by mouth)..." effective 5/16/12 and "Celexa Tablet 20 MG [Citalopram Hydrobromide] Give 20 mg enterally one time a day related to Depression..." with an order date 01/21/2014.</p> <p>At 10:30 AM, LN #2 was interviewed prior to administration of Resident #11's medications. The LN said that she looked at the current MAR and verified the physician's order, the resident was still NPO and the order stated to give enterally.</p> <p>2. On 9/9/14 at 12:25 PM, the North Medication Cart was examined with the DON. The surveyor and DON discovered 3 dark brown plastic bags with prefilled syringes that were not individually labeled. The label on the outside of each unsealed bag identified the resident, medication,</p>	F 431			

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F 431	Continued From page 25 strength, and directions for use. The label on the first bag documented, "Lorazepam 1MG/ML", with 28 unlabeled syringes and the label on the second bag documented, "Morphine 20MG/ML" with 21 unlabeled syringes for Resident #13. The label on the third bag documented, "Lorazepam 0.5MG/0.5 ML" with 14 unlabeled syringes for Resident #2. The DON declined to comment on why the syringes were not individually labeled and what would prevent mixing up unlabeled medications. 3. On 9/9/14, 4 blister medication packs for Resident #12, 8 blister packs for Resident #2, and 2 bottles of liquid medication for Resident #11 were discovered in the North Medication Cart. None of the 14 medications had a listed expiration date. 4. On 9/9/14 at 3:40 PM, the surveyor and DON discovered 2 expired biologicals in the South Medication Room including a sterile foam tipped applicator with an expiration of 06/2014 and a 27 by 1 1/4 inch Monojet needle with an expiration of 07/2013. On 9/10/14 at 4:45 PM, the Administrator and the DON were informed of the issues. No additional information was provided.	F 431			
F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be	F 464			

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F 464	<p>Continued From page 26</p> <p>adequately furnished; and have sufficient space to accommodate all activities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident group interview, and staff interview, it was determined the facility failed to provide adequate lighting in the main dining room. This failed practice affected 2 of 6 residents in the group interview and had the potential to affect other residents who dined in the main dining room. Findings included:</p> <p>The following observations were made in the main dining: -9/8/14 at 5:25 PM, during the dinner meal the ceiling was observed to be sectioned off in 3 areas with an approximately 18 inch barrier hanging down which separated the sections. The front and back section contained florescent lights close to the ceiling and the middle section only contained two sets of ceiling fans with 4 lights apiece, for a total of 8 light bulbs for the middle section. None of the 8 lights were lit. The middle section of the dining room appeared darker than the other two sections. There were two tables in the middle section where 5 residents dined. -9/9/14 at 12:00 PM, similar observation as above. -9/10/14 at 8:15 AM, similar observations as above.</p> <p>On 9/9/14 at 1:30 PM during the resident group interview, 2 out of 6 residents expressed concerns with the lighting in the main dining room and said it was dark.</p> <p>On 9/11/14 during the environmental tour from</p>	F 464	<p>F464</p> <p>Corrective Actions: Facility ordered new light fixtures and they were installed by on 10/17/14.</p> <p>Identification of others affected and corrective actions: All residents that eat in the main dining room could have been affected.</p> <p>Measures to ensure that the deficient practice does not happen again: Facility wide sweep of all light fixtures has been done to identify burned out lights and replaced as needed. The maintenance director will add this to his monthly PM checklist as an ongoing review for the facility. All staff were educated to notify the maintenance director when a light bulb is found to be burned out.</p> <p>Monitor corrective actions: The maintenance director will audit 1 x week for 6 weeks and the audit results will be brought to QA monthly. Audits to begin 10/1/14</p> <p>Corrective Actions will be completed</p>	10/17/14	

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F 464	Continued From page 27 9:55-10:30 AM, the Maintenance Supervisor was asked about why the lights were turned off in that section and he stated, "I don't have any idea." He then attempted to turn the lights on with a pull cord hanging from the bulbs and only 1 of the 8 bulbs illuminated. He said he would "change the bulbs." On 9/11/14 at 5:50 PM, the Administrator and DON were informed of the issue. No other information was provided.	F 464	F468 Corrective Actions: Facility immediately installed the proper hand rails per life safety. Identification of others affected and corrective actions: All residents that use hand rails in the facility could have been affected. Measures to ensure that the deficient practice does not happen again:		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all corridors were equipped with handrails. This affected 4 of 9 (#s 1, 4, & 8) sampled residents and had the potential to affect other residents who frequented the corridors without handrails. This practice created the potential for residents not to have a handrail for stability when needed. Findings included: On 9/8/14 from 2:45-2:50 PM, the following observations were made: -Handrails were observed to be missing in the corridor from the main entrance to the Activity Room, with 14 feet missing on the left side and 8 and 3 feet sections missing on the right side near the Administrator's Office. -Handrails were observed to be missing in the	F 468	Facility wide inspection of all hand rails was done to validate hand rails are installed per life safety codes. The maintenance director will add this to the monthly PM checklist. Monitor corrective actions: The maintenance director will audit hand rails in place 1 x week for 6 weeks. The audit results will be brought to QA monthly. Audits to begin 10/2/14 Corrective Actions will be completed	10/17/14	

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F 468	Continued From page 28 corridor from the south entrance to the sitting area, with two, 2 foot sections missing on each side of the corridor. On 9/11/14 during the environmental tour from 9:55-10:30 AM, the Maintenance Supervisor was shown the missing handrails and he made a note of them. When asked if handrails near the main entrance had been along the wall prior to the recent painting of the walls in that area, he stated, "Not that I know of." On 9/11/14 at 5:50 PM, the Administrator and DON were informed of the issue. No other information was provided.	F 468		
F 514 SS=D	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 by: Based on record review and staff interview, it was determined the facility failed to maintain clinical records on each resident in accordance	F 514	F514 Corrective Actions: Physician order was corrected to reflect Heparin. Identification of others affected and corrective actions: No other resident has a port-o-cath, so no other residents were affected. Measures to ensure that the deficient practice does not happen again: Education was provided on 10/2/14 to licensed staff on ensuring that all port-o-cath orders specifically list the medication to be used. Port-o-cath medication orders will be reviewed by D.N.S. or designee daily during normal work days in PCC. Monitor corrective actions: D.N.S. or designee will conduct an audit port-o-cath orders 3 x week for 4 weeks. Then 1 x week for 4 weeks. The audit results will be brought to QA monthly. Audits to begin 10/2/14 Corrective Actions will be completed	10/17/14

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F 514	<p>Continued From page 29</p> <p>with accepted professional standards and practices to ensure records were complete and accurate. This was true for 1 of 10 (#6) sampled residents. This deficient practice increased the risk for medical decisions to be based on incomplete or inaccurate information and increased the risk for complications due to inappropriate care or interventions. Findings included:</p> <p>Resident #6 was admitted to the facility on 12/26/12 with multiple diagnoses including chronic pain, Narcolepsy with Cataplexy, Epilepsy, Diabetes, Neurogenic Bladder, Chronic Airway Construction, and Depressive Disorder.</p> <p>The resident's 6/26/14 significant change MDS documented BIMS with a score of 15-cognitively intact. The resident's medications triggered were antidepressants, antibiotics, and diuretics.</p> <p>Resident #6's Physician Orders were documented as follows: -6/14/14, "...Normal Saline [NS] Flush Solution 0.9% (Sodium Chloride Flush) Use 10 ml intravenously one time a day every Sun [Sunday] for routine care to keep catheter line patent 0.9% Solution Intravenous (IV). Flush port-a-cath with 10cc every week and follow with heparin. DISCONTINUE 08/27/2014...REASON: NEW ORDER..."</p> <p>-6/14/14, "...Heparin Lock Flush Solution Use 5ml intravenously one time a day every Sun for routine cath care to keep line patent 100 UNIT/ML:5 ml Solution Intravenous (IV). Flush 5 ml through port-a-cath following 10cc normal saline flush weekly. USE 3/4 NEEDLE[.] DISCONTINUE 08/27/2014...REASON: NEW</p>	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/12/2014
NAME OF PROVIDER OR SUPPLIER MONTE VISTA HILLS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVENUE POCATELLO, ID 83201	
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F 514	<p>Continued From page 30 ORDER..."</p> <p>-8/27/2014, "...MAINTENANCE FLUSH-CENTRAL LINE/INPLANTED PORT: 10 ml NS then 5ml (10u/ml) Monthly every day shift every 30 day(s)..."</p> <p>-9/11/14, "...MAINTENANCE FLUSH-CENTRAL LINE/INPLANTED PORT: USE 10 ml NS [normal saline] then lock with 2.5ml normal saline mixed with 2.5ml of heparin 100units/ml for a 5ml total volume, every day shift every 30 day(s)."</p> <p>Resident #6's MARs were documented as follows: -6/1/14 through 8/31/14, "...Heparin Lock Flush Solution Use 5 ml intravenously one time a day every Sun for routine cath care to keep line patent 100 UNIT/ML:5 ml Solution Intravenous (IV). Flush 5 ml through port-a-cath following 10cc normal saline flush weekly..."</p> <p>-9/1 through 9/30/2014, "...Maintenance Flush-Central Line/Inplanted Port: 10 ml NS then 5ml (10u/ml) Monthly every day shift every 30 day(s) Order date 8/27/2014..."</p> <p>Note: Physicians' Orders and the MARs did not have Heparin documented as the medication to flush with, Heparin and Normal Saline amounts were not documented, and the Heparin concentration varied from 10u/ml to 100u/ml. The facility made corrections on the Physician's Order on 9/11/14, while survey was in process.</p> <p>The facility provided Resident #6's records on 9/9/14 which contained August 2014 MAR with no initials on any day to reflect a flush had been performed in August, however on 9/11/14 at 4:00</p>	F 514		

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NAME OF PROVIDER OR SUPPLIER MONTE VISTA HILLS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVENUE POCATELLO, ID 83201		
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F 514	<p>Continued From page 31</p> <p>PM, a second copy of the same page of the Resident's August MAR was provided by the facility which documented initials on 8/31/14.</p> <p>On 9/11/14 at 2:40 PM, the ADON was interviewed about Resident #6's physician's order for maintenance flushes on her port-a-cath. The ADON acknowledged Heparin had not been documented on the physician's orders and as of 8/27/14 they had went to monthly flushes. The ADON stated, "I wrote it down wrong and have corrected it to read Heparin."</p> <p>On 9/11/14 at 4:00 PM, the facility provided its Policy and Procedures, "Flushing the Port-A-Cath". The Policy and Procedure documented, "...a Port-A-Cath is flushed with 10mL of normal saline and locked with 2.5mL normal saline mixed with 2.5mL of heparin 100 units/mL for a 5m [mL] total volume..."</p> <p>On 9/11/14 at 5:50 PM, the Administrator and DON were informed of the issue. No further information was provided.</p>	F 514			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/12/2014
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NAME OF PROVIDER OR SUPPLIER MONTE VISTA HILLS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVENUE POCATELLO, ID 83201
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>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.</p> <p>The following deficiencies were cited during the State licensure and complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Linda Hukill-Neil RN, BSN</p>	C 000	C-119 See F154	
C 119	<p>02.100,03,c,iii Informed of Medical Condition by Physician</p> <p>iii. Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research;</p> <p>This Rule is not met as evidenced by: Refer to F154 regarding Guardian notification of type of side rails.</p>	C 119		
C 121	<p>02.100,03,c,v Encouraged/Assisted to Exercise Rights</p> <p>v. Is encouraged and assisted, throughout his period of stay, to exercise his rights as a patient/resident and as a citizen, and to this end may voice grievances and recommend changes in policies and</p>	C 121	C-121 See F242	

RECEIVED
OCT 17 2014
FACILITY STANDARDS

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

ADMINISTRATOR 10/14/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/12/2014
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C 121	Continued From page 1 services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; This Rule is not met as evidenced by: Refer to F242 regarding resident choice regarding menu variety.	C 121	C-389 See F468	
C 389	02.120,03,d Sturdy Handrails on Both Sides of Halls d. Handrails of sturdy construction shall be provided on both sides of all corridors used by patients/ residents. This Rule is not met as evidenced by: Refer to F468 regarding missing handrails.	C 389		
C 393	02.120,04,b Staff Calling System at Each Bed/Room b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Refer to F246 regarding call lights being readily	C 393	C-393 See F246	

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C 393	Continued From page 2 accessible to resident at all times.	C 393		
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 regarding a resident's fall care plan update not completed.	C 782	C-782 See F280	
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 relating to assessment, monitoring, and interventions for a pressure sore.	C 789	C-789 See F314	
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 regarding a resident's fall with fractures.	C 790	C-790 See F323	
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders 04. Medication Administration. Medications shall be provided to	C 798	C-798 See F281	

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C 798	Continued From page 3 patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Refer to F281 regarding administration of medications and following physician's orders.	C 798	C-821 See F431	
C 821	02.201,01,b Removal of Expired Meds b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days. This Rule is not met as evidenced by: Refer to F431 regarding expired medications and biologicals.	C 821	C-832 See F431	
C 832	02.201,02,f Labeling of Medications/Containers f. All medications shall be labeled with the original prescription legend including the name and address of the pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.) This Rule is not met as evidenced by: Refer to F431 regarding labeling of medications.	C 832		

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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 F514 regarding complete and accurate medical records.	C 879	C-879 See F514	



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
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September 23, 2014

Richard F. Cartney, Administrator
Monte Vista Hills Healthcare Center
1071 Renee Avenue
Pocatello, ID 83201-2508

Provider #: 135018

Dear Mr. Cartney:

On September 12, 2014, a Complaint Investigation survey was conducted at Monte Vista Hills Healthcare Center. Bradley Perry, L.S.W. and Linda Hukill-Neil, R.N. conducted the complaint investigation. The complaint was investigated in conjunction with the facility's Recertification and State Licensure survey conducted on September 8 through September 12, 2014.

The following observations were completed:

- The identified resident's room and bed were observed.

The following documents were reviewed:

- The entire medical record of the identified resident;
- Four other residents' records were reviewed for falls;
- The facility's grievance file from April to September 2014;
- Resident Council minutes from March to September 2014; and,
- The facility's Incident and Accident reports from March to September 2014.

The following interviews were completed:

- The identified resident was interviewed regarding the fall from bed;
- Three residents were interviewed regarding Quality of Care concerns;
- Two residents' family members were interviewed regarding Quality of Care concerns;

- Six residents were interviewed during the Resident Group regarding Quality of Care concerns;
- Two CNAs and a Nurse were interviewed regarding the fall; and,
- The Director of Nursing was interviewed regarding the fall.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006665

ALLEGATION #1:

The complainant stated an identified resident fell from bed and sustained bilateral femur fractures because she had reached for a water container that was left out of reach of the resident.

FINDINGS #1:

The identified resident's medical record and fall investigation revealed the facility failed to follow the resident's care plan when a water bottle was left out of the reach of the resident. When the resident reached for the bottle, she fell and fractured both femurs. Observations two days after the resident's fall revealed items were still left out of the resident's reach.

The facility was cited at F323 for non-compliance.

CONCLUSIONS:

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

ALLEGATION #2:

The complainant stated the resident's guardian was told by the facility the resident would have full-length side rails for the resident's safety, but at the time of a fall, the resident only had half-length side rails up.

FINDINGS #2:

The identified resident's bed was observed, and the bed contained four quarter-length rails; two on each side with a padded bolster that covered the length of the bed. The resident's medical record contained a consent signed by the guardian for All Side Rails to be used. The resident's care plan indicated four half-length side rails were to be used. The resident's fall investigation and interviews with staff revealed prior to a fall, only two quarter-length rails (one on each side) were in use.

Richard F. Cartney, Administrator
September 23, 2014
Page 3 of 3

The facility was cited at F154 for non-compliance.

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.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a stylized "S".

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

DS/dmj