



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7012 3050 0001 2125 6072

October 9, 2014

Robert D. Nahmensen, Administrator
Good Samaritan Society - Silver Wood Village
405 West Seventh Street, PO Box 358
Silverton, ID 83867-0358

FILE COPY

Provider #: 135058

Dear Mr. Nahmensen:

On **September 26, 2014**, a Recertification and State Licensure survey was conducted at Good Samaritan Society - Silver Wood Village by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 22, 2014**. Failure to submit an acceptable PoC by **October 22, 2014**, may result in the imposition of civil monetary penalties by **November 12, 2014**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

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

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

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

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 31, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 31, 2014**. A change in the seriousness of the deficiencies on **October 31, 2014**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **October 31, 2014** includes the following:

Denial of payment for new admissions effective **December 26, 2014**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 26, 2015**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **September 26, 2014** 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>

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

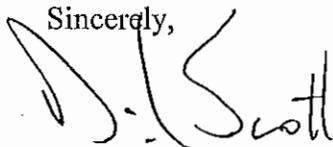
- BFS Letters (06/30/11)

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

This request must be received by **October 22, 2014**. If your request for informal dispute resolution is received after **October 22, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

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

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

DS/dmj
Enclosures

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST SEVENTH STREET SILVERTON, ID 83867
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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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: Lauren Hoard, RN, BSN Team Coordinator Linda Hukill-Neil, RN</p> <p>The survey team entered the facility on 9/22/14 and exited on 9/26/14.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CM = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligrams PRN = As Needed</p>	F 000		
F 154 SS=E	<p>483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS</p> <p>The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</p> <p>The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 154	<p>F154</p> <p>1. Residents and Resident representatives # 1, 3, 7, 8 have been educated on black box warning for antipsychotic medications. Black box warning: Drug may increase risk of cardiovascular or infection related death in elderly patients with dementia.</p>	

RECEIVED
10/26/2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robert M.</i>	TITLE Administrator	(X6) DATE 11-21-2014
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 154	<p>Continued From page 1</p> <p>by: Based on staff interview and record review, it was determined the facility failed to consider the risk identified with the use of psychoactive medications and the FDA Black Box Warning. This was true for 4 of 6 (#s 1, 3, 7 & 8) residents sampled for psychoactive medications. This deficient practice had the potential to cause harm when residents and resident representatives did not have the opportunity to make an informed decision regarding the potential risks associated with the Black Box Warning. Findings included:</p> <p>NOTE: Federal guidance at F 154 documented, "'Informed in advance' means that the resident receives information necessary to make a health care decision, including information about his/her medical condition and changes in medical condition, about the benefits and reasonable risks of the treatment, and about reasonable available alternatives."</p> <p>1. Resident #3 was admitted to the facility on 6/2/06 with multiple diagnoses which included depressive disorder, Alzheimer's disease and hallucinations.</p> <p>The medical record documented the facility was monitoring for screaming, paranoia and hallucinations.</p> <p>Resident #3's recapitulated Physician's Orders for September 2014 documented an order for, "ZyPREXA Tablet 7.5 MG (OLANzapine) Give 1 tablet by mouth one time a day related to HALLUCINATIONS..." with a start date of 9/30/13.</p> <p>The 2015 Nursing Drug Handbook documented:</p>	F 154	<ol style="list-style-type: none"> 2. Residents taking antipsychotics or who receive new orders for them have the potential to be affected by this practice. 3. All Residents and Resident representatives will be educated on black box warnings upon admission and/or new orders for antipsychotic medications. All nurses were education on Black box warning for Residents taking antipsychotic medications at nurses meeting Oct. 28, 2014. Black box warning: Drug may increase risk of cardiovascular or infection related death in elderly patients with dementia. 4. DNS or designee will review records of Residents using antipsychotic medications, records will be reviewed for education on black box warning weekly x4, monthly x2 All audit findings will be reported monthly to QAPI team for additional monitoring/modifications. QAPI team identified lack of nurse education as root cause of practice. 5. Compliance on or before November 21, 2014. 	

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F 154	<p>Continued From page 2</p> <p>Zyprexa, page 1040: "Black Box Warning: Drug may increased risk of CV [cardiovascular] or infection-related death in elderly patients with dementia. Olanzapine isn't approved to treat patients with dementia-related psychosis."</p> <p>A Permission For Use Of Psychoactive Medications form for Resident #3, dated 6/29/06, was provided which documented, "I have been informed of the type of psychoactive medication ordered for [Resident's name] and of its effects. I am aware of: a) the nature of the mental condition requiring this medication. b) the reason for taking such medication. c) the reasonable alternatives, if any. d) the name of the medication. e) possible side effects including side effects which may occur after long term use." The medication Zyprexa was handwritten and included the side effects of somnolence, nervousness, headache.</p> <p>The Permission forms did not include information about the Black Box Warnings for the antipsychotic medication.</p> <p>On 9/25/14 at 9:00 a.m., the DNS was asked about the process for informing residents and representatives of the Black Box Warnings for psychoactive medications. The DNS stated, "We just tell them of the side effects on the permission slip."</p> <p>2. Resident #7 was admitted to the facility on 9/15/11 and again on 8/8/14 with multiple diagnosis of anxiety state, unspecified psychosis and depressive disorder.</p> <p>The medical record documented the facility was monitoring for fearfulness, anxiety and delusions.</p>	F 154		
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F 154	<p>Continued From page 3</p> <p>Resident #7's recapitulated Physician's Orders for September 2014 documented an order for, "Saphris Tablet Sublingual 5 MG (Asenapine Maleate) Give 5 mg sublingually one time a day for anxiety related to," Persistent mental disorders due to conditions classified elsewhere, with a start date of 8/21/14.</p> <p>The 2014 Nursing Drug Handbook documented: Saphris, page 149: "Black Box Warning: Elderly patients with dementia-related psychosis treated with atypical or conventional antipsychotics are at increased risk for death. Antipsychotics aren't approved for the treatment of dementia-related psychosis."</p> <p>A Permission For Use Of Psychoactive Medications form for Resident #7, dated 11/28/12, was provided for the medication Saphris. The form included a sticker listing the side effects and nursing alert for anti-psychotic medications.</p> <p>The Permission forms did not include information about the Black Box Warnings for the anti-psychotic medication.</p> <p>On 9/25/14 at 12:45 p.m., the Administrator and DNS were informed of the lack of documentation regarding the Black Box Warning. No further information or documentation was provided.</p> <p>3. Resident #1 was admitted to the facility on 12/31/13 with multiple diagnoses which included sleep arousal disorder, dementia, depression, and pain.</p> <p>The resident's September 2014 daily "Behavior</p>	F 154		

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F 154	<p>Continued From page 4</p> <p>Documentation" form monitored the target behaviors:</p> <ul style="list-style-type: none"> *Disturbing nightmares; *Delusional statements about others and events around her; and *Angry, cursing, swearing. <p>The interventions associated with the above behaviors:</p> <ul style="list-style-type: none"> *1:1 assurance; *Diversion; *Validate feelings; and *Offer warm blanket. <p>Resident #1's recapitulated Physician's Orders for September 2014 documented an order for, "ZyPREXA Tablet 2.5 MG (OLANzapine) Give 2.5 mg by mouth at bedtime for night terrors with depression related to SLEEP AROUSAL DISORDER...," with a start date of 7/8/14.</p> <p>A Permission for Use of Psychopharmacological Medications form for Resident #8, dated 1/14/14 and signed by her authorized representative, was provided for Zyprexa. The form included an anti-psychotic sticker for Zyprexa and listed the side effects and nursing alerts, but did not include information about the Black Box Warning.</p> <p>On 9/24/14 at 8:25 AM, the surveyor asked LN #1 about medications with a Black Box Warning and if residents or their authorized representative signed a consent with the risks and benefits. LN #1 stated, "We don't go over the Black Box Warnings with the residents. We just go over them with the nurse."</p> <p>4. Resident #8 was admitted to the facility on 07/13/11 with multiple diagnoses which included schizophrenia, anxiety, and depression.</p>	F 154		
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F 154	Continued From page 5 The resident's September 2014 daily "Behavior Documentation" form monitored the target behaviors: *Fearful and anxious statements; *Paranoid about food; and *Hallucinations. The interventions associated with the above behaviors: *1:1; and *Reassurance. Resident #8's recapitulated Physician's Orders for September 2014 documented an order for, "ZyPREXA Tablet (OLANZapine) Give 5 mg by mouth one time a day related to UNSPECIFIED SCHIZOPHRENIA..." with a start date of 9/30/13. A Permission for Use of Psychopharmacological Medications form for Resident #8, dated 7/21/11 and signed by authorized representative, was provided for Zyprexa. The form included an anti-psychotic sticker for Zyprexa and listed the side effects and nursing alerts, but did not include information about the Black Box Warnings. On 9/25/14 at 12:45 PM, the Administrator and DNS were informed of the lack of signed consent regarding Black Box Warnings. No additional information was provided.	F 154		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	F226 1. Employee A has had her certification reinstated. 2. All Residents have the possibility to be affected by this practice.	

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F 226	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on review of the facility's abuse policies and procedures, staff personnel files and staff interview, it was determined the facility failed to operationalize its abuse policies and procedures when the facility failed to obtain a current/renewed certification for 1 of 5 employees (Staff A) reviewed for registry/licensure verification. This practice created the potential to place residents at risk for and subject to abuse, neglect or misappropriation of property. Findings included: The facility's abuse Policy and Procedure for Registry/Licensure Verification, revised on 1/2010, documented, "New Employees...2. If the position applied for requires a license...or certification, validity of certification or licensure will be obtained and noted on the Registry/Licensure Verification Form...Current Employees 1. It is the employee's responsibility to renew all documents as required and to provide his/her immediate supervisor with renewals and updates as they occur. a. If licenses are past due, the employee will not be allowed to work and placed on General Leave of Absence. Appropriate corrective action may take place. b. A copy of the renewed license, registration, certification and/or other credentials will be placed in the employee's permanent personnel file. 2. It is helpful to maintain a list of credentials and expirations in the center to ensure that no one is practicing with expired documents..." On 9/25/14 at 3:15 p.m., five employee personnel files were reviewed with the Human Resources	F 226	3. All CNA certifications are current. CNA certifications will be checked monthly to ensure they remain current. 4. Director of Nursing and receptionist will audit CNAs' certification to ensure they have been renewed timely. Audit findings will be compiled monthly x 3 months and forwarded to QAPI for additional modification/monitoring. QAPI has identified the need for a two-step verification process. 5. Compliance date on or before November 21, 2014.		

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F 226	Continued From page 7 Coordinator (HRC) for the State Nurse Aide Registry check. Staff A's original CNA certification date was 4/29/11 and expired 2/12/14. There were no negative findings. Staff A was hired on 5/27/14 with an expired CNA certification and continued to work until 9/25/14 without renewing the certification. On 9/25/14 at 3:35 p.m., the HRC was asked how the facility ensured staff licenses and certifications were kept current. The HRC said the Staff Development Coordinator (SDC) usually kept track but they currently did not have an SDC. When asked if anyone was keeping track of the certifications and licenses, the HRC stated, "Not unless the DNS is keeping a form." On 9/25/14 at 3:40 p.m., the DNS was asked who was keeping track of licenses and certifications. The DNS said it was, "Not assigned," and she was not personally keeping track of it. At 4:15 p.m., when asked, the DNS stated she did not know how the CNA was hired with an expired certification. On 9/25/14 at 12:45 p.m., the Administrator and DNS were informed of the expired CNA certification. No further information or documentation was provided.	F 226			
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.	F 280	F280 1. Resident #1 care plan has been updated to include foot cradle. Resident #2 care plan has been undated and wander guard and hand guard have been discontinued.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 8</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, it was determined the facility failed to revise care plans for 2 of 10 sampled residents (#s 1 and 2). The care plan for Resident #1 did not document the foot cradle on the bed. Resident #2's care plan was not updated to reflect the discontinuation of a Wanderguard on her wheelchair and the implementation of new interventions to meet the needs for a resident's refusal of wearing a left hand guard for protection and prevention of contractures and pressure sores. This had the potential to result in harm if the resident did not receive appropriate care due to the lack of direction in the care plan. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 12/31/13 with multiple diagnoses including hypertension, edema, peripheral vascular disease, congestive heart failure, and atrial</p>	F 280	<p>2. All Residents using foot cradle, wander guards and hand guards have the possibility to be affected by this practice.</p> <p>3. All Residents using foot cradle, wander guards and hand guards will have their care plans updated. Nursing staff will use Stop and Watch</p> <p>All nurses will be in serviced on stop and watch on care planning foot cradles, discontinuing wander guards and hand guards at nurses' meeting 10/28/14</p> <p>4. DNS or designee will audit stop and watch, care plans of Residents using foot cradles, hand guards and wander guards monthly weekly x 4, monthly x 2. All information compiled will be forwarded to Quapi for additional monitoring/modification.</p> <p>5. Completion date October 31, 2014</p>		

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F 280	<p>Continued From page 9 fibrillation.</p> <p>The resident's current skin integrity care plan documented a focus area dated 1/16/14, "...The resident has Peripheral Vascular Disease [PVD] R/T [related to] past history of smoking, Edema E/B [evidenced by] impaired LE [lower extremity]..." The interventions dated 1/16/14 documented: *"...Monitor/document/report...any skin problems related to PVD: redness, edema, blistering, itching, burning, bruises..." *"...Monitor/document/report...complications of extremities: coldness of extremity, pallor, rubor, cyanosis and pain. Keep skin on extremities well lubricated with lotion in order to prevent dry skin and cracking of the skin..."</p> <p>The resident's previous skin integrity care plan documented a focus area dated 1/16/14 with a 2/28/14 resolved/canceled date, "...RESOLVED: The resident has (sternal surgical incision) impairment to skin integrity R/T Heart Valve Replacement surgery E/B sternal surgical incision..." The interventions dated 2/22/14, with a resolved date of 2/28/14, documented: *"...RESOLVED: Resident needs protection for the feet: bed cradle on bed to keep bedding off of feet..."</p> <p>On 9/22/14 at 11:00 AM, the surveyor upon observation of Resident #1's room documented a foot cradle was being used on the bed. The foot cradle was in position on the lower portion of the bed throughout the survey.</p> <p>On 9/25/14 at 11:00 AM, the DNS was interviewed regarding the foot cradle on Resident #1's bed. The DNS stated, "[Resident's name]</p>	F 280		

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F 280	<p>Continued From page 10</p> <p>was having a lot of pain in her toes and had said the blankets were too heavy on her feet, so the foot cradle had been implemented." The DNS said the resident had experienced a huge amount of edema in the past, so her feet and legs had also been impacted with blistering, pain, and sensitivity. The resident's edema had significantly improved, but still present at times and taking Lasix. The resident liked having the foot cradle in place to keep the pressure off of her lower extremities. The surveyor asked the DNS if the care plan documented the foot cradle still being utilized. The DNS stated, "I hope so."</p> <p>2. Resident #2 was admitted to the facility on 2/1/12 with multiple diagnoses including hemiplegia affect due to CVA (cerebral vascular accident), calculus of kidney, pyelonephritis, and diabetes.</p> <p>a. The resident's current cognitive impairment care plan documented a focus area dated 5/27/14, "...The resident has potential for elopement R/T Cognitive impairment E/B no longer lets staff know when she is going outside..." The interventions dated 5/27/14 documented: **...PERSONAL ALARM; Wander Guard to left front w/c [wheelchair] used to alert staff to resident's movement and to assist staff in monitoring movement..."</p> <p>b. The resident's current pressure ulcer care plan documented a focus area dated 12/30/13 and revised on 7/24/14, "...The resident has potential for pressure ulcer development R/T HX [history] of scratching skin on forearms and excoriation recurrent @ [at] abdominal skin fold, abrasion on thigh..." The interventions dated 12/30/13 and</p>	F 280		
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F 280	<p>Continued From page 11 revised on 5/1/14 documented: *"...Palm shield guard to be worn during the day, resident manages guard but staff to assist with positioning as needed..."</p> <p>On 9/22/14 at 2:00 PM, the surveyor observed the resident in her room. The resident had a platform attachment to her left arm rest on her wheelchair with her arm and hand resting in it. Resident #2 did not have any palm shield guard on her left hand and she did not have any alarm system on her wheelchair or bed. The resident was observed throughout the survey without a hand guard or any wheelchair alarm in place.</p> <p>Resident #2's Administrative Meeting progress notes dated 6/19/14 documented, "...Discussion held with resident and she did not think an alarm would be good for her. She was receptive to a sign out and in protocol to let us know when she is going outside to allow us to increase checks during those outside times..."</p> <p>On 9/24/14 at 8:50 AM, the DNS was interviewed regarding her left palm shield guard. The DNS stated, "She is refusing it." The DNS acknowledged the care plan did reflect the palm shield guard was to be worn every day and the resident's refusal may not have been monitored consistently.</p> <p>On 9/25/14 at 9:45 AM, Resident #2 was interviewed by regarding her wheelchair alarm and her left palm shield guard. The resident stated, "I don't have to have the alarm on my wheelchair. I told them I would be good about signing out. I don't like wearing it (left hand guard), so don't."</p>	F 280			

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F 280	Continued From page 12 On 9/25/14 at 12:45 PM, the Administrator and DNS were informed of the issue. No additional information was provided.	F 280		
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to assess pain intensity and characteristics for scheduled and as needed pain medication; assess for effectiveness of scheduled pain medications; monitor for adverse side effects of pain medication and include pharmacological interventions and medication-related adverse side effects on the care plan. This was true for 3 of 6 residents (#s 3, 4 & 5) reviewed for pain. These failures created the potential for residents to experience complications, discomfort and/or compromised medical status. Findings included:</p> <p>1. Resident #3 was admitted to the facility on 6/2/06 with multiple diagnoses which included generalized pain and Alzheimer's disease.</p> <p>The most recent quarterly MDS assessment for Resident #3, dated 9/13/14, documented the resident had severely impaired cognition with a</p>	F 309	<p>F309</p> <p>1. Resident #3 has been reassessed; the care plan has been updated to include nonpharmacological pain interventions. Her medication orders have been updated to include monitoring for pain intensity and potential adverse side effects.</p> <p>Resident #4 has been reassessed, the care plan has been updated to include nonpharmacological interventions for pain. Medication orders have been updated to monitor adverse side effects and pain intensity.</p> <p>Resident #5 has been reassessed, care plan has been updated to include nonpharmacological interventions for pain and medication orders to monitor for adverse side effects, pain frequency and intensity.</p>	

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F 309	<p>Continued From page 13</p> <p>BIMS of 3, was on a scheduled pain medication regimen, received non-medication interventions for pain, was able to complete the pain assessment interview which documented the resident was not in pain. Pain frequency, pain effect on function and pain intensity were not documented.</p> <p>Resident #3's Care Plan documented a Focus of, "The resident has chronic pain/discomfort R/T [Related to] Generalized pain, history of pelvic fractures E/B [Evidenced by] complaints of pain or discomfort, increase in negative behaviors," with a date of 7/1/14. A Goal included, "Resident will not have discomfort related to side effects of analgesia through the review date." Interventions included observation, recording and reporting of non-verbal signs and symptoms of pain, changes in usual routine and monitoring/documenting for side effects of pain medication.</p> <p>The Care Plan did not include non-pharmacological or pharmacological interventions for pain.</p> <p>The September 2014 recapitulated Physician's Orders for Resident #3, documented 2 orders for Tylenol which included, "Tylenol Tablet (Acetaminophen) Give 500 mg by mouth one time a day related to GENERALIZED PAIN," with a start date of 9/30/13 and, "Tylenol Tablet (Acetaminophen) Give 500 mg by mouth two times a day related to GENERALIZED PAIN," with a start date of 9/19/13.</p> <p>Resident #3's MAR for September 2014 documented the resident had received the ordered Tylenol in the AM, at noon and in the PM. The MAR did not include documentation for pain</p>	F 309	<ol style="list-style-type: none"> 2. All Residents receiving pain medications have the potential to be affected by this practice. 3. All Resident's receiving pain medication careplans will be updated to include individualized nonpharmacological interventions, pain intensity and monitors for side effects <p>Nursing staff will be in serviced on or before 10/28/14 on care planning and documentation of nonpharmacological interventions, adverse side effects and pain intensity.</p> <ol style="list-style-type: none"> 4. DNS or designee will audit Resident care plans for documentation of nonpharmacological interventions, adverse side effects and pain intensity weekly x 4 weeks, monthly x2. Information will be compiled and forwarded to QAPI for additional modifications/monitors. QAPI identified the lack of care planning education as root cause analysis. 5. Completion date November 21, 2013 	

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F 309	<p>Continued From page 14</p> <p>intensity, effectiveness or the monitoring of adverse side effects.</p> <p>The medical record did not contain documented evidence the adverse side effects of pain medication were monitored.</p> <p>On 9/24/14 at 8:00 a.m., the DNS was interviewed regarding pain medication monitoring and care plan instruction. The DNS said pain intensity was monitored per scale and should be on the MAR, but could also be in progress notes, and instruction to monitor adverse side effects would be on the care plan and was charted by exception. The DNS added medication and non-medication interventions should be included on the care plan.</p> <p>2. Resident #4 was admitted to the facility on 1/29/13 with multiple diagnoses which included generalized pain, pain in joint shoulder region and osteoporosis.</p> <p>The most recent quarterly MDS assessment for Resident #4, dated 8/23/14, documented intact cognition with a BIMS of 12, received PRN pain medication, pain intensity rated a 7 out of 10 with the pain occurring frequently.</p> <p>Resident #4's Care Plan documented a Focus of, "The resident has chronic pain/discomfort R/T [Right] shoulder pain, generalized pain, compression FX [fracture] T7, osteoporosis w/deficiency FX bilateral sacrum, GERD [Gastroesophageal Reflux Disease], rash and chronic rhinitis; acute pain r/t mouth canker sores E/B c/o [complaints of] pain," with a start date of 11/6/13 and revised on 8/28/14. A Goal included, "Resident will not have discomfort related to side</p>	F 309		

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F 309	<p>Continued From page 15</p> <p>effects of analgesia through the review date." Interventions were, "Referral to restorative, if indicated...Attempt non-pharmacological interventions of resident's choice for pain/discomfort..."</p> <p>The Care Plan did not include pharmacological interventions for pain, nor did it provide instruction to monitor for adverse side effects.</p> <p>The September 2014 recapitulated Physician's Orders for Resident #4 documented 2 orders for pain medication which included, "Norco Tablet 7.5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for for [sic] severe pain related to GENERALIZED PAIN," with a start date of 1/28/14-and, "Ultram Tablet (TraMADol HCl) Give 50 mg by mouth every 6 hours as needed for FOR C/O PAIN related to GENERALIZED PAIN," with a start date of 8/7/14.</p> <p>Resident #4's MAR for August and September 2014 documented the resident received Norco 7.5-325 mg 24 times in August and 15 times in September, and received Ultram 50 mg once in August and once in September. Pain intensity and effectiveness were documented on the MARs.</p> <p>The medical record did not contain documented evidence the adverse side effects of pain medication were monitored.</p> <p>On 9/24/14 at 8:10 a.m., the DNS was asked if Resident #4's Care Plan included pharmacological interventions for pain. After reviewing the Care Plan, the DNS stated, "I don't see it." When asked how effectiveness of</p>	F 309		

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F 309	<p>Continued From page 16</p> <p>scheduled pain medications were documented, the DNS said effectiveness of scheduled pain medications were not monitored except on the quarterly pain assessments and the facility's comfort committee.</p> <p>3. Resident #5 was admitted to the facility on 6/19/07 and again on 8/6/13 with multiple diagnoses which included osteoarthritis and pathologic fracture at unspecified site.</p> <p>The most recent quarterly MDS assessment for Resident #5, dated 9/15/14, documented the resident was not on a scheduled pain medication regimen, was not receiving PRN pain medication, received non-medication interventions for pain, was able to complete the pain assessment interview which documented the resident was not in pain. Pain frequency, pain effect on function and pain intensity were not documented.</p> <p>Resident #3's Care Plan documented a Focus of, "The resident has chronic pain/discomfort R/T Osteoarthritis; probable compression fracture, lower back (pathologic), allergic rhinitis E/B c/o watery or itchy eyes," with a start date of 10/30/13 and revised on 4/4/14. A Goal included, "Resident will not have discomfort related to side effects of analgesia through the review date," and the interventions included, "Attempt non-pharmacological interventions of resident's choice for pain discomfort: 1. Massage 2. 1:1 visit 3. Quiet rest 4. Warm blanket."</p> <p>The Care Plan did not include pharmacological interventions for pain, nor did it provide instruction to monitor for adverse side effects.</p> <p>The September 2014 recapitulated Physician's</p>	F 309			

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F 309	<p>Continued From page 17</p> <p>Orders for Resident #5 documented, "Norco Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 8 hours as needed for for [sic] pain related to PATHOLOGIC FRACTURE..." with a start date of 11/30/13.</p> <p>Resident #5's MAR for September 2014 documented the resident received Norco 5-325 mg 5 times. The effectiveness was documented but did not include the pain intensity at the time pain medication was administered.</p> <p>Medication administration Progress Notes documented, "Norco Tablet 5/325 MG Give 1 tablet by mouth every 8 hours as needed for for [sic] pain...Monitor pain using 0-10 scale. 10 being worse pain." Resident #5 received the PRN Norco on 9/8/14, 9/10/14, 9/17/14, 9/18/14, 9/23/14 and 9/24/14. The pain intensity was not documented in the progress notes.</p> <p>The medical record did not contain documented evidence the adverse side effects of pain medication were monitored.</p> <p>On 9/24/14 at 8:00 a.m., the DNS was asked if anything was missing from Resident #5's Care Plan in regards to pain interventions and she stated, "Yes, there is no list of side effects," and added the care plan did not include pharmacological pain interventions.</p> <p>On 9/25/14 at 12:45 p.m., the Administrator and DNS were informed of the concerns related to pain management. No further information or documentation was provided.</p>	F 309		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=E	Continued From page 18 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 observation and staff interview, it was determined the facility failed to ensure the resident environment was as free from hazards as possible when equipment not in use was parked in the hallways blocking handrails. This was true for any resident needing access to the handrails in the East and West hallways. The deficient practice had the potential to cause harm if a resident became unsteady and fell when the handrail was unavailable. Findings included: On 9/22/14, the following observations were made by the surveyor of equipment not in use which blocked access to handrails: * From 9:55 a.m. until 10:54 a.m., a wheelchair was parked between rooms 204 and 206, a vital signs cart was parked near room 206, a sit-to-stand lift and a hooyer lift were both parked between rooms 210 and 212; * From 12:25 p.m. until 1:38 p.m., a vital signs cart was parked near room 303 and a 4 wheel walker with a magazine on the seat was parked outside of room 305; * At 12:30 p.m., a wheelchair was parked between rooms 204 and 206, a hooyer lift and a rolling cart with 3 shelves were parked between	F 323	F323 1. Equipment – wheelchairs, vital sign carts, sit to stand lift and hooyer lift were removed from hallway immediately and are stored in hallway nooks or as appropriate, within Resident rooms. 2. All Residents using hallways and needing handrails have the potential to be affected by this practice. 3. Resident equipment not in use will be placed in the hallway nooks or Resident rooms as determined by need. All staff will be educated at all staff meeting 10/20/14 on need to store equipment in hallway nooks or Resident rooms. 4. Environmental service supervisor or designee will audit hallways and hallway nooks to ensure equipment is stored appropriately weekly x 4 weeks and monthly x2 months. Audit results will be reported to QAPI committee for further monitoring/modification. 5. Compliance on or before October 31, 2014	

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F 323	<p>Continued From page 19 rooms 210 and 212; * At 1:38 p.m., a hooyer lift and sit-to-stand lift were parked outside room 311; and, * At 1:44 p.m., a wheelchair was parked between rooms 204 and 206, a sit-to-stand lift was parked outside room 206 and a hooyer lift was parked outside room 212.</p> <p>On 9/23/14, the following observations were made by the surveyor of equipment not in use which blocked access to handrails: * From 7:55 a.m. until 9:10 a.m., a vital signs cart was parked between rooms 303 and 305 and a 4 wheel walker was parked outside room 305; * From 7:55 a.m. until 8:25 a.m., a vital signs cart was parked between rooms 202 and 204, a wheelchair was parked outside room 204 and a hooyer lift was parked between rooms 210 and 212; and, * At 8:25 a.m., a sit-to-stand lift was parked outside room 206.</p> <p>On 9/24/14 at 3:40 p.m., the DNS was asked where equipment was stored when not in use. The DNS said the lifts were stored at bedside or in the nooks on each hallway. She added vital signs carts were stored in the storage room across from the nurse's station. The policy and procedure for equipment storage was requested.</p> <p>On 9/24/14 at 3:55 p.m., the DNS informed the surveyor the facility did not have a policy and procedure for equipment storage.</p> <p>On 9/24/14 at 4:55 p.m., the Administrator and DNS were informed of the equipment storage concerns. No further information or documentation was provided.</p>	F 323		
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F 329 F 329 SS=D	Continued From page 20 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents receiving psychoactive medications were monitored for target behaviors and adverse side effects, and duplicate therapy had clinical justification for use. This affected 2 of 6 residents (#s 3 & 7) reviewed for psychoactive medication. This deficient practice created the potential for	F 329 F 329	F329 1. Resident #3 care plan has been updated to contain adverse side effects of antipsychotic medication. Hallucinations are now monitored Resident #7 care plan has been updated to monitor for adverse side effects for antipsychotic medications. Her documentation records have been updated to include sad affect and adverse side effects of antidepressant. 2. Any Resident taking antipsychotic or antidepressant medications has the potential to be affected by this practice. 3. All nursing staff will be educated on the side effects of antipsychotic and antidepressant medication on or by 10/31/2014. Nursing staff were inserviced 10/28/14 on individualized behaviors monitoring. 4. DNS or designee will audit care plans for adverse side effects of antipsychotic medications and CPs for individualized behaviors and depression. Results will be forwarded to QAPI for additional monitoring, modification. QAPI identified lack of education on		

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F 329	<p>Continued From page 21</p> <p>harm to residents as unnecessary drugs can lead to adverse reactions and health decline. Findings included:</p> <p>1. Resident #3 was admitted to the facility on 6/2/06 with multiple diagnoses which included depressive disorder, Alzheimer's disease and hallucinations.</p> <p>The most recent quarterly MDS assessment, dated 9/13/14, documented Resident #3 had severely impaired cognition with a BIMS of 3, scored a 4 for depression, did not display any behaviors including hallucinations and delusions, and received antipsychotic medication 7 times out of 7 days.</p> <p>The September 2014 recapitulated Physician's Orders for Resident #3 documented, "ZyPREXA Tablet 7.5 MG (OLANzapine) Give 1 tablet by mouth one time a day related to HALLUCINATIONS. Document q [every] shift behavior s/s [signs and symptoms]...", with a start date of 9/30/13.</p> <p>Resident #3's MAR for September 2014 documented the antipsychotic medication was administered per Physician's orders.</p> <p>The Care Plan for Resident #3 documented: * Focus - "The resident has behavior symptoms R/T [related to] Alzheimers, Hallucinations E/B [Evidenced by] paranoid statements, screaming, irritability, striking out and verbally abusive with cares," with an initiation date of 10/30/13; * Interventions - "...BEHAVIOR #1 Screaming and cursing, ie calling lady, lady or take this from my table causing disruption to others. Advise resident that is disturbing others, reassure and offer to</p>	F 329	<p>side effects of antipsychotic and antidepressant medication and behavior monitoring.</p> <p>5. Compliance on or before November 21, 2014</p>		

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F 329	<p>Continued From page 22</p> <p>visit if helpful. Offer a nap if she appears fatigued or over stimulated; BEHAVIOR #2; Paranoid/fearful ideations. Provide calm supportive one on one. Reassure her of safety in the environment; BEHAVIOR #3 Hallucinations. Validate feelings. Reassure resident of safety. Alert Nurse;"</p> <p>* Focus - "The resident uses psychopharmacological medications (Zyprexa) R/T Hallucinations, Alzheimers Disease E/B paranoid statements, screaming, striking out with cares, and paranoia;" and,</p> <p>* Interventions - "...Monitor/record/report to health care provider prn side effects and adverse reactions of psychoactive medications..."</p> <p>The medical record did not contain documented evidence the adverse side effects of the antipsychotic were monitored.</p> <p>The August 2014 Behavior Documentation record for Resident #3 included the target behaviors: screaming, paranoid and hallucinations. The form contained areas to chart for night shift, day shift and evening shift. The evening shift did not document on behaviors 22 days out of 31.</p> <p>The September 2014 Behavior Documentation record for Resident #3 included the target behaviors: screaming and paranoid. The evening shift did not document on behaviors 18 days.</p> <p>Hallucinations were not monitored for the month of September 2014.</p> <p>On 9/24/14 at 8:12 a.m., the DNS was interviewed regarding Resident #3 and the use of an antipsychotic. The DNS said the resident was receiving Zyprexa for a, "Diagnosis of</p>	F 329		

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F 329	<p>Continued From page 23</p> <p>hallucinations," with a, "Second diagnosis of Alzheimers." The DNS said behaviors were to be monitored at least daily on the brown bordered paper, as well as on the computer system which was charting by exception. The DNS was shown the lack of documentation for behavior monitoring in August and September 2014 and she said the evening shift was, "Not very consistent with documenting," because the facility did not have an evening shift nurse and things fell through the cracks. The DNS also acknowledged hallucinations were not monitored for September 2014. When asked who made the Behavior Documentation records each month, the DNS said the nurses did it as well as Social Services and they get the information from previous Behavior Documentation records and the care plan.</p> <p>2. Resident #7 was admitted to the facility on 9/15/11 and again on 8/8/14 with multiple diagnoses which included anxiety state, unspecified psychosis and depressive disorder.</p> <p>The most recent annual MDS assessment, dated 8/7/14, documented Resident #7 was cognitively intact with a BIMS of 13, scored a 12 for depression, had no hallucinations or behaviors and received antipsychotic, antianxiety and antidepressant medication 7 times out of 7 days.</p> <p>a. The September 2014 recapitulated Physician's Orders for Resident #7 documented, "Saphris Tablet Sublingual 5 MG (Asenapine Maleate) Give 5 mg sublingually one time a day for anxiety related to," Persistent mental disorders due to conditions classified elsewhere, with a start date of 8/21/14.</p>	F 329		

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F 329	<p>Continued From page 24</p> <p>Resident #7's MAR for September 2014 documented the antipsychotic medication was administered per Physician's orders.</p> <p>Resident #7's Care Plan; dated 1/3/14, documented a focus of, "The resident is on antipsychotic medication therapy (Saphris) R/T Unspecified psychosis E/B hallucinations, statements that she has been shot," a goal was, "The resident will be free from any discomfort or adverse side effects from antipsychotic medication use through the review date," and interventions included, "BLACK BOX WARNING #1: SAPHRIS: Elderly patients with dementia-related psychosis treated with atypical or conventional antipsychotics are at increased risk for death. Antipsychotics aren't approved for the treatment of dementia-related psychosis."</p> <p>The Care Plan did not provide staff instruction to monitor for adverse side effects, and the medical record did not contain documented evidence the adverse side effects of the antipsychotic were monitored.</p> <p>The July 2014 Behavior Documentation record for Resident #7 included the target behaviors: fearful, anxiety and delusional. The evening shift did not document on behaviors 11 days out of 31.</p> <p>The August and September 2014 Behavior Documentation record for Resident #7 included the target behaviors: fearful and anxiety, delusional and on call light frequently. The evening shift did not document on behaviors 22 days out of 31 in August, and 18 days in September.</p> <p>Hallucinations were not monitored in July, August</p>	F 329		
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F 329	<p>Continued From page 25 or September 2014.</p> <p>On 9/25/14 at 9:00 a.m., the DNS was interviewed regarding Resident #7's antipsychotic medication. The DNS said the resident was receiving Saphris since 5/9/13 to treat the behaviors delusional thinking, paranoia, exit seeking, flight of ideas and may others listed on the Care Plan, and some of those behaviors were monitored daily or were documented by exception on the computer system. The DNS said hallucinations were also being monitored. The DNS said the adverse side effects of the antipsychotic were monitored on the Care Plan, and the adverse side effects being monitored were listed on the permission slip and Care Plan. When asked what persistent mental disorders due to conditions classified elsewhere meant, the DNS stated, "I'm not sure without looking that up."</p> <p>b. The September 2014 recapitulated Physician's Orders for Resident #7 documented the use of 2 antidepressants which included, "TraZODone HCl Tablet 50 MG Give 25 mg by mouth at bedtime related to DEPRESSIVE DISORDER NOT ELSEWHERE CLASSIFIED," with a start date of 7/15/14 and, "Zoloft Tablet 100 MG (Sertraline HCl) Give 100 mg by mouth in the morning for dementia related," Persistent mental disorders due to conditions classified elsewhere, with a start date of 12/13/13.</p> <p>Resident #7's MAR for September 2014 documented the antidepressant medication was administered per Physician's orders.</p> <p>Resident #7's Care Plan documented a focus of, "The resident uses antidepressant medications (Zoloft and Trazodone) R/T Depression E/B sad</p>	F 329			

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F 329	<p>Continued From page 26</p> <p>affect," with a start date of 1/3/14 and revised on 8/15/14. The goal was, "Resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date," and interventions included, "Report to Nurse s/s the following: confusion, mood change, change in normal behavior, hallucinations/delusions, social isolation, suicidal ideations, withdrawal, declining ability to help with/do ADLs, continence, cognitive functions, constipation, fecal impaction, no voiding, shuffle gait, rigid muscles..."</p> <p>The Behavior Documentation records for Resident #7 did not include the behavior/mood of sad affect. In addition, the medical record did not contain documented evidence of adverse side effect monitoring related to the antidepressant medications.</p> <p>On 9/25/14 at 9:00 a.m., the DNS was asked what the clinical justification was for the use of 2 antidepressants for Resident #7. The DNS said Trazodone was ordered for insomnia related to depression and did not have an answer when asked why insomnia wasn't mentioned in the Physician's Orders or Care Plan. The DNS said hours of sleep were not monitored. The DNS said Zoloft was ordered for, "Anxiety state, anxious statements." The DNS said sad affect was monitored, "Just via the Care Plan," and added the adverse side effects were documented by exception on the computer system.</p> <p>The medical record did not contain documented evidence of clinical justification for the use of duplicate therapy related to antidepressant medications.</p> <p>On 9/24/14 at 4:55 p.m., and on 9/25/14 at 12:45</p>	F 329		
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F 329	Continued From page 27 p.m., the Administrator and DON were informed of concerns related to psychoactive medications. No further information or documentation was provided.	F 329			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	F431 1. Outdated medications were removed from the medication cart and outdated IV fluids were removed from the medication room 9/24/2014. 2. Residents who receive medications or IV fluids have the potential to be affected by this practice. 3. Day shift charge nurse will ensure, by inspection that medication cart and IV fluids in med room are checked weekly for outdates. Report will be provided to DNS or designee. All nurses were inserviced on the change to this process and disposal of expired medications and IV fluids on or before 10/28/2014		

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F 431	<p>Continued From page 28</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interviews, it was determined the facility failed to ensure outdated medications and IV (intravenous) fluids were removed from the medication room and medication cart for residents' use. This failure created the potential for more than minimal harm if the outdated medications and IV fluids had a diminished efficacy and/or contamination. This had the potential to affect any resident who could receive expired medications and IV fluids.</p> <p>On 9/24/14 at 9:10 AM, the Medication Room was examined with LN #1. The surveyor and LN #1 discovered in a bottom cupboard, 11 bags of IV 0.9% Sodium Chloride 1000 mL fluid. The bags had an expiration date of August 2013. The LN stated, "I check for outdates every Wednesday." LN #1 said that she obviously missed the box of IV fluids with an expiration date of over a year ago.</p> <p>On 9/24/14 at 9:25 AM, the Medication Cart was examined with LN #2. The surveyor and LN #2 discovered 3 stock bottles with an expiration date as follows: -Bisacodyl (Stool Softner) expired March 2014; -Multivitamin with Iron expired August 2014; and, -Ferrous Sulfate expired July 2014.</p> <p>On 9/24/14 at 4:55 PM, the Administrator and DNS were informed of the expired medications and IV fluids. No additional information was provided.</p>	F 431	<p>4. Pharmacist, DNS or designee will audit med cart for expired meds and med room for expired IV fluids weekly x4, monthly x2. Audit results will be reported to QAPI committee monthly for further monitoring/modification. QAPI identified there was no responsible person assigned this task. The task of inspection was root cause of this practice.</p> <p>5. Compliance on or before November 21, 2014</p>	
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Bureau of Facility Standards

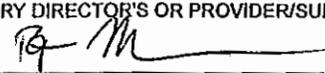
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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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: Lauren Hoard, RN BSN Team Coordinator Linda Hukill-Neil, RN	C 000		
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 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: Refer to F329 as it relates to psychoactive medications.	C 147	C 147 See POC for F329	
C 159	02.100,09 RECORD OF PTNT/RSDNT PERSONAL VALUABLES 09. Record of Patient's/Resident's Personal Valuables. An inventory and proper accounting shall be kept for all valuables entrusted to the facility for safekeeping. The status of the inventory shall be available to	C 159	C159 1. Resident #10 expired on 3/24/2014 2. Any discharging Resident have the potential to be affected by this practice.	

RECEIVED
10/24/2014
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11-21-2014
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001740	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2014
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C 159	<p>Continued From page 1</p> <p>the patient/resident, his conservator, guardian, or representative for review upon request.</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an accounting of personal belongings was completed upon discharge for 1 of 1 sample residents (#10). Findings included:</p> <p>Resident #10 was admitted to the facility on 2/4/14 with hospice involvement and expired in the facility on 3/24/14.</p> <p>On 9/24/14 at 11:20 AM, the Director of Health Information (DHI) was interviewed regarding the resident's personal belongings. The DHI stated, "We do not have a discharge summary." She said, that she was gone to Mexico for vacation during that time period and another individual filled in for her. The discharge summary would have contained this information, but did not appear that it was done. The only information provided to the surveyor for Resident #10, was a nursing progress note and a Mortician report. Neither mentioned final disposition of the resident's personal belongings.</p> <p>On 9/25/14 at 12:45 PM, the Administrator and DNS were informed of the issue. No additional information was provided.</p>	C 159	<p>3. Charge nurse will ensure discharge summary and inventory of personal effects are completed at time of death/transfer/discharge. Social Services will review records to ensure compliance oof discharge summary and personal inventory being completed.</p> <p>Licensed Nurses, Social Service director and HIM director will re re oriented to the discharge summary process including accounting for personal possessions on or before October 28, 2014.</p> <p>4. HIM or designee will audit discharge records for accounting of personal belongings weekly x 4, monthly x2. Audit reports will be reported to QAPI committee monthly for further monitoring and modification.</p> <p>5. Compliance on or before October 31, 2014</p>	
C 191	<p>02.105,05 APPLICABLE IDAHO & FEDERAL LAWS</p> <p>05. Applicable Idaho and Federal Laws. Applicable Idaho and federal laws shall be observed in relation to employment of any individual.</p>	C 191	<p>C191 See POC for F226</p>	

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C 191	Continued From page 2 This Rule is not met as evidenced by: Refer to F226 as it relates to the implementation of the facility's Policy and Procedure for screening employees.	C 191		
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 equipment blocking access to handrails.	C 790	C790 See POC for F323	
C 803	02.200,04,f Observed for Reactions f. Patients/residents are observed for reactions to medications and if a reaction occurs, it is immediately reported to the charge nurse and attending physician; This Rule is not met as evidenced by: Refer to F329 as it relates to monitoring for adverse side effects.	C 803	C803 See POC for F329	
C 856	02.201,04,c Documentation of Use and Results c. Reasons for administration of a PRN medication and the patient's/resident's response to the medication shall be documented in the nurse's notes. This Rule is not met as evidenced by: Refer to F309 as it relates to pain management.	C 856	C856 See POC for F309	
C 882	02.203,02,a Resident Identification Requirements a. Patient's/resident's name and	C 882	C 882 1. Resident #10 expired 3/24/14.	

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C 882	<p>Continued From page 3</p> <p>date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service (if applicable); name, address and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and disposition, signed by the attending physician, shall be part of the medical record.</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to document the final diagnosis or cause of death and obtain the signature of the Physician. This was true for 1 of 1 (#10) sampled residents for review of closed records. Findings included:</p> <p>Resident #10 was admitted to the facility on 2/4/14 with hospice involvement and expired in the facility on 3/24/14.</p> <p>On 9/24/14 at 11:20 AM, the Director of Health Information (DHI) was interviewed regarding the resident's discharge summary. The DHI stated, "We do not have a discharge summary." She said, that she was gone to Mexico for vacation during that time period and another individual filled in for her. The discharge summary would have contained the disposition of personal belongings, final diagnosis or cause of death and the signature of the the Physician. The only</p>	C 882	<ol style="list-style-type: none"> 2. Any discharging Resident has the potential to be affected by this practice. 3. Charge nurse will ensure documentation of final diagnosis or cause of death. HIM will obtain the signature of the Physician. <p>Licensed nurses and HIM director will be re oriented to the discharge process including final diagnosis and/or cause of death and need for physician signature.</p> <ol style="list-style-type: none"> 4. HIM or designee will audit discharge records for listing of diagnosis or cause of death and physician signature weekly x4 weeks and monthly x 2. Audit reports will be reported to QAPI committee monthly for further monitoring/modification. 5. Compliance on or before October 31, 2014. 	

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C 882	Continued From page 4 information provided to the surveyor for Resident #10, was a nursing progress note and a Mortician report. Neither mentioned the cause of death or had a Physician's signature. On 9/25/14 at 12:45 PM, the Administrator and DNS were informed of the issue. No additional information was provided.	C 882		