



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 83726
Boise, ID 83720-0009
PHONE 208-334-6626
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CERTIFIED MAIL: 7012 1010 0002 0836 2199

September 25, 2013

Steve E. Lish, Administrator
Discovery Care Center
600 Shanafelt Street
Salmon, ID 83467-4261

Provider #: 135129

**RE: SEPTEMBER 13, 2013, RECERTIFICATION AND STATE LICENSURE
SURVEY REPORT COVER LETTER**

Dear Mr. Lish:

On **September 13, 2013**, a Recertification and State Licensure survey was conducted at Discovery Care Center by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency 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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 8, 2013**. Failure to submit an acceptable PoC by **October 8, 2013**, may result in the imposition of civil monetary penalties by **October 28, 2013**.

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

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

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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 18, 2013, (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 18, 2013**. A change in the seriousness of the deficiencies on **October 18, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 18, 2013**, includes the following:

Denial of payment for new admissions effective **December 13, 2013**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 13, 2014**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will

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recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **September 13, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **October 8, 2013**. If your request for informal dispute resolution is received after **October 8, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

LT/dmj
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNEs AND NFs	PROVIDER # 135129	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 9/13/2013
NAME OF PROVIDER OR SUPPLIER DISCOVERY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SHANAFELT STREET SALMON, ID	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 278	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to accurately code residents' MDSs for medication administration. This affected 2 of 6 (#s 1 & 6) sampled residents. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 5/6/13 with multiple diagnosis including depression.</p> <p>Resident #1's 5/15/13 admission MDS coded moderately impaired cognition, moderately depressed mood, and did not receive anti-depressant medication.</p> <p>Resident #1's 8/13/13 quarterly MDS coded did receive anti-depressant medication the past 7 days.</p> <p>Resident #1's 9/13 "All Active Orders for September 2013" (recapitulation orders) contained the order, 5/6/13 Citalopram 20 milligrams (mg) by mouth every day for depression.</p> <p>Resident #1's Care Plan (CP) identified the 5/6/13 focus area, has the potential for psychosocial well-being related to the diagnosis of depression. One of the focus interventions was, administer Citalopram 20 mg by mouth daily for depression.</p> <p>Resident #1's current 9/13 Medication Administrator Record documented the resident received Citalopram once a day for depression.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135129	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 9/13/2013
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NAME OF PROVIDER OR SUPPLIER DISCOVERY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 600 SHANAFELT STREET SALMON, ID
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 278	<p>Continued From Page 1</p> <p>On 9/11/13 at 11:55 a.m., the surveyor informed the MDS Coordinator Resident #1's recapitulation orders contained an anti-depression medication ordered on 5/6/13 however the 5/15/13 admission MDS did not code for the use of an anti-depressant medication. The MDS Coordinator stated, "I will check that out."</p> <p>On 9/12/13 at 11:15 a.m., the MDS Coordinator stated, "Depression medications were not coded correctly on the 5/15/13 MDS. I am doing a correction."</p> <p>2. Resident #6 was admitted to the facility on 8/17/12 with multiple diagnoses including depressive disorder.</p> <p>Resident #6's 5/31/13 quarterly MDS coded moderately impaired cognition, minimal depression, and did not receive antidepressant medication.</p> <p>Resident #6's 8/27/13 annual MDS coded moderately impaired cognition, mild depression, and did not receive anti-depressant medication.</p> <p>Resident #6's 9/13 "All Active Orders for September 2013" (recapitulation orders) contained the order, 3/27/13 Bupropion (Buspar) extended release 150 mg by mouth every day for mood stabilizer.</p> <p>Resident #6's CP identified the 8/30/13 focus area potential for psychosocial well-being problem related to depression. One of the focus interventions was administer Buspar 150 mg every day.</p> <p>Resident #6's current 9/13 Medication Administration Record documented the resident received Bupropion every day for mood stabilizer.</p> <p>9/11/13 at 11:45 a.m., the surveyor informed the MDS Coordinator both the 5/31/13 and 8/27/13 MDSs coded did not receive anti-depressant medications although the recapitulation order for Buspar was 3/27/13. The MDS Coordinator stated, "Could have been an oversight. I will do a correction right now."</p> <p>On 9/13/13 at 10:00 a.m., the Administrator and the DON were informed of the finding. The facility did not provide additional information related to the finding.</p>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/13/2013
NAME OF PROVIDER OR SUPPLIER DISCOVERY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SHANAFELT STREET SALMON, ID 83467	
(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 survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Karen Marshall, MS, RD, LD Team Coordinator Arnold Rosling RN, BSN, QMRP Debbie Bernamonti, RN</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status BFS = Bureau of Facility Standards BM = Bowel Movement CAA = Care Area Assessment CNA = Certified Nurse Aide DNS/DON = Director Nursing Services/Director of Nursing D/T = Due to Dx = Diagnosis FDA = Food and Drug Administration HRS = Hours HS = At Bedtime LN = Licensed Nurse MDS = Minimum Data Set assessment MG = Milligram MAR = Medication Administration Record PRN = As Needed Pt = Patient RAI = Resident Assessment Instrument Res = Resident RN = Registered Nurse R/T = Related To SNF = Skilled Nursing Facility TAR = Treatment Administration Record TV = Television</p>	F 000		

RECEIVED
OCT 10 2013
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE **Executive Director** (X6) DATE **10/07/13**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 WC = Wheelchair	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and resident interview it was determined the facility failed to ensure the resident's choices and right to refuse were included in plan of care. This was true for 1 of 9 (#3) sampled residents. This had the potential to cause declines in residents' self-worth and quality of life. Findings include: Resident #3 was admitted 5/23/11 and readmitted on 2/15/13 and 2/26/13, with multiple diagnoses including pneumonia and congestive heart failure.	F 155	The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).	

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F 155	<p>Continued From page 2</p> <p>The resident's most recent annual MDS coded: -makes self-understood and usually able to understand others. -cognition intact and mild depression. -at risk for developing pressure ulcer. Resident #3 has a history of (H/O) recurring pressure ulcer on her buttocks. The plan of care initiated 05/21/11 documented: Focus- "Moderate Risk for further skin breakdown: H/O healed stage 2 bilateral buttocks (2/2/12)" Interventions- "...APPLY MEPILEX AND CHANGE QOD (every other day) B) [RESIDENT #3] REJECTS TO LAY DOWN IN BED AND CONTINUES TO SLEEP IN RECLINER.C) STAFF HAS EDUCATED RES. REGARDING RISK FOR NOT CHANGING POSITIONING AND [RESIDENT #3] CONTINUES TO REJECT BED. D) 9/9/13, RSD SPOKE WITH [RESIDENT] ABOUT NEED FOR REPOSITIONING OFF BUTTOCKS again, and if res rejects to lie down in bed tonight res recliner will be removed from room. FAX SENT TO MD REGARDING RES CURRENT SKIN ISSUES." - " ROHO CUSHION IN WHEELCHAIR B) REJECTS GEL CUSHION IN REGULAR CHAIR IN DINING ROOM. " On 9/10/13 at 3:25 pm, the RSD documented: "RSD spoke with [Resident #3] this AM. She said she had slept in her bed last night and would continue to do so but would rather be in her recliner. RSD stated she was able to keep her recliner and discussed again that she would have more skin breakdown if she were to choose to sleep in the recliner again. Recliner will remain in her room." On 9/12/13 at 9:30 am, the resident was interviewed regarding the bed, "...They said if I sleep in my bed it will become healed. I talked</p>	F 155	<p>A. Corrective Actions: Resident #3 has multiple co-morbidities but the right to refuse treatment/cares. The resident, in question, has been informed, educated, and documented as to the possible consequences of the refusal. Written information, as to the resident's rights, has also been provided at the time of admission. Existing interventions remain in place with additional interventions implemented, such as the resident agreeing to sleep in bed with the head of the bed elevated. The care plan has been updated with the resistive to cares added. The social service designee will provide education to nursing staff regarding resident's rights to reject care and where to document on the monthly behavior flow sheet.</p> <p>B. Identification of others affected and corrective actions: Any resident exercising their right to refuse treatment/cares will be identified by a certified nurse aide, a charge nurse, wound nurse, and Social Services Designee. A refusal of care form will be implemented upon rejections and forwarded to the charge nurse and the DON. If a resident continues to refuse, the family will be notified and</p>	

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F 155 F 156 SS=C	<p>Continued From page 3</p> <p>with my Doctor and he said it may not heal but it could get better. I sleep better in my chair. I've slept in my chair off and on for 3 years." On 9/12/13 at 3:10 pm the DON was interviewed regarding the resident's care plan and the threat of removing the recliner if the resident continued to spend the night in it. No information was received that altered the concern. The care plan did not incorporate the resident's choices into treatment, care and services.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)</p>	F 155	<p>then IDT Team will review, and the facility's revised policy and procedure will be followed.</p> <p>C. Measures to ensure that the deficient practice does not happen again: Staff education regarding the right to refuse cares. Proper notification forwarded to the Charge Nurse, DON and the IDT Team of refusals in order to appropriately address each matter individually will be ongoing. The subject matter will be added to the monthly QA committee for review.</p> <p>D. Monitor corrective actions: The IDT will review the rejections x 2 weekly and will monitor for ongoing compliance by reporting to the QA committee for an ensuing three month period, starting 10/14/13. The Committee can adjust the monitoring as it may deem necessary to ensure compliance.</p> <p>E. Corrective Actions will be completed: 10/17/13</p>	

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F 156	<p>Continued From page 4 (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p>	F 156	<p>A. Corrective Actions: The section, in question, of the facility's "Resident's Rights" that is provided to the resident/responsible party prior to or at the time of admission has been revised to include the appropriate wording "You have the right to access your medical records upon request to the Nursing Center. Copies may be obtained within 24 hours at the purchase price that is a going community rate."</p> <p>B. Identification of others affected and corrective actions: Any resident currently residing in the facility and all new admissions will be provided the revised "Resident's Rights" hand-out. A signature and date will be obtained for the individual's file and a copy given in return for their records. In the past, no fees have ever been charged for copies.</p>	

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F 156	<p>Continued From page 5</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the admission packet and administrator interview, it was determined the facility failed to ensure residents requesting copies of their medical records were able to obtain them by asking for them. This had the potential to affect all residents in the facility including 9 of 9 (#s 1-9) sampled residents. Findings include: The admission packet and Resident Rights were reviewed. Listed under " Notice of Rights and Services " the second bullet point stated " You have the right to inspect and purchase photocopies of your records within 24 hours of request. (Not including weekends and holidays) Request must be in writing, dated and signed. " On 09/12/13 at 4:25 pm the administrator was interviewed and he stated that this was not an issue before. On 09/13/13 at 10:10 am the administrator provided a revised copy of the Resident Rights to the survey team. The second bullet point stated, " You have the</p>	F 156	<p>C. Measures to ensure that the deficient practice does not happen again: The facility will work closely with company resources and professional associations to secure information relating to such changes, as they are made. Staff training will be conducted on record requests. Timely revisions will be completed and implemented accordingly.</p> <p>D. Monitor corrective actions: The Administrator, Business Office Manager, and Social Service Designee will monitor weekly for ongoing compliance by reporting to the QA committee for an ensuing three month period. The Committee can adjust the monitoring as it may deem necessary to ensure compliance. Audit will start 10/07/13.</p> <p>E. Corrective Actions will be completed: 10/17/13</p>	

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F 156	Continued From page 6 right to access your medical records upon request to the Nursing Center. Copies may be obtained within 24 hours at the purchase price that is at the going community rate. "			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure dignity while dining was maintained during interactions with residents. This affected 1 of 6 (#4) sampled residents. This practice created the potential for more than minimal harm should residents' feelings of self-worth be diminished. Findings include: During the evening meal on 9/9/13 at 5:50 pm in the assisted dining room, 4 residents were sitting at the same table including Resident #4. CNA #3 was seated on a stool assisting two of the residents to dine. CNA #4 was preparing to sit and assist Resident #4 to dine. The two CNAs were engaged in a conversation about their personal lives while assisting the residents and not provide individualized attention to the residents. On 9/12/13 at 3 pm the surveyor informed the DON of the observation. The DON said they would monitor the issue.	F 241	A. Corrective Actions: Through an all staff training mandatory in-service and a one-to-one in-service, staff will be provided notification to not discuss their personal lives while assisting resident #4. Doing so will better promote an environment that maintains or enhances resident dignity and respect by care providers solely giving their undivided and individualized attention to residents. B. Identification of others affected and corrective actions: Any resident residing in the facility could have potentially been affected. This will be corrected through staff training in-services. C. Measures to ensure that the deficient practice does not happen again: A daily emphasis, while monitoring the dining room by the Charge Nurses, other Department Heads, the Administrator and/or DON, will reduce the likelihood of reoccurrence. This will start with staff training on 10/10/13 as well as a one-to-one in-service to be concluded by 10/17/13. D. Monitor corrective actions: Beginning 10/07/13 a weekly audit will be conducted and discussed at daily stand up meetings. Results of the audits will be reported to the QA committee which meets monthly. Identified concerns will be reviewed and addressed immediately for continued compliance. Any deviation shall be immediately reported, appropriately dealt with from a personnel standpoint and addressed at the monthly QA committee meeting to ensure further compliance. E. Corrective Actions will be completed: 10/17/13	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES			

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F 242	<p>Continued From page 7</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, Activity Calendar review, and staff and resident interviews, it was determined the facility failed to ensure residents were provided the right to make choices about bathing preferences and staff accommodated the residents' bathing preferences. This affected 2 of 9 (#s 6 & 8) sampled residents. This practice created the potential for the residents to experience anxiety or loss of self-worth when preferences were not accommodated. Findings included:</p> <p>Federal guidance at F242 specifies in part, "...Residents have the right to have a choice over their schedules, consistent with their interests, assessments, and plans of care. Choice over "schedules" includes (but is not limited to) choices over the schedules that are important to the resident, such as...bathing...because he or she...is uneasy about the aide assigned to help or is worried about falling, the staff member should make the necessary adjustments realizing the resident is not refusing to be clean but refusing the bath under the circumstance provided. The facility staff should meet with the resident to make adjustments in the care plan to accommodate his or her preferences..."</p>	F 242			

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F 242	<p>Continued From page 8</p> <p>1. Resident #8 was originally admitted to the facility on 3/28/11 and most recently readmitted on 5/20/12 with multiple diagnoses including depressive disorder and hemiplegia affect to non-dominate side due to cerebrovascular disease.</p> <p>Resident #8's 6/4/13 annual MDS coded cognitively intact, no mood or behaviors, bathing required extensive assistance of one person, choosing between a tub bath, shower, bed bath, or sponge bath was very important, and no falls.</p> <p>Resident #8's 9/4/13 quarterly MDS coded cognitively intact, moderately depressed mood, feeling down, depressed, or helpless, trouble falling or staying asleep, or slept too much, feeling tired or having little energy, trouble concentrating on things such as reading the newspaper or watching television, and no falls.</p> <p>On 9/12/13 at 9:05 a.m., Resident #8 stated, a) "I prefer a shower right after breakfast. I am more aware, not too tired and my medication is working best then. I am afraid of falling. There is usually an argument between me and the CNA [CNA #14] about washing my hair. When I was admitted I do not remember being asked about showers for care planning. I do not want a bed bath or tub bath. I have such a fear of falling. I do not sleep well the night before when it is time for a shower. Closing my eyes and tilting my head back for washing my hair is what I fear the most. I dream I fall in my sleep. The beauty shop is here quite often and I can get my hair done there. Right now, I think a shower every 5 days would be fine as long as the aides do not wash my hair." b) "The seat of the shower chair is plastic and it</p>	F 242		

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F 242	<p>Continued From page 9</p> <p>hurts my upper legs to sit on the plastic. I think some padding or cushioning should be placed between my skin and the plastic seat of the shower chair."</p> <p>On 9/12/13 at 10:00 a.m., the surveyor informed the Administrator of the interview with Resident #8 as identified above. The Administrator stated, "I know [Resident #8] had some preferences but I was unaware of everything you just told me about Resident #8." At 10:08 a.m., the Administrator said the facility has a minimum of 2 baths or showers per week. I'll find out about the argument with the CNA."</p> <p>2. Resident #6 was admitted to the facility on 8/17/12 with multiple diagnoses including depressive disorder.</p> <p>Resident #6's annual 8/27/13 MDS coded moderately impaired cognitive skills, moderately depressed mood, and bathing required one person extensive assist.</p> <p>The facility's September 2013 Activity Calendar documented, in part, for 9/11/13 at 10:00 a.m. Balloon Toss, at 11:15 a.m. Sittercise, and at 12:00 p.m. Senior Citizens.</p> <p>On 9/11/13 at 10:09 a.m., the Activities Director (AD) was observed wheeling Resident #6 past the nurse's station towards the assisted dining room. CNA #7 approached the resident and stated, "It's time for her shower." The resident stated, "I do not want one [a shower] now." The AD stated to the resident, "We are not having Senior Citizens for about an hour." Resident #6 turned to CNA #7 and stated, "I prefer a shower in the evening." CNA #7 then said to the resident,</p>	<p><i>F 242 admin said both Res #6 + #8 were interviewed & their preferences will be followed. See F 280 for update KM</i></p> <p>A. Corrective Actions: Starting 10/01/13 during admissions, every quarterly and change of condition residents are interviewed about important preferences regarding everyday activities through Section F of the MDS. Specific items that are deemed important to the resident will be asked specifics. On 10/10/13 an in-service training for all licensed, certified and non-licensed staff will be conducted to educate and reinforce the importance for residents to have the right to have a choice over their schedules, consistent with their interests, assessments and plans of care.</p> <p>B. Identification of others affected and corrective actions: Potentially any resident residing in the facility could have been affected. Will identify the important preferences through Section F of the MDS and update preferences on the care plan.</p> <p>C. Measures to ensure that the deficient practice does not happen again: Beginning 10/07/13 during daily observation and during one-to-one contact from the resident interviews the IDT (Social Services, Activities, MDS Coordinator, DON), will</p>	

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F 242	Continued From page 10 "Yes, I know you prefer to have a shower in the evening." The CNA then wheeled the resident into the assisted dining room. On 9/11/13 at 10:15 a.m., the resident was observed in the assisted dining room with 3 other residents participating in a Balloon Toss activity. On 9/11/13 at 6:17 p.m., CNA #13 stated, "I was not told at shift change that Resident #6 wanted showered this evening." - At 6:19 p.m., CNA #1 and CNA #2 both stated they were not told at shift change, Resident #6 wanted a shower tonight. Both of the CNAs also said they knew Resident #6 preferred to shower right before bed. On 9/12/13 at 9:15 a.m., Resident #6 stated, "I got my shower last night." On 9/13/13 at 10:00 a.m., the Administrator and DON were informed of the findings for Resident #s 6 & 8. The facility did not provide additional information related to the findings. <u>Note:</u> Please refer to F280 as it related to care planning residents' preferences for showers.	F 242	address these issues as well as Resident Council Meetings or the grievance process which will minimize reoccurrence. D. Monitor corrective actions: The IDT (Social Services, Activities, MDS Coordinator, DON), will report to the <u>monthly QA Committee Meeting</u> the outcomes of the observations and one-to-one contacts, for continued compliance. The QA Committee will determine when the system is effective. This will start on 10-07-13. E. Corrective Actions will be completed: 10/17/13		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248			

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F 248	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, review of the facility's 9/13 Activity Calendar, and staff interviews, it was determined the facility failed to ensure residents had an ongoing activity program which met the interests of the residents. This affected 3 of 9 (#s 2, 5, & 9) sampled residents and 2 (#s 11 & 12) random residents who triggered specifically for activities through the RAI process. Failing to have an ongoing activity program potentially could create boredom for residents which could lead to more than minimal psychological harm. Findings include:</p> <p>The facility had a census of 31 at the time of the survey. The facility's Activity Calendar was posted on the bulletin board in the area by the nurse's station. Review of the calendar provided evidence there were no activities scheduled after the 3:00 p.m. Monday through Friday and on Saturdays the only activity was Bingo at 3:00 p.m.</p> <p>On 9/12/13 at 12:25 p.m. the Activity Director (AD) was interviewed. During the interview it was found the AD was also the "facility van driver." The AD was asked about the activity, "Our Daily Bread" scheduled on 9/10/13 at 9:30 a.m. It was discovered the AD had to transport a resident to an appointment so the activity "Our Daily Bread" on 9/10/13 did not happen. There were several activities which were done on the assisted living side of the building and not on the long term care (LTC) side of the building. In addition, residents from the assisted living side attended several activities on the LTC side of the building.</p> <p>Observations of the layout of the facility, activities and residents during the survey were as follows:</p>	F 248		

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F 248	<p>Continued From page 12</p> <p>The LTC assisted dining room was located adjacent to the kitchen. In the assisted dining room (DR) there was a TV and what appeared to be speakers in the ceiling. If a person was to stand at the nurse's station and look right, there were three resident rooms. If a person was to stand at the nurse's station and look straight toward the LTC assisted DR, there was a large open hallway area. On the left of this hallway was a 4 foot high half-wall. This half-wall enclosed a large area used for independent dining. In the independent dining area, there was a 32 inch television on the far wall. The area also had a stereo that played music from ceiling speakers. If a person was at the nurse's station and look to the left, there was another hallways with resident rooms. However, just to the left of the nurse's station, there was an 8 foot open area where 2 to 5 chairs were placed during the survey process. Residents were observed sitting in these chairs at different times during the survey process. This area between the LTC assisted DR, the independent dining area, and the area in the hallway where the chairs were placed will be referred to as the "area by the nurse's station."</p> <p>The following information is grouped by activities scheduled and observations by date and time of day.</p> <p>Activities Scheduled: September 9, 2013 from 5:00 to 7:00 p.m., the Activity Calendar did not include any activities.</p> <p>On 9/9/13 at 6:15 to 6:42 p.m., 15 residents with various levels of cognition were located in the area by the nurse's station, 8 of the 15 residents were in wheelchairs. Residents were sitting in the</p>	F 248			

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F 248	<p>Continued From page 13</p> <p>chairs placed along the walls. In the LTC independent dining area, a talk show program was on the TV, the volume was low, and it was hard to hear what was being said on the talk show program. No other activities were going on. One resident with dementia was wandering around the area in her wheelchair. She went into the independent dining area and the housekeeper informed her, she was cleaning the area. At 6:42 p.m. CNAs started taking residents to their rooms and appeared to be getting them ready for bed.</p> <p>Activities Scheduled: September 10, 2013, 9:30 a.m., Our Daily Bread, 10:00 a.m., Patio Talk, 11:30 a.m. Fit 'N Fall Proof, and 2:30 p.m., Men's Outing.</p> <p>Note: The Resident Group Interview, required as part of the survey process, was held on 9/10/13 at 10:30 a.m.</p> <p>On 9/10/13 at 7:45 to 7:55 a.m. the residents were observed going to their assigned dining locations. The LTC assisted DR was filling up with residents. The TV and radio in the LTC assisted DR were not on. The DR was devoid of music, TV, interactions with staff, or any other type of interactions.</p> <p>- At 9:10 a.m. 11 residents were located in the area by the nurse's station. Eight residents were in wheelchairs and 3 were sitting in the chairs placed by the wall. The radio in the independent dining area was on and old time country music was coming out of the speakers.</p> <p>- At 9:20 to 9:25 a.m. the DON brought two residents into the independent dining area. One resident was given beads to sort and the other resident was given a pile of rags to fold.</p> <p>- At 9:27 to 10:02 a.m. there were 6 residents left in the area by the nurse's station with various</p>	F 248		

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F 248	<p>Continued From page 14</p> <p>levels of alertness. Two were sleeping. The DON woke one resident and asked her if she wanted to go to bed and the resident's response was, "Oh, yes I would." The DON wheeled the resident to her room. The CNAs were observed taking residents to their rooms. The 2 residents engaged in the beads and rag folding were left in the independent dining area.</p> <p>*NOTE: The 9:30 a.m. scheduled activity: "Our Daily Bread." The scheduled activity did not occur. Please refer to the AD's interview on 9/12/13, as the AD was assigned another responsibility.</p> <p>- At 10:10 to 10:35 a.m. a miniature horse came into the facility with three handlers and went down the hallway. They went into 3 resident rooms and then left the building.</p> <p>- At 1:35 to 2:10 p.m. residents were brought out from the LTC assisted DR and were parked in the area by the nurses station. There were 12 residents in the area at this timeframe with various levels of alertness and 3 of the 12 were sleeping. Two of the residents were in reclining geri-chairs. In the independent dining area, an afternoon soap opera was on the TV. Resident #4 was observed sleeping in her wheelchair. At 2:05 p.m. Resident #13 said to Resident #14, "What are we sitting here for?" Resident 14 responded, "I don't know." Resident #13 left the area and went to her room.</p> <p>*NOTE: The 2:30 p.m. scheduled activity: "Men's Outing." The AD took several of the men on a bus ride. There were no activities scheduled for the women who remained at the facility.</p> <p>- At 2:10 to 2:50 p.m. several residents were in</p>	F 248		

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F 248	<p>Continued From page 15</p> <p>the area by the nurse's station. As CNAs finished with a resident in their room, the CNAs came down the hall and took another resident to their room and laid them down. Resident #15 was in a reclining geri-chair and did not want to go to her room, the aides left her in the hallway. In the independent dining area, the TV was off and old time country music was heard on the overhead speakers.</p> <p>- During this time frame at 2:43 p.m., Resident #9 told the DON he had to use the bathroom. She told him to turn on his call light, he informed her he had already turned his call light on. At 2:45 p.m. the Administrator walked into the area and the resident informed the Administrator, "I have to use the bathroom." The Administrator told two CNAs about the resident's request. At 2:50 p.m. the CNAs came to the resident to assist him to the toilet and he stated, "I done it myself in my pants." The CNAs took him into the bathroom and changed him.</p> <p>Activities Scheduled: 9/11/12 at 9:30 a.m. Our Daily Bread, 10:00 a.m. Balloon Toss, 11:15 a.m. Sittercise, 12:00 a.m. Senior Citizens, and 3:00 p.m. Bingo.</p> <p>- At 9:30 to 10:15 a.m. there was no activity going on and there were 4 residents parked in the area by the nurse's station. One resident was taken to her room and the CNA said the resident was, "restless."</p> <p>Note: On 9/11/12 at 9:35 a.m., another surveyor walked through the assisted living side of the building and the LTC side of the building. There were no activities being conducted. At 10:05 a.m., the surveyor asked the AD about activities. The AD stated "I just got back from taking a resident</p>	F 248		

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F 248	<p>Continued From page 16 to [stated a specific location]. I am the AD and the van driver."</p> <ul style="list-style-type: none"> - At 10:15 a.m. the AD was with 4 residents in the LTC assisted DR and was doing the "Balloon Toss" activity with them. The rest of the residents were in their rooms and not parked at the area by the nurse's station. - At 11:45 a.m. there were 9 residents sitting in the area by the nurse's station. In the independent dining area, country music was playing from the overhead speakers. The residents were waiting to go into the dining area and several were also going to the noon activity of Senior Citizens. - At 2:15 to 2:20 p.m. there were 10 residents sitting in the area by the nurse's station. Three were sleeping and there was no activity for the residents. The afternoon CNAs and LPN were taking residents to their rooms to lay down. - At 3:00 p.m. the scheduled activity was Bingo and the assisted dining room was full. There were also residents from the assisted living side of the building playing bingo. * NOTE: No further activities were scheduled for 9/11/13. - At 4:50 to 5:04 p.m. seven residents were observed sitting in the LTC assisted DR. The TV and radio in the LTC assisted DR were not on. The DR was devoid of music, TV, interactions with staff, or any other type of interactions. - At 6:09 to 6:45 p.m. several of the residents were brought out of the LTC assisted DR and parked in the area by the nurse's station. There were 3 CNAs working. The CNAs were wheeling residents to their respective room, one at a time. In the independent dining area, the TV was on but the volume was low and hard to hear. No other activity was happening. 	F 248		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/13/2013
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F 248	Continued From page 17 Activity Scheduled: 9/12/12 at 9:30 a.m. Our Daily Bread, 10:00 a.m. Poetry Corner, 10:00 Catholic Mass, 11:30 a.m. Fit 'N Fall Proof, 2:00 p.m. Local News, and 3:00 p.m. Game Time. - At 9:30 a.m. the AD was observed going around to the residents sitting in chairs and wheelchairs asking them if they wanted to hear the devotion of the day. She read it to them if they wished. - At 9:50 a.m. the AD was asked to deliver a lab to the hospital. Please refer to the AD interview on 9/12/13. * NOTE: The 10:00 a.m. scheduled activity was, "Poetry Corner and Catholic Mass." - At 10:15 a.m. The activity Poetry Corner was started in the LTC assisted DR. There were 2 residents in attendance, one was Resident #16. The Catholic mass was on the assisted living side of the building and one resident from the LTC side of the building attended. - At 10:20 a.m. there were 3 residents in the LTC independent dining area engaged in a crafts activity. The TV was turned on to a sports channel. * NOTE: The 11:30 a.m. scheduled activity was, "Fit 'N Fall Proof." This activity was scheduled on the assisted living area side of the building, not the LTC side of the building. - 11:30 a.m. Three residents were sitting together in the area by the nurse's station. Resident #16 made a comment to Resident #3 of, "They just come and take [Activity Director name] and have her do other duties." [Note: It was found during the interview she had been asked to take lab work to the hospital during an activity.] - 11:35 a.m. to 12:00 noon, Two residents went to	F 248			

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F 248	<p>Continued From page 18</p> <p>the scheduled activity, Fit 'N Fall Proof, on the assisted living side of the building. Seven residents were in the area by the nurse's station and there was not an activity with these residents in the area by the nurse's station.</p> <p>Issues identified with the Activity Program were:</p> <ul style="list-style-type: none"> - scheduled activity did not start on time, - residents sat idle around the nurse's station for long periods of time, - there was lacking meaningful activities for residents with dementia, - no activities were scheduled after 3:00 p.m. and on evenings. - the Activity Director was also the van driver, given additional responsibilities that detracted from conducting activities, and due to these other responsibilities, was unable to ensure scheduled activities were conducted as planned. - CNAs brought residents from their rooms to dine and from dining to bed. The CNAs were not observed to taken residents to activities. - The location of activities scheduled on the assisted living side of the building was not identified on the schedule, therefore residents were not made aware of where to go for the activity. <p>Review of resident records revealed the following.</p> <ol style="list-style-type: none"> 1. Resident #2's most recent admission to the facility was 5/22/13 with diagnoses of anemia, renal failure, wound infection, asthma and anxiety disorder. <p>The 5/22/13 admission MDS documented the resident:</p> <ul style="list-style-type: none"> * was cognitively intact with a BIMS of 14, * had mild depression, 	F 248		

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F 248	<p>Continued From page 19</p> <p>* had activity preferences of: have books, newspapers, magazines to read; do things with groups of people; do favorite activities; and go outside when good weather.</p> <p>The resident triggered for activities and a care plan to be developed. The resident did not have an activity care plan nor was he involved in any of the group activities. The resident spent his time isolated in his room during the survey and there were not always activities provided which were listed on the calendar of interest to the resident. The resident did not participate in any scheduled activities.</p> <p>2. Resident #5 was admitted to the facility on 8/18/13 with diagnoses of tibia/fibula fracture aftercare, multiple sclerosis and diabetes mellitus.</p> <p>The 9/6/13 admission MDS documented the resident: * was cognitively intact with a BIMS of 14, * had activity preferences of: have books, newspapers, magazines to read; be around animals/pets; keep up with the news; do favorite activities; go outside when the weather is good; and participate in religious practices.</p> <p>The resident triggered for activities and a care plan to be developed. The resident did not have an activity care plan nor was she involved in any of the group activities. The resident spent her time in her room during the survey and there were not always activities provided which were listed on the calendar of interest to the resident. The resident did not participate in any scheduled activities.</p>	F 248		

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F 248	<p>Continued From page 20</p> <p>3. Resident #9 was admitted to the facility on 9/14/12 with diagnoses of after care for pathological fracture of hip, muscle weakness and insomnia.</p> <p>The 11/2/12 admission MDS assessment documented the resident: * was moderately cognitively impaired, BIMS=9, * had activity interests of going outside when good weather and participating in religious practices.</p> <p>The resident triggered for activities and a care plan to be developed. The resident did not have an activity care plan nor was he involved in any of the group activities. The resident spent his time not engaged, either in the hallway or in his room during the survey and there were not always activities provided which were listed on the calendar of interest to the resident. The resident did not participate in any scheduled activities.</p> <p>4. Resident #11 was admitted to the facility on 12/26/2012 with diagnoses of coronary artery disease, dysphagia and generalized weakness.</p> <p>The 9/4/13 significant change MDS documented the resident: * was severely cognitively impaired, BIMS =2 * was not able to complete the activity preferences. Staff interview indicated the resident preferences were: reading books, newspapers, magazines; listening to music; and keeping up with the news.</p> <p>The resident triggered for activities and a care plan to be developed. The resident did not have an activity care plan nor was she involved in any of the group activities. The resident spent her</p>	F 248	<p>A. Corrective Actions: The facility must better provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental, and psychosocial well-being of each resident. Two part-time van drivers as well as other staff members will assist with coordinating and sharing the transportation duties. This will allow for the Activity Director to not be pulled away from her job responsibilities and more consistently conduct a meaningful activities program. For resident #2, #5, #9, #11, and #12 the care plans have been updated to include their specific preferences for activities.</p> <p>B. Identification of others affected and corrective actions: Any resident wanting to participate in activities could have been affected.</p> <p>C. Measures to ensure that the deficient practice does not happen again: A weekly audit will begin 10/01/2013 to review the activity schedule for any missed programs that were scheduled. Any deviation will be discussed and dealt with, at the time, and results reported to the monthly QA committee.</p> <p>D. Monitor corrective actions: The audit will be recapped on a weekly basis</p>

Handwritten note:
KYN 10.18.13 3:00pm Rev Release
Admin's letter will do needed

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F 248	Continued From page 21 time not engaged, either in the hallway by the dining room or in her room sleeping during the survey and there were not always activities provided which were listed on the calendar of interest to the resident. The resident did not participate in any scheduled activities. 5. Resident #12 was admitted to the facility on 6/6/2013 with diagnoses of atrial fibrillation, heart failure, diabetes mellitus, and anxiety disorder. The 6/18/13 significant change MDS documented the resident: * was cognitively impaired with a BIMS=3, * was not able to complete the activity preferences. Staff interview indicated the resident preferences were: reading books, newspapers and magazines and being around pets and animals. The resident triggered for activities and a care plan to be developed. The resident did not have an activity care plan nor was she involved in any of the group activities. The resident spent her time not engaged, either in the hallway by the dining room or in her room sleeping during the survey and there were not always activities provided which were listed on the calendar of interest to the resident. The resident did not participate in any scheduled activities. The Administrator, DON and Consultant were informed on 9/12/13 at 5:00 p.m. The Administrator and the DON both acknowledged there was an issue with the speakers in the ceiling of the LTC assisted DR. No further information was provided.	F 248	for four weeks then every two weeks, for one month then for one month by the IDT. The results of the audits will be reported to the QA committee each month. The committee can adjust the frequency of monitoring as it deems necessary if the desired outcomes are not being reached. This will start 10-14-13. E. Corrective Actions will be completed: 10/17/13		
F 272	483.20(b)(1) COMPREHENSIVE	F 272			

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F 272 SS=B	Continued From page 22 ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272			

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F 272	<p>Continued From page 23</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to complete an activity CAA for 3 of 9 (#s 2, 5 & 9) sampled residents and 2 (#s 11 & 12) additional residents. Findings include:</p> <p>1. Resident #2's most recent admission to the facility was on 5/22/13 with diagnoses of anemia, renal failure, wound infection, asthma and anxiety disorder.</p> <p>The Admission MDS assessment, dated 5/22/13, documented the resident had the following activity preferences: have books, newspapers, magazines to read; do things with groups of people; do favorite activities; and go outside when good weather.</p> <p>The resident triggered for activities. Review of the CAA showed there was no summary of activity interests and rationale to proceed or not to proceed to care planning.</p> <p>2. Resident #5 was admitted to the facility on 8/18/13 with diagnoses of tibia/fibula fracture aftercare, multiple sclerosis and diabetes mellitus.</p> <p>The Admission MDS assessment, dated 9/6/13, documented the resident had the following activity preferences: have books, newspapers, magazines to read; be around animals/pets; keep up with the news; do favorite activities; go outside when the weather is good; and participate in religious practices.</p>	F 272		

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F 272	<p>Continued From page 24</p> <p>The resident triggered for activities. Review of the CAA showed the facility failed to describe the impact of activity triggers for the resident and the rationale for the care plan decision.</p> <p>3. Resident #9 was admitted to the facility on 9/14/12 with diagnoses of after care for pathological fracture of hip, muscle weakness and insomnia.</p> <p>The Admission MDS assessment, dated 11/2/12, documented the resident had activity interests of going outside when good weather and participating in religious practices.</p> <p>The resident triggered for activities. Review of the CAA showed the facility failed to describe the impact of activity triggers on the resident and the rationale for the care plan decision.</p> <p>4. Resident #11 was admitted to the facility on 12/26/12 with diagnoses of coronary artery disease, dysphagia and generalized weakness.</p> <p>The Significant Change MDS assessment, dated 9/4/13, documented the resident was not able to complete the activity preferences. Staff interview indicated the resident preferences were: reading books, newspapers, magazines; listening to music; and keeping up with the news.</p> <p>The resident triggered for activities. Review of the CAA showed the facility failed to describe the impact of activity triggers on the resident and the rationale for the care plan decision.</p> <p>5. Resident #12 was admitted to the facility on 6/6/13 with diagnoses of atrial fibrillation, heart</p>	F 272	<p>A. Corrective Actions: When a resident triggers through the CAA, a summary will include the resident's interests and the rational of whether to proceed or not proceed to the care plan.</p> <p>Clinical and MDS Resource will provide training to all involved with MDS, to provide further education. For resident #5, #2, #9, #11, and #12 the care plans have been updated to include their specific preferences for activities.</p> <p>B. Identification of others affected and corrective actions: Any resident living on the facility could have been affected.</p> <p>C. Measures to ensure that the deficient practice does not happen again: Will ensure that every quarter all CAA's have a summary that includes the resident's interest and the rational whether to proceed or not to proceed to the care plan.</p> <p>D. Monitor corrective actions: The DON, MDS Coordinator, Activity Designee and Social Service Designee will check all admission, annual, and significant change of condition CAA's for a summary that includes resident's interests and the rational whether to proceed to the care plan or not, starting 10/07/13.</p> <p>E. Corrective Actions will be completed: 10/17/13</p>		

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F 272	Continued From page 25 failure, diabetes mellitus, and anxiety disorder. The Significant Change MDS assessment, dated 6/18/13, documented the resident was not able to complete the activity preferences. Staff interview indicated the resident preferences were: reading books, newspapers and magazines and being around pets and animals. The resident triggered for activities. Review of the CAA showed the facility failed to describe the impact of activity triggers on the resident and the rationale for the care plan decision. On 9/12/13 at 12:25 p.m. the activity director was interviewed about the CAAs not being completed for residents that triggered. The Activity Director did not have any additional information and indicated a lack of understanding of what was required to complete a CAA.	F 272			
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	F 280			

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F 280	<p>Continued From page 26</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interviews, it was determined the facility failed to individualize care plans to include residents' choices and preferences for bathing. This affected 2 of 7 (#s 6 & 8) sampled residents. This practice created the potential for more than minimal harm should the resident experience anxiety or lack of self-worth related to the facility not addressing individual preferences. Findings included:</p> <p>1. Resident #8 was originally admitted to the facility on 3/28/11 and most recently readmitted on 5/20/12 with multiple diagnoses including depressive disorder and hemiplegia affect to non-dominate side due to cerebrovascular disease.</p> <p>Resident #8's 6/4/13 annual MDS coded cognitively intact, no mood or behaviors, bathing required extensive assistance of one person, choosing between a tub bath, shower, bed bath, or sponge bath was very important, and no falls. Section V of the MDS documented ADL functional status triggered and was care planned.</p>	F 280	<p>A. Corrective Actions: The Care plans for residents #8 and #6 have been reviewed and updated to reflect their personal preferences.</p> <p>B. Identification of others affected and corrective actions: Any resident with a potential care plan concern could be affected. The IDT has reviewed (and revised where needed) all resident care plans to ensure accuracy.</p> <p>C. Measures to ensure that the deficient practice does not happen again: Potentially any resident residing in the facility could have been affected. The facility will identify the important preferences through Section F of the MDS and update preferences on the care plan.</p> <p>D. Monitor corrective actions: The DON, MDS Coordinator, Activity Designee and Social Service Designee will check all admission, annual, and significant change of condition CAA's for a summary that includes resident's interests and the rational whether to proceed to the care plan or not, starting 10/07/13.</p> <p>E. Corrective Actions will be completed: 10/17/13</p>		

10.18.13 8:00 pm
 Administrator said also during 8thly review.

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F 280	<p>Continued From page 27</p> <p>Resident #8's 6/5/13 Care Area Assessment (CAA) Worksheet did not document any bathing preferences or input from the resident regarding bathing preferences.</p> <ul style="list-style-type: none"> - In the section titled, "Provide input from resident and/or family/representative regarding this care area" the following was documented, "[Resident #8] can alert staff to her wants and needs." - In the section titled, "Describe impact of this problem/need on the resident and your rationale for care plan decision" the following was documented, "...has fear of falling so is not willing to push self to improve beyond her current level..." <p>Resident #8's Care Plan (CP) identified,</p> <ul style="list-style-type: none"> - 8/30/12 Focus area Moderate risk for falls: history of falls, left sided weakness and fear of falling, anxiety. The focus area interventions did not include bathing preferences. - 5/21/13 Focus area At risk for an ADL Self Care Performance Deficit related to left sided hemiplegia. The bathing intervention did not include the resident's bathing preferences. <p>On 9/12/13 at 9:05 a.m., Resident #8 stated,</p> <p>a) "I prefer a shower right after breakfast. When I was admitted I do not remember being asked about showers for care planning. I do not want a bed bath or tub bath. I have such a fear of falling. Closing my eyes and tilting my head back for washing my hair is what I fear the most. I dream I fall in my sleep. The beauty shop is here quite often and I can get my hair done there. Right now, I think a shower every 5 days would be fine as long as the aides do not wash my hair."</p> <p>b) "The seat of the shower chair is plastic and it hurts my upper legs and bottom to sit on the plastic. I think some type of padding or</p>	F 280		

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F 280	<p>Continued From page 28</p> <p>cushioning should be placed between my skin and the plastic seat of the shower chair."</p> <p>On 9/12/13 at 10:00 a.m., the surveyor informed the Administrator of the interview with Resident #8 as identified above. The Administrator stated, "I know [Resident #8] had some preferences but I was unaware of everything you just told me about Resident #8." At 10:08 a.m., the Administrator also said the facility has a minimum of 2 baths or showers per week, we can update the care plan with the resident's preferences."</p> <p>2. Resident #6 was admitted to the facility on 8/17/12 with multiple diagnoses including depressive disorder.</p> <p>On 9/11/13 at 10:09 a.m., CNA #7 approached the resident and stated, "It's time for a shower." The resident stated, "I do not want one [a shower] now. I prefer a shower in the evening." CNA #7 then said to the resident, "Yes, I know you prefer to have a shower in the evening." The CNA then wheeled the resident into the assisting dining room at which time Resident #6 became involved in an activity.</p> <p>Resident #6's CP included a focus area 8/30/13 at risk for an ADL Self Care Performance Deficit related to limited mobility. The bathing intervention did not include the resident's bathing preference.</p> <p>On 9/11/13 at 1:07 a.m., the surveyor informed the MDS Coordinator about a CNA approaching Resident #6 to shower the resident in the morning when the resident preferred to shower in the evening. The MDS Coordinator reviewed the CP and stated, "The resident's preference for bathing</p>	F 280		

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

PRINTED: 09/25/2013
FORM APPROVED
OMB NO. 0938-0391

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F 280	Continued From page 29 is not on the CP." Note: Please refer to F242 as it related to Resident #6's and Resident #8's preferences for bathing. On 9/13/13 at 10:00 a.m., the Administrator and the DON were informed of the observations and findings. The facility did not provide any additional information related to bathing preferences and care plans.	F 280		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews, it was determined the facility failed to ensure a resident admitted with pressure ulcers (PU) received services to promote healing and prevent new ulcers from developing. This was true for 1 of 2 (#3) residents sampled for high risk PUs. Resident #3 was harmed when she developed recurring Stage 2 PU on the right and left buttocks. Findings include: Resident #3 was originally admitted to the facility on 5/23/11 and most recently readmitted on	F 314		

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F 314	<p>Continued From page 30</p> <p>2/26/13, with multiple diagnoses including pneumonia and congestive heart failure. The resident's 7/29/13 most recent annual MDS coded:</p> <ul style="list-style-type: none"> -makes self-understood and usually able to understand others. -cognition intact and mild depression -rejection of care "not exhibited" - extensive to total assist for most ADLs (eating was supervision only and walk in corridor was limited assist). -Upper and lower functional ROM limitations to both sides of the body -continent of bowel and occasional incontinence of bladder. -pain intensity was an 8 (0-10 pain scale) with scheduled and as needed pain medication. -at risk for developing pressure ulcers, unhealed PU Stage 1 or higher, and one Stage 2 PU, date of oldest Stage 2 PU 3/5/13. -One Unstageable PU and one Unstageable PU that was present upon admission/reentry - worsening in PU status since prior assessment, One Stage 2 -Section V triggered for pressure ulcers and indicated the area was care planned. <p>Resident #3's 5/21/11 Care Plan contained numerous focus areas and interventions however the CP also documented "CANCELLED" for each focus, goal and intervention entry.</p> <p>NOTE: On 9/11/13 at 9:30 am, the MDS Coordinator stated, "The CP is the current CP and the computer printed canceled in order to do the care plan conversion." The MDS Coordinator confirmed the CP provided to the survey team was, "the most current care plan for Resident #3."</p> <p>The care plan focus was: A. Moderate Risk for further skin breakdown: H/O</p>	F 314		

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F 314	<p>Continued From page 31</p> <p>(history of) healed stage 2 bilateral buttocks. (2/2/12), "3/19/13 area to buttocks is healed." Interventions documented in care plan included, "L [left] buttocks appears to be worse A) will change dressing from foam cleanser, stoma adhesive, and saran wrap to cleanse with wound cleanser, apply Mepilex and change QOD [every other day] B) [Resident #3] rejects to lay down in bed and continues to sleep in recliner. C) Staff has educated Res [resident] regarding risk for not changing positioning and [Resident #3] continues to reject bed. D) (9/9/13) RSD[resident services director] spoke with [Resident #3] about need for repositioning off buttocks, again, and if res rejects to lie down in bed tonight, res recliner will be removed from room. Fax sent to MD regarding res current skin issues."</p> <p>"[Resident #3] states at times she does lay down in bed but needs assist to get up and out of bed." "Rejects to sleep in bed at night. Sleeps in recliner B) Nursing has educated [Resident #3] RE: [regarding] benefits of sleeping in bed, repositioning side to side while in bed." "ROHO cushion in wheelchair B)rejects gel cushion in regular chair in dining room."</p> <p>NOTE: There was no care plan for use of the Roho cushion or any form of pressure relief while the resident was in the recliner.</p> <p>Also documented in the care plan: B. "Alteration in comfort: DJD. Severe pain in shoulders, knees, hips"</p> <p>Interventions documented: - "Resident will sit in recliner stating it is hard to get in and out of bed. Resident complains cannot lay flat in bed and has to have head of bed elevated to tolerance. Resident prefers sitting/sleeping in recliner."</p> <p>Medical records documented: -03/15/13 bilateral buttocks healed.</p>	F 314		

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F 314	Continued From page 32 -06/25/13 bilateral buttocks are more discolored and fragile looking. -07/30/13 open areas to left buttock. -08/12/13 change treatment to foaming body cleanser, instead of wound cleanser. -08/19/13 left buttocks smaller. -09/03/13 left buttocks larger in size, change treatment to cleanse with wound cleanser, Mepilex and apply skin prep change QOD (every other day). -09/08/13 right buttocks-opened-implemented wound cleansers with Mepilex and skin prep, change QOD. -09/10/13 Added Arginaid (nutritional supplement) to BID (twice a day), Vitamin C and Zinc x 14 days." Resident #3's Braden Scale for Predicting Pressure Sore Risk, dated 06/27/13, scored low risk at 18. Resident #3's 9/13 "All active orders for September 2013" (Recapitulation) contained in part the following: -02/26/13 ALT (alternating) Air Mattress -03/18/13 Weekly skin checks-PMs... Specific days of week: Mon., 1400-2200. -04/15/13 Wound Care: buttocks-Topical-every shift every day, 0600-1400, 1400-2200, 2200-0600. Cleanse area with wound cleanser, apply stoma powder, and cover with saran wrap. -08/13/13 Left buttocks: Cleanse area with foaming body cleanser; apply stoma adhesive powder to bilateral buttocks and small piece of saran wrap only to open area to left buttocks. TID (three times a day) 0700, 1600, 1900. The care plan had two focused areas with conflicting interventions: For the problem "Alteration in comfort: DJD, severe pain in shoulders, knees, hips and left foot ..." Intervention dated 5/22/11 documented, "Res	F 314			

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F 314	<p>Continued From page 33</p> <p>will sit in recliner stating it is hard to get in and out of bed. Complains cannot lay flat in bed and has to have head of bed elevated to tolerance, prefers sitting/sleeping in recliner" There was no stop date for this intervention.</p> <p>-intervention dated 9/9/13 after review by the IDT (Interdisciplinary team) in response to treatment plan. "Resident now has open area to R buttocks, no change to L Buttocks....IDT response to treatment plan: "will treat R buttocks same as left. RSD had informed Resident if she does not sleep in her bed then the chair will be removed from her room."</p> <p>Progress Notes dated 7/30/13 by Nursing documented, "Lengthy discussion with Res about sleeping in chair vs. bed. Resident argued that she never told anyone that she 'would' sleep in her bed, but that she would think about it. Res states 'The Dr. said to sleep where I was comfortable.' At HS (hour of sleep) Res was assisted into her recliner per her request. Call light within reach."</p> <p>The progress notes also documented: 9/10/13 "Res lying in bed this am." 9/10/13 "RSD spoke with Res this AM. She said she had slept in her bed last night and would continue to do so but would rather be in her recliner. RSD states she was able to keep her recliner and discussed again that she would have more skin breakdown if she were to choose to sleep in the recliner again. Recliner will remain in her room." 9/12/13 "Res has allowed staff to assist her into bed at HS for that last 3 nights ...Res does complain of pain when transferring both into and out of her bed ..."</p> <p>On 9/12/13 at 9:3 am. Resident #3 stated, "They said if I sleep in my bed it will become healed. I talked with Doctor and he said it may not heal but</p>	F 314		

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F 314	<p>Continued From page 34</p> <p>it could get better. I sleep better in my chair. I have slept in my chair off and on for 3 years." The surveyor reviewed a list of "Document all Ulcers, Wounds, and Other Skin Problems" in the facility's electronic medical record data base. The following information was printed for the surveyor. The measurements of the wounds were as follows:</p> <p>8/6/13 the left buttocks was 1 x 0.3 cm 8/27/13 the left buttock was 0.5 x 0.3 cm 9/8/13 right buttocks were opened. (No measurement found) 9/12/13 at 10:20 am, the wound was observed. The right wound measured 1 cm x 1 cm circular shape, red with split skin. The left buttocks measured 1 cm x 1 cm circular in shape and approximately ¼ to ½ cm deep. On 9/12/13 at 4:17 pm, 2 surveyors discussed with the DON, Resident #3's skin conditions and reopened pressure ulcers. No information was received that altered the findings.</p> <p>2. Resident #6 was admitted to the facility on 8/17/12 with multiple diagnoses including depressive disorder.</p> <p>Resident #6's 8/27/13 annual MDS coded moderately impaired cognition, at risk for developing pressure ulcers, and no unhealed pressure ulcers. Section V of the MDS triggered for pressure ulcer and indicated the care area was care planned.</p> <p>Resident #6's Care Plan (CP) contained a 8/30/13 focus area, moderate risk for skin breakdown. One of the focus interventions was. "assist [Resident #6] with positioning, "floating heals {sic} [heels] using pillows..."</p>	F 314	<p>A. Corrective Actions:</p> <p>Resident #3 Resident continues to accept lying down in bed during the night, continues to sit in wheelchair during the day and is now agreeable to ambulate short distances to meals to assist relieving pressure off of buttocks. Resident was also started on Effexor 09/17/13 to decrease tearfulness. The IDT will monitor for any future rejections and continue to educate resident. Staff has been educated regarding resident rejections and if a resident rejects.</p> <p>Resident #6 Staff will be educated through a one-to-one in-service training for proper positioning techniques for floating heels.</p> <p>B. Identification of others affected and corrective actions: Any resident with a potential for skin break down could be affected. The IDT has reviewed and updated, where discrepancies were found. The plan of care has been updated to reflect these changes. Licensed staff will be educated regarding pressure ulcer prevention and the risk identified from the Braden Scale necessary to prevent skin breakdown when the risk is known on 10/10/13.</p>	

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F 314	Continued From page 35 On 9/10/13 at 2:45 p.m., CNA #1 and CNA #6 were observed assisting Resident #6 to lie down in her bed. A pillow was placed under the resident's legs and a blanket was placed over the resident's body. The CNAs adjusted the head of the bed and lowered the bed to the resident's request. The CNAs finished assisting the resident and were about to leave the room. At this time, the surveyor ask CNA #6 why the pillow was placed under the resident's legs. The CNA replied, "To float her heels." The surveyor asked the CNA to lift the blanket so the resident's heels could be observed. When the CNA lifted the blanket, both the right and left heels were in direct contact with the surface of the pillow. The CNA moved the pillow back towards the resident's torso away from the heels and said, "They are floated now." On 9/13/13 at 10:00 a.m., the Administrator and the DON was informed of the observation. The facility did not provide any additional information related to the observation.	F 314	C. Measures to ensure that the deficient practice does not happen again: Staff has been in-serviced regarding the need to inform the nurse of any concerns related to the resident's skin, including interventions and refusal of cares. The IDT has reviewed all residents with current skin issues to ensure that appropriate measures are in place (to include refusals for cares) and the treatment record and care plan reflects the resident's current skin status. The IDT has also reviewed the residents' behavior monitoring sheets and behavior care plan to ensure the resident's current status of refusal of cares is reflected. Any resident who refuses to follow the plan of care was educated regarding the risk versus benefit of that refusal. The IDT will continue to problem solve refusals to ensure all interventions possible are implemented.		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff and family		D. Monitor corrective actions: DON or designee will monitor refusals daily and IDT will be involved for problem solving as necessary. Audits will begin 10/14/13. (The IDT will review the rejections weekly and will monitor for ongoing compliance by randomly evaluating three residents.) E. Corrective Actions will be completed: 10/17/13		

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F 323	Continued From page 36 interviews, it was determined the facility failed to take precautions to prevent a resident fall. This was true for 1 of 10 (#4) sampled residents. There was a potential for more than minimal harm when she was given a suppository for bowel care at 2:30am and got out of bed and fell. Findings include: Resident #4 was admitted to the facility on 3/3/11 and readmitted on 2/23/13 with multiple diagnoses including dehydration and a history of bowel obstruction. The resident's 5/30/13 quarterly MDS coded severe cognitive impairment, required extensive to total assist for all ADLs, not able to walk, and no falls. The resident's 9/13 "All Active Orders for September 2013" (recapitulation orders) contained 2 suppository orders: -08/29/12 "Dulcolax/Glycerin 10 mg-1 suppository rectal (R)-PRN: as needed if no BM x72 hours. ***Give in PM [afternoon or early evening]" -01/14/13 "Dulcolax (Bisacodyl) 10mgs Rectal (R) - PRN: PRN [for] constipation" Review of the resident's 6/13 MAR provided evidence the resident was administered Dulcolax at 2:30 am for bowel care. Review of the facility's Incident and Accident reports revealed, on 06/13/13 at 4:15 am, the resident was noted by a CNA to be sitting on the floor with her back to the wall. The "Investigation" section documented, in part, "...given a suppository at 02:30 [am] for bowel care, and then checked shortly afterwards to see if needing to be toileted. Resident had been asleep, but did not wake up enough to answer aide..." The Investigation section also documented the nurse checked on the resident at 3:30 am and the	F 323			

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F 323	Continued From page 37 resident had no complaints. The CNA found the resident at 4:15 am. The "Description of any Injury" section documented, in part, "...Resident did not have any noted fractures and back/hip hardware were intact according to the emergency physician..." The resident's Progress Notes (nursing notes) reviewed from 6/12/13 at 3:00 pm through 6/13/13 at 2:12 pm documented on 6/13/13 at 4:15 am, "Res on floor setting back at wall res CO [complained of] RT [right] hip and back pain skin tear to LT [left] forearm [sic] 1.5cm approximated edges cleansed N/S [normal saline] applied 2 steri strips sent res to [a local hospital emergency room] will monitor." The entry was signed by a LN. During the interview with a family member on 09/13/13, at 2:15 pm the family member stated, "...[The resident] had no falls until the new company took over. They [nursing staff] gave her the suppository and she probably fell back asleep, woke up and forgot she could not walk. We requested side rails and offered to sign a waiver but were told they [side rails] were not allowed. We were told about a special mattress to prevent rolling out of bed but nothing became of it." On 9/12/13 at 8:30 am, the surveyor asked the DON about the resident's fall on 6/13/13. The DON stated, "The times for administration of suppositories have been changed to just before residents get up for the day. The shifts have been adjusted so that the outgoing shift and the ongoing shift are available to assist residents."	F 323	A. Corrective Actions: For Resident #4, a revised Bowel and Bladder Policy & Procedure has been implemented, and staff will be educated 10/10/13 with a one-to-one in-service training about appropriate times to administer suppository and the changes to the policy and procedure. B. Identification of others affected and corrective actions: Any resident administered a PRN suppository could have been effected. All MARs will be changed to reflect the new change. C. Measures to ensure that the deficient practice does not happen again: Licensed nursing staff will be educated to the new Policy and Procedure and monitoring of administration times. D. Monitor corrective actions: Weekly the DON, will review three residents randomly picked, who were given suppositories and report this to the QA team that meets monthly, starting on 10/14/13. E. Corrective Actions will be completed: 10/17/13	
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		

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F 329	<p>Continued From page 38</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to monitor the use of psychopharmacological medications. This affected 1 of 6 (#6) residents sampled for psychopharmacological medication use. This practice created the potential for more than minimal harm should a resident receive medications unnecessarily. Findings included:</p> <p>Resident #6 was admitted to the facility on 8/17/12 with multiple diagnoses including depressive disorder.</p>	F 329	
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F 329	Continued From page 39 Resident #6's quarterly 5/31/13 and annual 8/27/13 MDSs coded the resident received anti-psychotic medication the past 7 days and anti-anxiety medication the past 7 days. Section V of the 8/27/13 MDS triggered for Psychotropic Drug Use and indicated the care area was care planned. Resident #6's 8/28/13 Care Area Assessment (CAA) Worksheet, "Care Plan Considerations" section documented, "Res. [resident] sees telehealth psychiatrist as scheduled." Resident #6's 9/13 "All Active Orders for September 2013" (recapitulation orders) contained the orders: - 8/17/12, Abilify 4 milligrams (mg) by mouth every day at bedtime for psychosis - 12/5/12, Lorazepam 1 mg by mouth every day for chronic anxiety The above recapitulation orders contained a column for the medication orders to the far left side, and two different columns to the far right side of the orders. One of the two different columns was titled Order Date. The other column was titled Start Date. Ability had an order date: 8/17/12 and start date: 7/1/13. Lorazepam had an order date: 12/5/12 and start date: 6/28/13. On 9/12/13 at 2:26 p.m., the Social Services Director (SSD) said the start dates for the above identified medications did not reflect a change was made to the medication dosage or order. Staff may have been reviewing the medication in the electronic database and the possibility existed what occurred on the start dates entered was not verifiable. The order date was the date the	F 329			

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F 329	<p>Continued From page 40</p> <p>medications were ordered by the resident's physician.</p> <p>Resident #6's CP identified the 8/30/13 focus area potential for psychosocial well-being problem related to anxiety and psychosis. The focus interventions included administer Lorazepam 1 mg by mouth at bedtime for chronic anxiety and Ability 4 mg by mouth every day for psychosis.</p> <p>Resident #6's current 9/13 Medication Administration Record (MAR) documented the resident received Lorazepam and Ability every day per the 9/13 recapitulation orders. On the 9/13 MAR, the Lorazepam order date was 12/5/12 and the Ability order date was 8/7/12.</p> <p>Review of the resident's medical record did not provide evidence of how the diagnosis of psychosis was determined for Abilify or if a dose reduction was considered for either Abilify or Lorazepam.</p> <p>On 9/11/13 at 11:00 a.m., the surveyor asked the SSD for information regarding the use of Abilify and Lorazepam for the resident. The surveyor requested evidence of:</p> <ul style="list-style-type: none"> *Abilify, how the diagnosis of psychosis was determined, *Abilify, a dose reduction or a statement from the physician a dose reduction was clinically contraindicated, and *Lorazepam, a dose reduction or a statement from the physician a dose reduction was clinically contraindicated. <p>During this interview, the surveyor and the SSD reviewed the Federal guidance at F329 as</p>	F 329			

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F 329	<p>Continued From page 41 indicated below. The SSD nodded her head in an up and down motion and said she was aware of the requirements at F329.</p> <p>Federal guidance at F329 indicated, "...Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated..."</p> <p>"...During the first year in which a resident is admitted on a psychopharmacological medication (other than an antipsychotic or a sedative/hypnotic), or after the facility has initiated such medication, the facility should attempt to taper the medication during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a tapering should be attempted annually, unless clinically contraindicated..."</p> <p>On 9/11/13 at 1:30 p.m. the SSD provided the surveyor with the following documentation: - 3/12/13 Abilify order, handwritten across the bottom was, "...per [name of two different doctors] resident is to cont [with] 2 mg [two] tabs qhs [continue with 2 tablets 2 milligram each at every bedtime]." - 7/2/13 physician visit. The upper portion the visit contained a handwritten entry, "... Resident has less episodes of tearfulness..." The upper portion was signed by a licensed nurse. The bottom portion of the visit contained a handwritten entry, "...[no] changes to medications..." The entry appeared signed by the resident's physician. The</p>	F 329			

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F 329	<p>Continued From page 42</p> <p>SSD also stated, "I am still trying to find something about Lorazepam."</p> <p>On 9/11/13 at 5:30 p.m., the SSD provided the surveyor a copy of a local medical center tele-medicine note, dated 6/26/12, that documented in part, "...was taking 6 milligram (mg) Ability at night and this has been reduced to 2 mg at night...may have been overly sedated from her medications and appropriate adjustments have been made...I would not make any changes in her current medications..." The surveyor asked the SSD why the resident's Abilify order was changed from 2 mg as indicated in the 6/26/12 local medical center note to 4 mg as ordered on 8/17/12 on the 9/13 recapitulation orders.</p> <p>Note: The 6/26/12 local medical center tele-medicine note was prior to Resident #6's admission date, 8/17/12. Review of the MDS database did not provide evidence Resident #6 was in the facility or another long term care facility prior to 8/27/12.</p> <p>On 9/12/13 at 2:26 p.m., the SSD stated, "I do not have data as to why Resident #6's Abilify order went from 2 mg to 4 mg. I do not have data about the diagnosis of psychosis for the use of Abilify. I do not have data for Lorazepam. I thought the medication Lorazepam was discontinued."</p> <p>On 9/12/13 at 3:03 p.m., the SSD stated, "I contacted the hospital discharge planner. For the diagnosis of psychosis for Abilify, the discharge hospital planner is sending a letter apologizing for using the diagnosis. We contacted the resident's physician to clarify the diagnosis for Ability. I do not have information about why the resident was</p>	F 329	<p>A. Corrective Actions:</p> <p>During last tele-health visit resident #6, staff has asked for a GDR (for both Abilify/Lorazepam) from her tele-health physician. Physician has changed Abilify dose to be split to 2mg in AM and 2mg in PM. We have discussed the need to decrease both the Abilify and Lorazepam with our Registered Pharmacist Consultant. Per Pharmacist, he has recommended to the physician to decrease the Lorazepam, and will further discuss with physician on 10/13/13 and during next scheduled physician rounds on 10/22/13.</p> <p>B. Identification of others affected and corrective actions:</p> <p>Any resident with a psychoactive medication could potentially be affected. The IDT will evaluate all residents with psychoactive medications for prospective GDR.</p> <p>C. Measures to ensure that the deficient practice does not happen again:</p> <p>When residents are evaluated every quarter the IDT will monitor for a most recent GDR. IDT will monitor with our monthly pharmacy review starting this month (October 2013).</p>		

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F 329	Continued From page 43 on 2 mg after the 6/26/12 hospital stay and is now on 4 mg." The facility did not provide evidence the anti-psychotic medication Abilify was administered to the resident based on quantifiable data and monitored for dose reduction. The facility did not provide evidence the anti-anxiety medication Lorazepam was monitored for dose reduction. On 9/13/13 at 10:00 a.m., the Administrator and the DON were informed of the finding. The facility did not provide any additional information related to the use of the above identified medications.	F 329	D. Monitor corrective actions: The DON or licensed designee will perform a baseline audit of all residents receiving psychotropic medication to establish the schedule for GDR by 10/14/13. Monthly review of the schedule will begin 10/14/13 and included oversight that scheduled GDRs are being attempted or sufficient clinical justification is present if the GDR is not indicated. This oversight will be ongoing monthly. IDT will forward the results to the QA Committee monthly meeting to be reviewed until it has been determined by the committee that the system is effective.		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure food was prepared and served under sanitary conditions. This affected 9 of 9 (#s 1-9) sampled residents and had the potential to affect all residents who dined in the facility. This practice created the potential for contamination of	F 371	E. Corrective Actions will be completed: 10/17/13		

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F 371	<p>Continued From page 44</p> <p>food and exposed the residents to potential sources of pathogens. Findings included:</p> <p>On 9/9/13 at 5:03 p.m., Dietary Cook #10 was observed in the kitchen plating food from the steam table on to individual serving plates for residents. Cook #10 had a mustache that extended across and down past the sides of his mouth and also had hair extending down from and across the entire length of the lower lip. The length of the facial hair appeared to be approximately one to one and a half inches in length. Cook #10 was not wearing a beard restraint.</p> <p>On 9/10/13 at approximately 12:30 p.m., Cook #11 was observed serving food in the kitchen. Cook #11 had facial hair that extended across and down past the sides of his mouth to the chin. The facial hair appeared to be the shape commonly known as a goatee. Cook #11 was not wearing a beard restraint.</p> <p>The 2009 FDA Food Code, Chapter 2, Part 2-4, Hygiene Practices, Hair Restraints, subpart 402.11, Effectiveness, indicates, "(A) Except as provided in ¶ (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. (B) This section does not apply to food employees such as counter staff who only serve beverages and wrapped or packaged foods, hostesses, and wait staff if they present a minimal risk of contaminating exposed food; clean equipment, utensils, and linens; and</p>	F 371	<p>A. Corrective Actions: During the survey a determination was made that two male cooks had facial hair that exceeded established guidelines. The cooks, in question, will wear a procedure mask/beard restraint or be clean shaven.</p> <p>No illnesses were observed or reported for Residents #1-9 as of 09/12/13 related to the possible exposure to pathogens from their 09/09/13 evening meal. Cooks #10 and #11 were informed and have been counseled on 10/10/13 regarding wearing beard restraints or being clean shaven. Beard restrains were also ordered on this date.</p> <p>B. Identification of others affected and corrective actions: While no other residents were affected, any resident residing in the facility could potentially have been affected.</p> <p>C. Measures to ensure that the deficient practice does not happen again: The Dietary Manager will give an in-service on 10/10/13 regarding hygiene practices and beard restraints to ensure all dietary employees understand how to prevent contamination of exposed food, utensils, linens and the likes.</p>		

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F 371	Continued From page 45 unwrapped single-service and single-use articles." On 9/12/13 at 12:13 p.m. the surveyor informed the Dietary Manager (DM) of the observations. The surveyor and the DM then reviewed the FDA Food Code Chapter 2, subpart 402.11 for the use of "beard restraints." The DM stated, "I thought in my training there was a provision that allowed for facial hair." On 9/13/13 at 10:00 a.m., the Administrator and the DON were informed of the finding. The facility did not provide any additional information related to the finding.	F 371	D. Monitor corrective actions: The Dietary Manager will audit hygiene practices on a daily basis weekly x 4 weeks, the q2 weeks x 4 weeks then monthly x 1 month and present the findings at the QA committee meeting until such time the committee determines the system is effective. E. Corrective actions will be completed: 10/17/13	
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff used appropriate skills and equipment while ambulating a resident. For 1 of 1 (#13) residents observed to be ambulated by staff, staff members failed to use a gait belt. This action placed the resident at risk for potential harm by putting stress on the resident's shoulders and could subluxate the resident's shoulder. Findings include:	F 498		

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F 498	<p>Continued From page 46</p> <p>Random Resident #13 was admitted to the facility 11/18/11 with diagnoses of cancer, non-Alzheimer's dementia, anxiety and depression.</p> <p>The most recent comprehensive MDS assessment, dated 11/27/12, documented the resident: * had short and long term memory problems, * required extensive assistance of two staff for ambulation. * was 65 inches tall and weighed 88 pounds.</p> <p>On 9/11/13 at 5:25 p.m. Resident #13 was observed to be ambulated from her room to the dining room by CNAs #1 and #2. The resident did not have a gait belt in place around her mid-section. One CNA was on each of the resident with their forearms in the axilla (armpits) of her right and left arms. The resident wobbled from side to side as the CNAs tried to get her to stand and walk. The resident's arms were pulled from side to side as she walked toward the dining room.</p> <p>On 9/11/13 at 6:09 p.m. CNA #2 was observed to ambulate Resident #13 from the dining room back to her room. The aide had her arm tucked into the left axilla area of the resident and was holding onto her right arm. The resident was wobbly as she was walked toward her room. The resident did not have a gait belt on.</p> <p>On 9/11/13 at 6:22 p.m. CNA #2 was interviewed and indicated she did not carry a gait belt but there was one in the room behind the nurse's station if she needed it.</p> <p>On 9/11/13 at 6:30 p.m. the DON was interviewed</p>	F 498	<p>A. Corrective Actions: Resident #13 was not observed, noted or reported as sustaining any injury or increase in pain as of the evening of 09/11/13 through 09/14/13 after being ambulated without the gait belt. CNA #1 and #2 were counseled by the DON on 09/11/13 regarding the mandatory use of gait belts.</p> <p>B. Identification of others affected and corrective actions: While no other residents were affected, any resident residing in the facility who has been identified as needing assistance, to ambulate, transfer, change position, etc., could have been affected.</p> <p>C. Measures to ensure that the deficient practice does not happen again: A mandatory gait belt in-service training including checking all CNA's off on the correct application and usage of gait belts will be held 10/10/13. The Charge Nurses and DON beginning 10/10/2013 will conduct weekly audits x 4 weeks, then q2 weeks x 4 weeks and then monthly for 1 month to review compliance. Any deviation will be discussed and dealt with, at the time, and results reported to the monthly QA committee.</p> <p>D. Monitor corrective actions: The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the system is effective.</p> <p>E. Corrective actions will be completed: 10/17/13</p>		

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F 498	Continued From page 47 and said the resident did not like a gait belt and gets upset with staff when they use one on her. On 9/12/13 at 9:10 a.m. Resident #13 was observed to be ambulated by two CNAs. They were using a gait belt and the resident appeared to be steady and the aides had control of the resident's walking. The resident did not appear to be upset with using the gait belt as she ambulated toward her room.	F 498			
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff were able to explain the emergency procedure in the event of a power failure. This was true for 1 of 5 (CNA #12) staff interviewed for emergency procedures. This practice created the potential for more than minimal harm should a power failure occur and staff did not know how to respond. Findings included: On 9/12/13 at 9:30 a.m., CNA #12 was asked what outlets in the facility would be used in the event of a power failure. The CNA did not reply. The surveyor provided a scenario of the power goes out, the emergency generator starts up, you have a resident with a piece of equipment that	F 518	A. Corrective Actions: While such information is provided during each new employee orientation and periodically at in-service trainings, throughout the year, the subject has been line-item added to the signed/dated new employee checklist. CNA # 12 was counseled and re-taught on 09/12/13 the procedures in the event of a power failure. B. Identification of others affected and corrective actions: Potentially, any resident residing in the facility could have been affected. C. Measures to ensure that the deficient practice does not happen again: A revised new employee orientation checklist has been implemented effective 10/10/13 by the facility's Human Resources Designee. An in-service was held on 10/10/13 to ensure all staff know the procedures in the event of a power failure. All new employee paperwork will be audited monthly x 4 weeks, then q 2 weeks x 4 weeks, then monthly x 1 month starting 10/10/13 by the Dept. manager of the employee and the Human Resources Designee.		

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

PRINTED: 09/25/2013
FORM APPROVED
OMB NO. 0938-0391

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F 518	Continued From page 48 must be powered by the emergency power source. CNA #12 stated, "I am not sure." The surveyor and the CNA then walked through an empty resident room. The CNA was not able to identify or locate a power outlet used in the event the power went out. On 9/12/13 at 10:25 a.m., the Administrator was informed of the finding. The Administrator stated, "We had a power outage last week and had to implement emergency procedures. I'll have an inservice with staff."	F 518	D. Monitor corrective actions: The Human Resources Designee will randomly question a minimum of five facility employees as to what the emergency procedures are in the event of a power outage on a weekly basis for three months. This information will be presented to the QAA committee on a monthly basis until they determine the system is effective. E. Corrective actions will be completed: 10/17/13	

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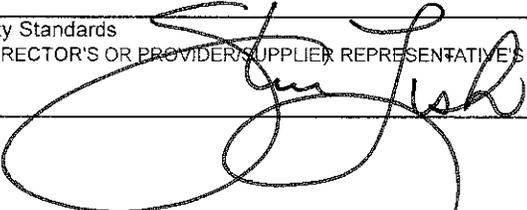
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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the State Licensure survey of your facility. The surveyors conducting the survey were: Karen Marshall, MS, RD, LD Team Coordinator Arnold Rosling RN, BSN, QMRP Debbie Bernamonti, RN	C 000	The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).	
C 121	02.100.03,c,v Encouraged/Assisted to Exercise Rights 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 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: Please refer to F155 and F242 as each related to residents bathing preferences and choices.	C 121	Please refer to the response for F155 and F242.	
C 147	02.100.05,g Prohibited Uses of Chemical Restraints g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that	C 147	Please refer to the response for F329.	

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OCT 10 2013
FACILITY STANDARDS

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:  TITLE: **Executive Director** (X6) DATE: **10/07/13**

STATE FORM 6899 LC6U11 If continuation sheet of 7

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001170	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/13/2013	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 147	Continued From page 1 interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Please refer to F329 as it related to the use of an anti-psychotic medication without indications for the use of the medication, not considering a dose reduction for an anti-psychotic and for an anti-anxiety medication.	C 147		
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F371 as it related to not using beard restraints while preparing and serving food in the kitchen.	C 325	Please refer to response for F371	
C 422	02.120,05,p,vii Capacity Requirments for Toilets/Bath Areas vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds.	C 422	On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds. It was determined that the facility failed to maintain the minimum number of bathing facilities for the number of licensed beds. A request for a "waiver" will be made. 10/17/13	

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C 422	<p>Continued From page 2</p> <p>Tubs, showers, and lavatories shall be connected to hot and cold running water.</p> <p>This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to maintain the minimum number of bathing facilities for the number of licensed beds. This affected 9 of 9 (#s 1-9) sampled residents and had the potential to affect all residents who resided in the facility. Findings included:</p> <p>The facility was licensed for 45 certified beds. At the beginning of the survey process, 31 residents resided in the facility.</p> <p>On 9/12/13 at 8:35 a.m. during the General Observations of the Facility with the Maintenance Supervisor (MS), the Bathing Room was observed with two bathtubs and one shower stall. However, one bathtub was covered with plywood or particle board, numerous articles were on top of the board over the bathtub, and numerous pieces of equipment were stored in the area where the bathtub was located, blocking access to the bathtub. There was plumbing projecting from the wall above the bathtub however there was no shower head attached to the plumbing.</p> <p>The MS stated, "There is only one bathing room and none of the individual resident rooms have a tub or a shower." The surveyor and the MS reviewed the requirement of one tub or shower for every 12 certified beds. Forty-five (45) certified beds divided by 12 equaled 3.75.</p> <p>On 9/12/13 at 10:00 a.m., the surveyor informed the Administrator of the finding. The Administrator said, "The Maintenance Supervisor told me."</p>	C 422		
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C 422	Continued From page 3 On 9/13/13 at 10:00 a.m., the Administrator and DON were informed of the finding. The facility did not provide any additional information.	C 422		
C 679	02.151,03,d Individualized Activity Plan d. Develop and implement an individual activity plan for each patient/resident which reflects the interests and needs of the patient/resident. This Rule is not met as evidenced by: Refer to F 248 as it relates to activities.	C 679	Please refer to the response for F248.	
C 685	02.151,04,a RECORDS - NEEDS AND INTERESTS 04. Records. The individual patient's/resident's medical record shall contain: a. An assessment of his needs and interests which is: This Rule is not met as evidenced by: Refer to F272 as it relates to failure to assess the activity needs and interests for the resident.	C 685	Please refer to the response for F272.	
C 778	02.200,03,a PATIENT/RESIDENT CARE 03. Patient/Resident Care. a. A patient/resident plan of care shall be developed in writing upon admission of the patient/resident, which shall be: This Rule is not met as evidenced by: Please refer to F280 as it related to care planning residents preferences.	C 778	Please refer to the response for F280.	

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C 782	Continued From page 4	C 782		
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F280 as it related to care planning residents preferences.	C 782	Please refer to the response for 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: Please refer to F314 as it related to development of pressure ulcers and not following the care plan for floating a resident's heels.	C 789	Please refer to the response for 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 as it relates to accident prevention.	C 790	Please refer to the response for F323.	
C 880	02.203,01 RESPONSIBLE STAFF 01. Responsible Staff. The administrator shall designate a staff member the responsibility for the accurate maintenance of medical records. If this person is not a	C 880		

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C 880	<p>Continued From page 5</p> <p>Registered Records Administrator (RRA) or an Accredited Records Technician (ART), consultation from such a qualified individual shall be provided periodically to the designated staff person.</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to have in place periodic consultation from a qualified medical records individual. This affected 9 of 9 (#s 1-9) sampled residents and had the potential to affect all residents in the facility. Findings included:</p> <p>On 9/9/13 at approximately 5:30 p.m. during the entrance interview, the facility provided the name of RHIT #5 (Record Health Information Technician) and RHIT #5's American Health Information Management Association's (AHIMA) number. The surveyor requested a copy of the RHIT's AHIMA card and to review an agreement or contract for periodic consultation provided by RHIT #5.</p> <p>On 9/10/13 at 12:49 p.m., the Administrator provided the survey team with copies of two emails. The first email, dated 8/29/13, from the Administrator was addressed to a person not identified as the RHIT, and requested to arrange a visit to the facility during the month of September 2013. The second email, dated 9/10/13, appeared to be from RHIT #5. The body of the email documented, "Here are my credentials. Good luck with survey. Will schedule something and get back to you."</p> <p>On 9/11/13 at 9:15 a.m., the Administrator provided the survey team with another email dated 9/10/13 at 2:03 p.m. Attached to the email on a plain piece of white paper was what</p>	C 880		

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C 880	<p>Continued From page 6</p> <p>appeared to be a letter signed by RHIT #5. The body of the letter contained, "I am a RHIT at [name of a different facility in a different town in the state]. I will review the medical record remotely beginning September 2013, once [name of corporation] has allowed me access to review the records at [name of facility]. I will review the record for completeness. Deficiencies will be reported to administration in a timely manner. I will audit documentation per State, Federal and corporate regulations and guidelines."</p> <p>The Administrator provided the survey team with copies of emails related to the planning of establishing periodic consultation from a qualified medical records professional. However, the facility did not have periodic consultation in place at the time of the survey.</p> <p>On 9/13/13 at 10:00 a.m., the Administrator and DON were informed of the finding. The facility did not provide any additional information related to the finding.</p>	C 880	<p>A qualified Registered Records Administrator (RRA), Accredited Records Technician (ART) or Record Health Information Technician (RHIT) consultant shall be provided periodically to Medical Records staff who do not possess such qualifications. <u>An agreement will be in place and consultation provided by 10/17/13.</u></p>	