



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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BUREAU OF FACILITY STANDARDS
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PHONE 208-334-6626
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CERTIFIED MAIL: 7012 1010 0002 0836 2168

October 9, 2013

Bryan K. Lindsay, Administrator
Life Care Center of Coeur d'Alene
500 West Aqua Avenue
Coeur d'Alene, ID 83815-7764

Provider #: 135122

RE: SEPTEMBER 27, 2013, RECERTIFICATION AND STATE LICENSURE SURVEY
REPORT COVER LETTER

Dear Mr. Lindsay:

On **September 27, 2013**, a Recertification and State Licensure survey was conducted at Life Care Center of Coeur d'Alene 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 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. 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 22, 2013**. Failure to submit an acceptable PoC by **October 22, 2013**, may result in the imposition of civil monetary penalties by **November 12, 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

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October 9, 2013
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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 **November 1, 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 **November 1, 2013**. A change in the seriousness of the deficiencies on **November 1, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 1, 2013** includes the following:

Denial of payment for new admissions effective **December 27, 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 27, 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.

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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 27, 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 22, 2013**. If your request for informal dispute resolution is received after **October 22, 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,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj
Enclosures

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/27/2013
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COEUR D'ALENE			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST AQUA AVENUE COEUR D ALENE, ID 83815	
(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: Karen Marshall, MS, RD, LD Team Coordinator Bradley Perry, LSW, BSW Linda Kelly, RN Lauren Hoard, RN Debra Bernamonti, RN</p> <p>Survey Definitions:</p> <p>ADL = Activities of Daily Living ADON = Assistant Director of Nursing CAA = Care Area Assessment CM = Centimeters CNA = Certified Nurse Aide DNT = Do Not Taper DON/DNS = Director of Nursing or Director of Nursing Services GDR = Gradual Dose Reduction IDCT = Initial Data Collection Tool/Nursing Service IV = Intravenous LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligrams NPSCR = Non-Pressure Skin Condition Record PO = By Mouth/Oral PRN = As Needed PUSR = Pressure Ulcer Status Record RCM = Resident Care Manager RN = Registered Nurse ST = Speech Therapy</p>	F 000	<p>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p> <p style="text-align: right;">RECEIVED OCT 24 2013 FACILITY STANDARDS</p>	10-31-13
F 253	483.15(h)(2) HOUSEKEEPING &	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Bryan Lindsay Executive Director
TITLE
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
TITLE
(X6) DATE
10-22-13

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 253 SS=B	<p>Continued From page 1 MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to ensure a sanitary and comfortable environment was provided in facility shower rooms. This was true for 3 of 6 shower rooms examined. Findings included:</p> <p>On 9/24/13 from 7:30 to 7:50 AM and on 9/25/13 at 1:50 PM, the following were observed on the walls of the 100, 300, and 400 hallway shower rooms:</p> <ul style="list-style-type: none"> * Shower room 100 had a 3 inch diameter area under the faucet handle where paint was missing and the drywall exposed, * Shower room 100 had a foot print sized area next to the area mentioned above, with over 50 thumb tack size areas of missing paint, where the drywall was exposed, * Shower room 400 had a 2 to 4 inch area all the way around the faucet handle where paint was missing and the drywall exposed, * Shower room 300 had an approximate 1 foot area of missing paint with exposed drywall, 3 feet from the door entrance and a few inches above the floor. <p>On 9/25/13 during the environmental tour from 4:05-5:15 PM with the Assistant Maintenance Director, the Housekeeping Director, and the Administrator, the shower room walls were observed. While in shower room 300 the</p>	F 253	<p>F 253</p> <p>SPECIFIC AREA Shower rooms on <u>100</u>, <u>300</u> and <u>400</u> halls were painted on 9/25/13.</p> <p>OTHER AREAS Other facility shower rooms were inspected and no other issues were noted.</p> <p>SYSTEMIC CHANGES <u>Weekly</u> environmental rounds will be done by the maintenance department to ensure that the shower walls are intact, with no holes or chipped paint.</p> <p>MONITOR Audits will be turned in to the Executive director <u>weekly x 4 weeks</u>, then <u>monthly for 2 months</u>. Findings will be reported to the Quality Assurance team.</p> <p>Executive Director to ensure ongoing compliance.</p> <p>DATE OF COMPLIANCE 10/25/2013</p>		

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F 253	Continued From page 2 Housekeeping Director stated the wall, "Needs paint." The Assistant Maintenance Director stated, "I will get to that today." Similar comments were made by the Assistant Maintenance Director about the 100 and 400 shower room walls.	F 253			
F 272 SS=D	No further information was provided. 483.20(b)(1) COMPREHENSIVE 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	F 272	F272 SPECIFIC RESIDENT Resident # 8 was assessed and determined to be safe with the use of side rails. OTHER RESIDENTS Other residents who require side rails were assessed for the safe use of side rails. SYSTEMIC CHANGES Side rail assessments were reviewed to include individual safety. A nursing inservice was held to review side rail assessment procedures		

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F 272	<p>Continued From page 3</p> <p>areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure bed/side rails were assessed to determine if a resident was safe with use of the side rails. This was true for 1 of 3 sample residents (#8) reviewed for side rail use. The failed practice placed Resident #8 at risk for potential harm should he become entrapped in one of the side rails. Findings included:</p> <p>Resident #8 was admitted to the facility on 11/4/11, and readmitted on 12/25/11, with multiple diagnoses which included a history of cerebrovascular accident (CVA or stroke), left hemiparesis, dementia, and seizure disorder.</p> <p>The resident's most recent quarterly MDS assessment, dated 8/7/13, coded, in part:</p> <ul style="list-style-type: none"> * Severely impaired cognition; * Understood by others; * Usually able to understand others; * Extensive 2 person assistance for bed mobility; * Extensive 1 person assistance for transfers; * Not steady, only able to stabilize with staff assistance when moving from seated to standing position, moving on and off toilet, and surface-to-surface transfer (transfer between bed 	F 272	<p>MONITOR</p> <p>DNS/RCM's will audit side rail assessment for individual safety assessment <u>weekly for four weeks</u> started 10/18/13 then <u>monthly for three months</u> to ensure side rail assessments are completed on an individual basis DNS to review with Quality Assurance team for further monitoring needs.</p> <p>DNS to ensure ongoing compliance.</p> <p>DATE OF COMPLIANCE 10/25/2013</p>

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F 272	<p>Continued From page 4 and chair or wheelchair); and, * Functional limitation in range of motion with impairment in 1 upper and 1 lower extremity.</p> <p>Resident #8's care plan, dated 11/4/11, identified alteration in mobility as a problem. One approach was, "Assist for bed mobility-cue to use grab bars to assist with repositioning."</p> <p>The resident's Physician Orders for September 2013 (recapitulation) included an order for grab bars. The order was dated 8/25/12.</p> <p>An "Evaluation for Use of Side Rails," dated 8/25/12, documented side rails were needed related to weakness and balance deficit with a recommendation for, "[G]rab bars r/t [related to] bed mobility." The form was dated as reviewed on 5/16/13 with the comment, "[R]es[ident] still prefers bed rails for bed mobility."</p> <p>An Initial and Quarterly Restraint Assessment, dated 5/6/13 and 8/6/13, documented the resident had impaired muscle strength, or decreased range of motion to the hips/knees; decreased "righting" reflex or response time; slides down (sitting balance); seizures; and, use of the following medications: antianxiety, antidepressant, and one that increased the potential for hypotension (low blood pressure). The assessment also documented, "...A score of 18 or greater indicates need for interventions..." Resident #8's total score was 32 both times.</p> <p>Even though Resident #8 was always observed in a wheelchair (w/c) during the survey week, quarter (1/4) side rails were also observed in the raised position bilaterally near the head of the resident's bed on 9/24/13 at 9:30 a.m., 9/25/13 at</p>	F 272		

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F 272	Continued From page 5 10 a.m. and 2 p.m., and 9/26/13 at 10:55 a.m. and 11:05 a.m. On 9/26/13 at 10:55 a.m., Resident #8 was observed in his w/c near the 300 Hall Nurses' Station. When asked if he still used the side rails, Resident #8 stated, "Oh yeah! Go look." On 9/26/13 at 11:00 a.m., both the ADON and RCM #2 were at the 300 Hall Nurses' Station. When asked if Resident #8 had been assessed to determine if he was safe with the use of side rails, RCM #2 stated, "The side rail assessment is the safety assessment." When asked if the side rail assessment documented the resident had been determined to be safe with the use of side rails, RCM #2 stated, "No it doesn't say that on this document." When asked if there was any other documentation that the resident had been assessed to determine if he was safe with the use of side rails, RCM #2 stated, "No." On 9/26/13 at 11:05 a.m., RCM #2 accompanied the surveyor to Resident #8's room. The RCM identified the side rails on each side of the resident's bed as "grab bars" and she acknowledged that the "grab bars" were in the raised position. On 9/26/13 at 5:45 p.m., the Administrator, DON, and ADON were informed of the issue. No other information or documentation was received from the facility regarding the side rail safety assessment issue.	F 272			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281			

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F 281	<p>Continued From page 6 must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of the facility's Policies for Medication Administration, and staff interviews, it was determined the facility failed to ensure nursing staff followed accepted standards of practice when administering medications. This affected 1 of 1 (#16) random residents. This practice created the potential for the resident to receive medications in incorrect dosages should the LN administering the medications have to respond to an emergent situation. Findings included:</p> <p>Random Resident #16 was admitted to the facility on 4/24/06 with multiple diagnoses including hypertension and generalized pain.</p> <p>The resident's current care plan contained, in part, the following problems. - Onset date 5/4/06, alteration in comfort. One of the problem approaches was, administer pain meds per MDO (medications per medical doctor order). - Onset date 4/24/07, potential for alteration in cardiac output. One of the problem approaches was, administer meds per MDO.</p> <p>The resident's 9/13 Physician Orders (recapitulation) contained in part: - 9/2/10, Acetaminophen (Tylenol) 325 milligram tablet by mouth (mg tab po) every 8 hours, Give 2 tabs (650 mg) for pain at 8:00 a.m. - 9/2/10, Aspirin 81 mg tab po daily for sinoatrial node dysfunction at 8:00 a.m. - 9/2/10, Metoprolol succinate 50 mg tab po daily</p>	F 281	<p>F281</p> <p>SPECIFIC RESIDENT Resident # 16 was assessed and monitored for adverse effects of medication administration. MD and family were notified.</p> <p>OTHER RESIDENTS No other residents were affected.</p> <p>SYSTEMIC CHANGES A nursing inservice was held to review medication administration. New hires will be inserviced during orientation.</p> <p>MONITOR DNS/SDC will complete a medication administration audit <u>twice weekly for two weeks</u>, then <u>weekly for three weeks</u>, then <u>monthly for 2 months</u> DNS to review with the Quality Assurance team for further audit needs. DNS to ensure ongoing compliance.</p> <p>DATE OF COMPLIANCE 10/25/2013</p>		

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F 281	<p>Continued From page 7 for hypertension at 8:00 a.m. - 6/27/12, Zantac (ranitidine) 150 mg capsule po two times a day for upset stomach - 8/20/13, Tramadol 50 mg tab po three times a day for pain</p> <p>On 9/24/13 at 9:04 a.m., LN #3 was observed at the medication cart with what appeared to be medications prepared for administration in a plastic medication cup. The LN had a writing implement in her hand and appeared to be entering information on a form in a large 3-inch type binder. The LN then took the medications and a glass of water to Random Resident #16 and remained with the resident until the medications were swallowed.</p> <p>- At 9:08 a.m., the surveyor and the LN returned to the medication cart and reviewed the resident's 9/13 Medication Administration Record (MAR). Several medications were initialed including, Tylenol, Aspirin, Metoprolol, Zantac, and Tramadol. At this time LN #3 stated, "I initialed [those medications] before administering."</p> <p>On 9/24/13 at 9:35 a.m., the DNS spoke with the survey team. The DNS stated, "LN #3 told me what she did. I just wrote [LN #3] up [counseled LN #3]." The DNS also provided the survey team with an "Education Acknowledgment Form" dated 9/24/13 and a copy of the facility's Policies of Medication Administration dated 4/20/13. The DNS stated she counseled the LN because the LN pre signed medications prior to giving and for medication error related to time when not giving medications in a timely fashion. The Policy directed nursing staff to, "...Initial each medication in the correct box on the MAR after the medication is given..."</p>	F 281		

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F 281	Continued From page 8 The Bureau of Facility Standards Informational Letter #97-3 dated 4/17/97, indicated, "...when the Board of Nursing received information that long term care facility staff were signing medications as given at the time of medication preparation, not after the residents actually had taken the medication...the Board's expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do. Upon checking with Idaho nursing education programs, it was confirmed that the schools continue to instruct students to document what they have done, seen or heard, after these events occur..."	F 281			
F 309 SS=D	On 9/27/13 at 11:00 a.m., the Administrator and ADON were informed of the finding. The facility did not provide any additional information. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure physician's orders were consistently followed for orthostatic blood pressures, and bowel care orders were implemented for residents who had not had a bowel movement for 2 days. This was	F 309	F309 SPECIFIC RESIDENT Resident #4 had an Orthostatic Blood pressure completed on 9/14/2013 and again on 9/27/2013 with no negative findings. Resident #5 and Resident #1 were assessed for constipation and no negative findings or other action was required. OTHER RESIDENTS Residents who have monthly Orthostatic blood pressures were reviewed to ensure completion. Residents Bowel movement records were reviewed to ensure bowel records were complete.		

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F 309	<p>Continued From page 9</p> <p>true for 3 of 13 (#s 1, 4, & 5) sample residents reviewed for orthostatic blood pressures and bowel care. These failed practices created the potential for residents to not receive appropriate treatment for their specific conditions. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 8/1/11, and readmitted on 8/10/11, with multiple diagnoses which included hypertension, atrial fibrillation, cerebrovascular accident (CVA) with hemiplegia, coronary artery disease, and ischemic cardiomyopathy.</p> <p>Resident #4's most recent quarterly MDS assessment, dated 9/8/13, documented in part: * Severe cognitive impairment with a BIMS score of 3; * Extensive assistance with 2 people or more for bed mobility, transfers, and toilet use; and, * Extensive assistance with 1 person for dressing and personal hygiene.</p> <p>Resident #4's September 2013 Physician Orders (recapitulation orders) documented in part: * "Orthostatic B/P [blood pressure] & pulses with Monthly summary."</p> <p>Resident #4's August 2013 Treatment Administration Record (TAR) documented, "Orthostatic B/P & pulses monthly. Monthly summary day shift check every month on the 14th day." The column for the 14th day of August was outlined to indicate it as the day to perform the orthostatic blood pressures. However, the column was left blank.</p> <p>On 9/25/13 at 10:45 a.m., the Resident Care Manager (RCM) #7 was asked about the blank</p>	F 309	<p>SYSTEMIC CHANGES</p> <p>Nursing staff were inserviced on obtaining orthostatic blood pressures Nursing staff were educated on monitoring of bowel movements with emphasis on documentation of bowel movements. New hires will be inserviced during orientation.</p> <p>MONITOR</p> <p>RCM/DNS will audit orthostatic blood pressures and bowel movement record to ensure appropriate action taken and correct documentation occurred. This will be done <u>weekly for four weeks</u>, then <u>monthly for two months</u>. Audits started on 10/21/2013 DNS to review with the Quality Assurance team for further audit needs. DNS to ensure compliance.</p> <p>DATE OF COMPLIANCE 10/25/2013</p>		

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F 309	<p>Continued From page 10 column for the orthostatic blood pressure for Resident #4. She stated she would look into it.</p> <p>On 9/25/13 at 4:55 p.m., RCM #7 was asked if information regarding the orthostatic blood pressure had been found. The RCM stated, "We couldn't find it." She said they were trying to track down the nurse who was responsible for the orthostatic blood pressure on the 14th of August.</p> <p>On 9/25/13 at 6:22 p.m., the DON was informed of the orthostatic blood pressure issue. However, no further information or documentation was provided that resolved the issue.</p> <p>2. Resident #5 was admitted to the facility on 10/19/11 with multiple diagnoses including constipation.</p> <p>The resident's Physician's Orders for September 2013 (recapitulation orders) included the order, "2nd evening of no BM (bowel movement) recorded for 2 days...give 4-6 oz (ounces) prune juice or 1 oz fruit butter with evening med[ication] pass." The order was dated 10/20/11.</p> <p>The August 2013 MAR documented prune juice or fruit butter was not administered as ordered when Resident #5 did not have a BM for 2 consecutive days on 3 separate occasions as follows: 8/13 and 8/14/13; 8/19 and 8/20/13; and, 8/29 and 8/30/13.</p> <p>On 9/25/13 at 3:30 p.m., the DNS was asked about the issue regarding Resident #5. The DNS acknowledged the physician ordered interventions were not administered when the resident did not have a BM by the second day.</p> <p>On 9/26/13 at 5:45 PM the Administrator was also</p>	F 309		

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F 309	<p>Continued From page 11</p> <p>informed of the issue. No other information or documentation was received from the facility which resolved the issue.</p> <p>3. Resident #1 was admitted on 4/12/13 with multiple diagnoses including acute venous embolism and thrombosis of deep vessels of lower extremities, acute kidney failure, and gout.</p> <p>The resident's Physician's Orders (recapitulation orders) dated 4/12/13 documented, "2nd evening of no BM recorded for 2 days...give 4-6 oz prune juice or 1 oz fruit butter with evening med pass."</p> <p>The resident's September 2013 MAR documented the resident did not have a BM on 9/12 and 9/13/13.</p> <p>The resident's September 2013 PRN Administration Record for 9/13/13 was blank, indicating prune juice or fruit butter was not given.</p> <p>On 9/25/13 at 2:15 PM the ADON was interviewed regarding the BM issue. When asked about 9/12 and 9/13/13 she stated the prune juice, "should have been given."</p> <p>On 9/26/13 at 5:45 PM the Administrator, DON, and ADON were informed of the issues. No further information was provided.</p>	F 309		
F 314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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</p>	F 314	<p>F314</p> <p>SPECIFIC RESIDENT Resident # 7 and # 4, wounds were evaluated by wound team to ensure accurate documentation of skin.</p>	

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F 314	<p>Continued From page 12</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure skin assessments of residents were accurate and reflected the residents' actual skin status. This affected 2 of 6 (#s 4 & 7) residents sampled for pressure ulcers (PUs). This practice created the potential for more than minimal harm should the facility fail to implement appropriate preventive measures related to residents' risks, level and nature of risk, or presence of PUs. Findings included:</p> <p>1. Resident #7 was originally admitted to the facility on 4/17/13 and readmitted on 6/6/13 with multiple diagnoses including aftercare for healing of traumatic fracture, history of falls, and muscle weakness.</p> <p>Resident #7's most recent MDS, significant change, dated 6/16/13, coded in part:</p> <ul style="list-style-type: none"> -moderately impaired cognitive skills -at risk for developing PUs -has one or more unhealed PUs at Stage 1 or higher -one unstageable PU due to coverage of wound bed by slough -M0610, dimensions of unhealed PUs, 2.0 length, 1.5 width, depth unknown -M0700, most severe tissue type, slough -M0900, one healed Stage 2 (II) PU 	F 314	<p>OTHER RESIDENTS</p> <p>other residents with pressure ulcers were reviewed by wound team to ensure accurate documentation of skin condition.</p> <p>SYSTEMIC CHANGES</p> <p>Licensed Nurses were inserviced on wound care policies and procedures, documentation of wounds, and accurate staging documentation. New hires will be inserviced during orientation.</p> <p>MONITOR</p> <p>RCM/Wound team will audit skin assessments to ensure documentation is present and accurate, audits will be done <u>weekly for four weeks</u> and then <u>monthly for four months</u> DNS will bring audits to Quality Assurance team to determine further audit needs. Audits were started 10/18/2013.</p> <p>DNS to ensure compliance.</p> <p>DATE OF COMPLIANCE 10/25/2013</p>		

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F 314	<p>Continued From page 13</p> <p>The resident's "Initial Data Collection Tool/Nursing Service (IDCT)" form, dated 4/17/13, documented on original admission the resident had two abrasions on the back. The abrasions were documented as Site C, 5 x (by) 2 and Site D, 3 x 2. On this form, the entries were signed by LN #4.</p> <p>Resident #7's Non-Pressure Skin Condition Record" (NPSCR) contained sections for nursing staff to identify specific "Sites." On this form, Site C and Site D entries were signed by LN #5, were first observed on 4/17/13, and were documented on the upper third of the form as follows.</p> <ul style="list-style-type: none"> - Site C, abrasion, location was the resident's "back," which according to the body diagram was above Site D. The measurements were 5 x 2 cm (centimeters). This entry was lined through with a handwritten entry, "See pressure sheet." The entry, see pressure sheet, was not dated or initialed - Site D, abrasion, location was the resident's "back," which according to the body diagram was below Site C. The measurements were 3 x 2 cm. This entry was lined through with a handwritten entry, "blanchable redness." The entry, blanchable redness, was not dated or initialed. <p>The remaining parts of the NPSCR did not include any additional entries for Site C or Site D.</p> <p>Resident #7's Pressure Ulcer Status Record (PUSR), dated 4/17/13 through 5/17/13, documented:</p> <ul style="list-style-type: none"> * Date first observed 4/17/13, location "upper mid spine," Stage II (2), length and width 3 x 2 cm. * On 4/25/13, Stage II, length and width 2 x 2 cm and depth of less than 0.1 cm. This entry was signed by RCM #2. 	F 314		

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F 314	<p>Continued From page 14</p> <p>* 5/17/13, resolved. This entry was signed by RCM #2.</p> <p>On 9/24/13 at 2:51 p.m., the surveyor asked the DNS why the IDCT form documented abrasion at Site C, the NPUSR documented see pressure sheet, and the PUSR documented a Stage II PU. The DNS stated, "Initially, the wounds were documented as abrasions. On 4/25/13, after the wound team reviewed [Resident #7's] skin, it was determined Site C was caused by pressure from the back of the wheelchair although we had a foam cushion on the back of her wheelchair to relieve pressure."</p> <p>Note: The surveyor requested and the facility provided evidence of interventions and the date the interventions were put into place to prevent pressure ulcer development.</p> <p>Note: The documentation identified above was conflicting due to the following. The initial assessment, 4/17/13 IDCT form, for Resident #7 documented Site C and Site D were abrasions and the NPUSR documented on 4/17/13 two different skin areas of concern, Site C and Site D. However, it was confusing as to whether Site C or Site D was the area that became the Stage II PU. The initial measurements for Site D, not Site C, were documented on the PUSR as 3 x 2 cm. The resident had 2 abrasions documented on the NPSCR, however, on 4/25/13 (8 days after 4/17/13), the resident's PUSR documented a Stage II PU. Therefore, the initial assessment of the wounds as non-pressure skin conditions was inaccurate and which site became the Stage II PU was in question.</p> <p>Resident #7's electronic Progress Notes, dated</p>	F 314		

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F 314	<p>Continued From page 15</p> <p>6/11/13 at 12:20 a.m. through 6/13/13 at 3:11 a.m. were reviewed. There were no entries related to the resident's skin conditions during this timeframe.</p> <p>On 6/13/13 at 6:47 a.m., the resident's Progress Notes documented, "Weekly Wound note, area is @x1.5 [2 x 1.5 cm] peri wound is 4.5 x 5 cm red with 1/2 balnchable [blanchable]..."</p> <p>Resident #7's PUSR, dated 6/13/13 through 7/18/13, documented the following.</p> <p>At the top of the form was a section titled, "Description of Stages." This section identified, in part, a Stage II was, "...without slough..." Stage III was, "...slough may be present but does not obscure the depth of tissue loss..." Unstageable was, "...Not stageable due to the coverage of wound bed by slough and/or eschar..."</p> <p>* The "Description of Site" section documented, date first observed "6/11/13", Stage II, location: "mid spine." No measurements were documented in this section.</p> <p>* 6/13/13, Stage II, 2x 1.5 x 0.1, scant drainage, wound bed "100% yellow slough" with red periwound measured 4.5 x 5 cm. Appearance of wound, "slough." This entry was signed by RCM #1.</p> <p>* 6/20/13, Stage II, 3 x 2.5 x 0.1, scant drainage, 40% slough, 60% beefy red ruddy purple 5 x 6 cm, appearance of wound "slough." This entry was signed by LN #6.</p> <p>* 6/26/13, Stage II, 3.2 x 3.0 x less than 0.1, small drainage, open area pink/red peri-wound deep dark purple, appearance of wound epithelial. This entry was signed by LN #7.</p> <p>* 7/18/13, area resolved. This entry was signed by RCM #1.</p>	F 314			

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F 314	<p>Continued From page 16</p> <p>On 9/24/13 at 2:51 p.m., the surveyor asked the DNS why Resident #7's skin re-opened on 6/11/13. The DNS stated, "[Resident #7] went to the hospital for 2 days. I believe she may have had damage to her skin as a result of laying in her hospital bed. Previously, [Resident #7] had two areas on the spine that healed. [Resident #7's] skin re-opened where the scar tissue was. The 6/11/13 wound matched up to the back of the wheelchair. We had an extra cushion on the back of the wheelchair at that time. After her skin re-opened, we cut out the middle to relieve the pressure of her skin against the foam."</p> <p>On 9/25/13 at 2:35 p.m., the surveyor asked the DNS and the RCM #1 about the different forms used to document and monitor the resident's skin and the staging of the pressure ulcer. The surveyor asked if the skin was initially an abrasion or a Stage II PU. The DNS stated, "Initially there were abrasions. On 4/25/13, the wound team reviewed the resident's skin and determined Site C was not an abrasion but pressure." The surveyor also asked about the Stage II PU at midspine which was described as, "100% yellow slough." The surveyor referred the DNS to the Description of Stages section of the PUSR, as identified above, in which Stage II was, "...without slough..." and Stage III was, "...slough may be present but does not obscure the depth of tissue loss..." RCM #1 stated, "The wound nurse practitioner said a Stage II could have some slough." The survey team also discussed with the DNS, the IDCT form, dated 4/17/13, which documented two different abrasions on [Resident #7's] back, the NPSCR documented abrasions, and then the PUSR documented a Stage II PU. The survey team discussed with the DNS the documentation on these forms lead to the</p>	F 314		

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F 314	<p>Continued From page 17</p> <p>question of which form was accurate; the IDCT or the NPSCR or now the PUSR.</p> <p>Note: The resident's chart contained conflicting information about the resident's actual skin conditions: The facility documented the resident's pressure ulcer as a Stage II with "100% slough," however the guidance on the facility's form identified a wound without slough as a Stage II and a wound with slough as a Stage III. Therefore, the assessment of the wound as a Stage II PU was inaccurate.</p> <p>On 9/25/13 at 4:20 p.m., the DNS and RCM #1 said they provided treatment to Resident #7 on 6/13/13. The DNS and RCM #1 both stated, "On 6/13/13 we documented the PU as we saw it. We placed a sterile gauze over the slough, sprayed the gauze with moisture, and allowed the moisture to soak into the gauze pad over the slough. When we lifted the gauze, the slough came off and we could see the wound bed and it presented as a Stage 2."</p> <p>On 9/26/13 at 9:00 a.m., the surveyor asked the MDS Coordinator if she was familiar with Resident #7's skin condition specifically the PUs. The MDS Coordinator stated, "I coded an unstageable PU on [Resident #7's] 6/16/13 MDS due to the slough identified on the Pressure Ulcer Sheet. The RAI process requires PUs with slough to be coded as unstageable."</p> <p>On 9/26/13 at 2:55 p.m., the DNS and RCM #1 reviewed the resident's 6/13/13 Progress Note with the surveyor. The Note documented, in part, Weekly Wound note, "area is @x1.5 [2 x 1.5 cm] peri wound is 4.5 x 5 cm red with 1/2 balnchable [blanchable]..." This entry was electronically</p>	F 314			

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F 314	<p>Continued From page 18</p> <p>signed by the DNS. The DNS and RCM #1 both stated, "We should have documented exudate and not slough on the PUSR. We should have documented in the 6/13/13 Progress Note, we removed exudate from the wound."</p> <p>On 9/26/13 at 3:45 p.m., the DNS and the survey team reviewed additional information provided by the facility. The surveyor informed the DNS it appeared the initial skin assessment was not accurate when the resident was admitted. The DNS replied, "Yes [it appears the assessment was not accurate]."</p> <p>On 9/26/13 at approximately 5:00 p.m., the facility provided the survey team with an order signed by a Nurse Practitioner on 9/26/13 which documented in part, Unavoidable Risk for Pressure Ulcer to re-occur to mid - spine.</p> <p>On 9/27/13 at 11:00 a.m., the Administrator was informed of the confusing and conflicting information regarding Resident #7's skin conditions. The facility did not provide any additional information.</p> <p>2. Resident #4 was admitted to the facility on 8/1/11, and readmitted on 8/10/11, with multiple diagnoses which included hypertension, atrial fibrillation, cerebrovascular accident (CVA) with hemiplegia, coronary artery disease, and ischemic cardiomyopathy.</p> <p>Resident #4's most recent quarterly MDS assessment, dated 9/8/13, documented in part:</p> <ul style="list-style-type: none"> * Severe cognitive impairment with a BIMS score of 3; * Extensive assistance with 2 or more people for bed mobility, transfers, and toilet use; * Extensive assistance with 1 person for dressing 	F 314			

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F 314	<p>Continued From page 19 and personal hygiene; and, * At risk for developing pressure ulcers.</p> <p>Resident #4's Risk for Pressure Ulcers Care Plan, dated 8/27/11, documented in part: * Problems - Resident is at risk for developing a pressure ulcer related to impaired mobility, weight gain, history of CVA with left sided weakness, skin alteration due to dry flaky skin. Edema management in progress. Braden assessment 9/19/13 score of 16, and 9/23/13 - Discoloration to left lateral outer underside of foot; and * Approaches - Complete Braden Scale Risk Assessment quarterly and PRN; Complete weekly skin assessment to include fingernails and toenails. Monitor skin under brace to the left foot for changes; Left slipper top removed to ensure nothing is touching his toes; 9/23/13 - Sage boots to bilateral lower extremities (BLE) at all times when in bed; and 9/23/13 - bed cradle to foot of bed (FOB) at all times.</p> <p>Resident #4's September 2013 Physician Orders (recapitulation orders) documented in part: * Weekly skin assessment, dated 8/10/11; and, * Splint to left foot to be applied in morning and removed at bedtime. 2 times per day check skin at bedtime under braces to rule out breakdown in skin integrity, dated 3/15/12.</p> <p>The Treatment Administration Record (TAR), from June 2013 through August 2013, contained documentation that Resident #4's left foot was monitored before placing the splint to the left lower extremity and after removing the splint each day. Therefore, the facility was monitoring the left foot before and after the blistered area occurred to the left 2nd toe.</p>	F 314			

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F 314	<p>Continued From page 20</p> <p>A Non-Pressure Skin Condition Record for Resident #4 documented 4 different skin conditions, including one labeled Site D. Site D was first observed on 6/28/13 and documented as a "Blistered Area" to left foot 2nd digit, measuring 0.25 cm by 0.25 cm. On 7/7/13, a note on the Non-Pressure Skin Condition Record for Site D documented, "On Pressure record."</p> <p>A Pressure Ulcer Status Record for Resident #4 documented: * 6/27/13 - A Stage II (2) pressure ulcer to the left 2nd toe that was first observed; and, * 7/1/13 - Stage II, 0.8 cm by 0.9 cm, no depth, purple mushy area - blood blister-like.</p> <p>Note: On 6/28/13 a Non-Pressure Skin Condition Record documented a blistered area was observed to the left 2nd toe. However, on 6/27/13 the Pressure Ulcer Status Record documented a Stage II was observed to the left 2nd toe. It is unclear which date was the actual date the blister/stage II pressure ulcer was first observed, and what kind of skin condition was actually on the left 2nd toe.</p> <p>On 9/25/13 at 11:15 a.m., RCM #1 was asked why there were conflicting dates for observing the skin condition to the left 2nd toe. After reviewing the skin records, RCM #1 stated, "I'm wondering why I put 6/27 and not 6/28. I don't know why." The RCM was asked why the area on the left 2nd toe was first documented as a blistered area on 6/28/13, but documented as a stage II pressure ulcer on 7/1/13. The RCM said on 7/1/13 the wound team re-assessed the left 2nd toe wound and determined it to be a stage II pressure ulcer, rather than a non-pressure related wound. She stated the wound was due to Resident #4's toe</p>	F 314			

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F 314	Continued From page 21 rubbing against the top of his slipper. Note: F314, "Pressure Sores," defines pressure ulcers as, "...any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). Although friction and shear are not primary causes of pressure ulcers, friction and shear are important contributing factors to the development of pressure ulcers." It defines friction as, "Friction is the mechanical force exerted on skin that is dragged across any surface." And, it defines stage 2 pressure ulcers as, "Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister." Additionally, Non-compliance for F314 states facilities must, "Accurately or consistently assess a resident's skin integrity on admission and as indicated thereafter." Note: The initial assessment of the left 2nd toe for Resident #4 on 6/28/13 documented the wound as a blister. However, after the wound team re-assessed the wound, they determined it to be a stage II pressure ulcer. Therefore, the initial assessment of the wound as a non-pressure skin condition was inaccurate, and the facility failed to identify the pressure area when it was a Stage I pressure ulcer despite the monitoring of Resident #4's left foot two times per day. On 9/26/13 at 5:47 p.m., the Administrator and DON were informed of the skin assessment issues for Resident #4. However, no further information or documentation was provided that resolved the issue.	F 314			
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329			

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F 329 SS=D	<p>Continued From page 22</p> <p>UNNECESSARY DRUGS</p> <p>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.</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 ensure residents who used psychotropic drugs received gradual dose reductions (GDR), unless clinically contraindicated. This was true for 2 of 5 (#s 8 & 12) sample residents reviewed for psychotropic medication use. Without a GDR or the rationale regarding why a GDR was contraindicated, Resident #8 received an unnecessary medication</p>	F 329	<p>F329</p> <p>SPECIFIC RESIDENT Resident # 8 psychotropic medications were reviewed and a GDR was completed Resident # 12 diagnosis was reviewed for her psychotropic medications.</p> <p>OTHER RESIDENTS Residents with a Diagnosis of Dementia and on antipsychotic medication were reviewed to ensure a correct diagnosis was present and that a GDR was accurately completed.</p> <p>SYSTEMIC CHANGES Social services and licensed nurses were educated on correct documentation of behaviors on the monitoring sheet and GDR schedules. Licensed Nurses were educated on appropriate Physician Orders for diagnosis that is accurate with the use of Antipsychotic medications. New hires will be inserviced during orientation.</p>	

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F 329	<p>Continued From page 23</p> <p>which placed the resident at risk for adverse reactions and health decline. Findings included:</p> <p>1. Resident #8 was admitted to the facility on 11/4/11, and readmitted on 12/25/11, with multiple diagnoses which included acute renal failure, cerebrovascular accident (CVA) with hemiparesis, seizures, and depression.</p> <p>Resident #8's most recent quarterly MDS assessment, dated 8/7/13, documented in part:</p> <ul style="list-style-type: none"> * Severely impaired cognition with a BIMS score of 5; * Little interest or pleasure in doing things; * Feeling down, depressed, or hopeless; * 7 days of antidepressant medication use in the last 7 days; * Trouble falling or staying asleep, or sleeping too much; * Extensive assistance for bed mobility and toilet use; and, * Extensive assistance with 1 person for transfers, dressing, and personal hygiene. <p>The Care Plan for Resident #8, dated 5/18/12, documented in part:</p> <ul style="list-style-type: none"> * Problems - Alteration in mood state: Verbal expressions of distress; sad, apathetic, anxious appearance; lack of motivational interest; social isolation; and risk of harm to others, behaviors (statements) "Shut up woman or [I'll] shut it up for you," and is verbally inappropriate; * Approaches - Discuss with resident ways to utilize present coping skills to deal with situation that arise: physical activity, daily decision making, socialization, and leisure activities; Encourage and allow open expression of feelings; Encourage frequent contact with family and friends, if desired by resident; Report to the physician changes in 	F 329	<p>MONITOR</p> <p>Social Worker/RCM will audit completion of GDR's and appropriate behavior monitoring, and appropriate diagnosis of Antipsychotic medication, this will be done <u>weekly for three weeks then monthly for two months</u>. Audits were started on 10/21/2013. Social Worker will share results of audits with Quality Assurance team for need of further auditing needs. DNS to ensure compliance.</p> <p>DATE OF COMPLIANCE 10/25/2013</p>	

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F 329	<p>Continued From page 24</p> <p>mood status, monitor behaviors, speak to family as needed, refer to social services as needed, request mood stabilizer, and initiate depakote; and Support resident's strengths and coping skills;</p> <p>* Problems - Alteration in mood and behavior related to diagnoses of delusions, agitative features, anxiety, and depression. Resident exhibits the following behaviors: restlessness, repetitive behavior, and hopelessness, agitation, resistive, and paranoia delusions. Harm to self or others, verbally inappropriate, sleep disturbances. Note order, to do not taper Depakote; and,</p> <p>* Approaches - Discuss side effects of Depakote, Clonazepam, Zyprexa and Effexor, with resident and family; Observe side effects, document, and report to doctor; Pharmacy consultant review of medications monthly; and Interventions: validate feelings, offer activities of his choice, call wife, keep noise and light low, encourage good behavior, and monitor hours of sleep per day.</p> <p>Resident #8's September 2013 Physician Orders (recapitulation orders) documented in part: * Venlafaxine Extended Release (ER) 150 mg capsule, 24 hour by mouth (PO) daily, consent signed: Depressive disorder. Order date 6/7/12.</p> <p>A Psychotropic/Behavior Management Summary for Resident #8, dated 8/5/13, documented medication, start date, diagnosis, behavior, number of behaviors in last month, last GDR, outcome, and next GDR due date. The medication Effexor (venlafaxine ER) had a start date of 6/7/12. A zero with a slash through it was documented for number of behaviors in the last month. The column for last GDR documented DNT with a date of 8/12/12. The outcome column was left blank. The next GDR due date was</p>	F 329			

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F 329	<p>Continued From page 25 documented as 8/13.</p> <p>On 9/25/13 at 5:30 p.m., RCM #2 was asked to provide documentation for the 8/13 GDR or DNT letter for Resident #8's Effexor medication. The RCM stated, "Effexor didn't get done this month, I don't know why." She acknowledged the GDR was overdue by one month and said she would send the physician a fax (fascimile). Later that day a copy of the fax the RCM sent to the physician was provided that requested a "DNT letter R/T [related to] behaviors being stable."</p> <p>On 9/25/13 at 6:22 p.m., the DON was informed of the GDR issue for Resident #8. However, no further information or documentation was provided that resolved the issue.</p> <p>2. Resident #12 was originally admitted to the facility on 12/21/06 and readmitted on 1/21/07 with multiple diagnoses including dementia in conditions classified elsewhere with behavioral disturbance.</p> <p>Resident #12's quarterly 7/14/13 MDS coded:</p> <ul style="list-style-type: none"> - severely impaired cognition, - verbal behavioral symptoms directed toward others, - other behavioral symptoms not directed toward others, - no rejection of cares, - wandering occurred 4 to 6 days, but less than daily, - did not receive anti-anxiety medications, and - received antipsychotic medications in the past 7 days. <p>Resident #12's "Physician Orders September 2013" (recapitulation orders) contained, in part,</p>	F 329		

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F 329	<p>Continued From page 26</p> <p>the following orders:</p> <ul style="list-style-type: none"> - Order date, 7/14/12, Quetiapine (Seroquel) 100 milligram tablet by mouth at bedtime (mg tab po hs) for the diagnosis of, "dementia in conditions classified elsewhere with behavioral disturbance." - Order date, 2/19/13, Lorazepam (Ativan) 0.5 mg tab po as needed every 6 hours for anxiety - Order date, 2/19/13, Ativan 2 tablets (1mg) every 6 hours as needed for anxiety <p>Review of Resident #12's Behavior/Intervention Monthly Flow Record (BIMFR)" forms revealed the following for the use of Ativan.</p> <ul style="list-style-type: none"> - July 2013 "Behavior/Intervention Monthly Flow Record (BIMFR)" form documented the resident was monitored for angry statements (0 episodes) and verbally striking out (no episodes). At the bottom of the page, the psychoactive drug was Ativan for anxiety. - August 2012 BIMFR form documented the resident was monitored for angry statements (1 episode) and verbally striking out (1 episode) from 8/1/13 through 8/7/13. The form contained a handwritten entry for angry statements, "New Behavior Sheet, 8/5/13." The form contained a handwritten entry for verbally striking out. "D/C [discontinued] 8/5/13. Both handwritten entries contained what appeared to be initials. <p>Review of Resident #12's BIMFR forms revealed the following for the use of Seroquel.</p> <ul style="list-style-type: none"> - July and August 2013 BIMFR forms provided evidence the facility monitored the resident for paranoia (2 episodes) and calling out for family members (no episodes). The bottom of the form documented in the Psychoactive Drug section, Seroquel, and documented in a separate section, "dementia [with] behaviors." 	F 329		

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F 329	<p>Continued From page 27</p> <p>- August 2013 Medication Administration Record (MAR) provided evidence the resident was administered Seroquel at 8:00 p.m. every day for the diagnosis of, "dementia in conditions classified elsewhere with behavioral disturbance."</p> <p>- On 8/5/13, on a separate BIMFR form, facility began monitoring Resident #12 for repetitive statements (5 episodes) and hallucinations (no episodes). The bottom of the form documented in the Diagnosis section, "Psychosis." The Psychoactive Drug section was blank.</p> <p>On 9/26/13 at 12:50 p.m., the Social Services Assistant and Social Services Director provided the surveyor with a copy of a 7/2/13 Antipsychotic form, signed by the resident's physician on 7/29/13, that changed the diagnosis for Seroquel to Psychosis.</p> <p>On 9/26/13 at 2:25 p.m., RCM #1 provided the survey team with a copy of a 4/15/13 Antipsychotic form that documented the physician did not recommend a taper at this time as (Resident #12) was stable and a change may cause psychosocial harm. The form also included to change the diagnosis for Seroquel to paranoia with physical aggression. The form was signed by the resident's physician on 4/15/13. The surveyor informed the RCM, the order for the antipsychotic medication as documented on the recapitulation orders had the diagnosis of, "dementia in conditions classified elsewhere with behavioral disturbance." The RCM stated, "The Physician Orders and the MAR have not been updated. The diagnosis was not transcribed onto the Physician Orders correctly."</p>	F 329			

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COEUR D'ALENE			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST AQUA AVENUE COEUR D ALENE, ID 83815		
(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 329	Continued From page 28 Note: The BIMFR forms did not provide a clear, logical picture of why the resident required the continued use of the anti-psychotic medication. On 9/27/13 at 11:00 a.m., the Administrator, the DON, and the ADON were informed of the finding.	F 329	F371 SPECIFIC RESIDENTS Resident's 1-8, 10, 12, 13, 16 Other Residents Other residents had the potential to be affected.		
F 371 SS=E	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, sanitizing solution evaluation, and staff interview, it was determined the facility failed to ensure food was prepared and sanitizing solutions were maintained under sanitary conditions. This affected 13 of 13 (#s 1-13) sampled residents and had the potential to affect residents who dined in the facility. This practice created the potential for contamination of food and exposed residents to potential sources of disease causing pathogens. Findings included: On 9/23/13 at 2:32 p.m. the Dietary Service Manager (DSM) accompanied the surveyor during the initial tour of the facility's kitchen. The following was determined.	F 371	SYSTEMIC CHANGES Kitchen staff was educated on to ensure sanitation buckets are tested and at proper levels of solution in buckets are 300 PPM. Sanitation buckets are to be monitored to ensure each bucket contains 4 to 5 quarts of solution. Staff was also educated to clean mixer properly and have another staff member to inspect it to ensure cleanliness. MONITOR DSM will audit mixer and sanitation buckets <u>daily</u> X 4 weeks then <u>monthly</u> X 3 . Audits to begin 10-01-2013. ED will bring audits to CQI to report on findings. DATE OF COMPLIANCE: 10-25-2013		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	Continued From page 29 1. A counter type white KitchenAid mixer was located on the shelf under a food preparation counter and covered with an opaque plastic bag. A bag over a mixer normally indicated a mixer was cleaned and ready for use. The surveyor requested to observe the mixer for cleanliness. The DSM removed the plastic cover. The mixer had visible grey debris over 80 % of the mixer frame and was sticky, tacky, and rough to the touch. The area directly above where the mixing bowl would be placed when in use had what appeared to be a greasy yellow substance. To the touch, the substance felt like butter or margarine. The DSM stated, "I do not believe we have used this mixer for at least 2 years." At this time, two other dietary staff were in the vicinity and also acknowledged the mixer had not been used for "some time." 2. One of 2 red plastic buckets contained what appeared to be sanitizing solution. The DSM placed a test strip into the solution located in Bucket #2. The test strip did not change color. The DSM immediately discarded the solution. The DSM stated, "This is a quaternary solution and should register a minimum of 150 parts per million (ppm)." The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart 601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils indicated, "(C) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris...(5) At any time during the operation when contamination may have occurred." Subpart 602.13, Nonfood-Contact Surfaces, indicated,	F 371			

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F 371	Continued From page 30 "Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues." Federal guidance at F371 specified, in part, "...the recommended sanitization concentrations are...QAC space (Quaternary) 150-200 ppm concentration..." On 9/27/13 at 11:00 a.m., the Administrator was informed of the finding. The facility did not provide any additional information related to the finding.	F 371			
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all corridors were equipped with handrails. This affected 3 of 13 (#s 2, 4, & 10) sampled residents and had the potential to affect other residents who frequented the corridors without handrails. This practice created the potential for residents to not have a handrail for stability when and if needed. Findings included: On 9/23/13 from 3:10-3:40 PM and on 9/24/13 at 9:10 AM, the following handrails were observed to be missing: * Approximately 4 feet outside of the 400 hallway storage room, * Approximately 3 feet 9 inches across from the 400 hallway storage room,	F 468	F 468 SPECIFIC AREA Handrails on the 400 hall and the maintenance corridor will be installed 10/31/13. OTHER AREAS Other facility corridors were inspected and no other issues were noted. SYSTEMIC CHANGES Monthly environmental rounds will be done by the maintenance department to ensure that the all corridors are equipped with handrails.		

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F 468	Continued From page 31 * Approximately 10 feet in the Therapy hallway off of the Therapy Foyer, * Approximately 2 feet in the Therapy hallway next to the Janitor's Closet, * Approximately 4 feet outside of the Rehab Track door. On 9/23/13 at approximately 3:10 PM, a Physical Therapy staff member was observed pushing a resident in his wheelchair through the Therapy hallway, the Therapy Foyer and into the Physical Therapy room. On 9/25/13 during the environmental tour from 4:05-5:15 PM with the Assistant Maintenance Director, the Housekeeping Director, and the Administrator, the missing handrails were brought to their attention. While in the 400 hallway the Assistant Maintenance Director stated, "We will add a rail here and there", while pointing to both sides of the hallway where the missing handrails were observed. While observing the missing handrails in the Therapy areas identified he stated, "We'll just do the whole thing." No further information was provided.	F 468	MONITOR Audits will be turned in to the Executive director monthly x 3 months. Any adjustments to the walls where handrails are removed will be reported to the Executive Director who will ensure handrails are reinstalled. Findings will be reported to the Quality Assurance team. Executive Director to ensure ongoing compliance. DATE OF COMPLIANCE 10/31/2013		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514	F514 SPECIFIC RESIDENT Resident # 15 was discharged. Resident #4 and #5 POST and advance directives were reviewed for accuracy and reviewed with resident/responsible party.		

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F 514	<p>Continued From page 32</p> <p>resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices to ensure records were complete and accurate. This was true for 3 of 15 (#s 4, 5, & 15) sampled residents. This deficient practice increased the risk for medical decisions to be based on incomplete or inaccurate information and increased the risk for complications due to inappropriate care or interventions. Findings included:</p> <p>1. Resident #15 was admitted to the facility on 7/11/13 with multiple diagnoses which included central nervous system disorder, dysphasia, muscle weakness, chronic airway obstruction, and acute respiratory failure. The resident was discharged on 7/31/13.</p> <p>a. Review of Resident #15's closed medical record revealed the following in the Care Plan: * Problems - Resident is at nutrition risk as evidenced by - Resident has diagnosis of acute respiratory failure, chronic airway obstruction, muscle weakness, hypertension, and shortness of breath. Per History and Physical (H&P) resident has chronic back pain. Risks are decrease in appetite, increase in weight loss; Requires some or total assistance to eat/drink; Behaviors interfere with adequate</p>	F 514	<p>OTHER RESIDENTS POST completion for other residents were reviewed to ensure review with resident/responsible party.</p> <p>SYSTEMIC CHANGES Admission team was educated on accurately completing of POST followed by resident/responsible party review. Social services were educated on review of advance directives and POST to ensure information is reviewed with family/resident and/or responsible party. New hires will be inserviced during orientation.</p> <p>MONITOR Social Worker/Admission nurse will audit POST completion and consistent information on POST and advance directives and that information was shared with resident/responsible party or family. RCM/DNS will audit new admissions to ensure that advance directives, POST and living are accurate and have no conflicting information. Audits were started on 10/21/2013 Both audits will be</p>		

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F 514	<p>Continued From page 33</p> <p>nutrition/hydration; and Chewing, swallowing or choking problem; and</p> <p>* Approaches - Provide diet as ordered - thickened liquids.</p> <p>A Diet Order and Communication form for Resident #15, dated 7/23/13, documented in part:</p> <p>* Communication: Diet Change;</p> <p>* Diet Order: "Please advance liquids to thin in addition to her established regular texture diet and previously-stated physician parameters."</p> <p>A fascimile (fax) sheet for Resident #15, dated 7/23/13, was sent to the physician by the Speech Therapist. It documented in part: "[Resident's name] has completed trials of thin liquids safely during the week of 8/8/13. Client and speech are requesting an order to advance to thin liquids in addition to her established diet of regular textures. Please sign [and] refax if you agree."</p> <p>The bottom portion of the fax sheet had a small form to write in the facility name, address, LN signature, resident's first and last name, admission number, room number, attending physician, date of order, time ordered, medication/order, dosage/form, route, schedule, diagnosis, physician's signature, and date. The medication/order documented in part, "Please advance liquids to thin in addition to her established regular texture diet and previously-stated physician parameters." The order was dated 7/23/13. The physician signed the order with the date of 7/29/13.</p> <p>Resident #15's Discharge Assessment Summary and Discharge Instructions, dated 7/29/13, documented in part:</p> <p>* Nutritional Status/Requirements/Current Diet:</p>	F 514	<p><u>completed weekly for three weeks, then monthly for three months with results being brought to Quality Assurance team for further audit needs. DNS to ensure compliance.</u></p> <p>DATE OF COMPLIANCE 10/25/2013</p>	

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F 514	<p>Continued From page 34 Regular / Regular with Nectar thick liquids.</p> <p>On 9/26/13 at 1:00 p.m., the Speech Therapist was asked why the resident was discharged on nectar thick liquids. The Speech Therapist said, "That is incorrect. Social Services fills out the discharge summary. We never see it." The Speech Therapist added that if she would have seen the discharge summary, she would have changed the diet order and signed it to make the order accurate. When asked how Resident #15 participated in a trial of thin liquids the week of 8/8/13 when the resident was discharged on 7/31/13, the Speech Therapist stated it was, "Supposed to be the week of July 15th, 2013. I have no idea why I wrote 8/8/13."</p> <p>b. Resident #15's Discharge Record Checklist, dated 7/31/13 and reviewed on 8/13/13, included a check-off list which identified the documents that were in the closed record. The "Personal Effects inventory signed/dated by resident/responsible party" was left blank and circled.</p> <p>On 9/26/13 at 1:27 p.m., the DON was asked why the "Personal Effects inventory signed/dated by resident/responsible party" was circled for Resident #15. The DON stated, "That's telling me we never had it. If its not in here I don't know where else it'd be."</p> <p>On 9/26/13 at 5:47 p.m., the Administrator and DON were informed of the liquid consistency and inventory of personal belongings issues. However, no further information or documentation was provided that resolved the issue.</p> <p>2. Resident #4 was admitted to the facility on</p>	F 514			

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F 514	<p>Continued From page 35</p> <p>8/1/11 and readmitted on 8/10/11 with multiple diagnoses which included hypertension, atrial fibrillation, cerebrovascular accident (CVA) with hemiplegia, coronary artery disease, and ischemic cardiomyopathy.</p> <p>Resident #4's most recent quarterly MDS assessment, dated 9/8/13, documented in part:</p> <ul style="list-style-type: none"> * Severe cognitive impairment with a BIMS score of 3; * Extensive assistance with 2 or more people for bed mobility, transfers, and toilet use; and, * Extensive assistance with 1 person for dressing and personal hygiene. <p>Resident #4's September 2013 Physician Orders (recapitulation orders) documented in part:</p> <ul style="list-style-type: none"> * Full Code, dated 8/10/11. <p>Resident #4's "Idaho Physician Orders for Scope of Treatment (POST)," dated 8/2/11, documented the resident's desire to be a full code with limited additional interventions, artificial fluids and nutrition: feeding tube and IV fluid, antibiotics and blood products, advanced directives with a living will, and signatures from the resident, responsible party, and physician. However, the POST form was incomplete as the basis for the orders, and with whom the desires/orders were discussed were both blank.</p> <p>On 9/25/13 at 11:30 a.m., RCM #1 was asked about the incomplete POST form for Resident #4. The RCM said the issue was for a lawyer.</p> <p>3. Resident #5 was admitted to the facility on 10/19/11 with multiple diagnoses which included Parkinson's, depression, chronic airway obstruction, and brain trauma secondary to a fall.</p>	F 514		
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F 514	Continued From page 36 Resident #5's most recent quarterly MDS assessment, dated 7/20/13, documented in part: * Cognitively intact with a BIMS score of 14; * Independent with bed mobility and walking in room; and, * Supervision for transfers, dressing, eating, toilet use, and personal hygiene. Resident #5's September 2013 Physician Orders (recapitulation orders) documented in part: *Full Code, dated 10/20/11. Resident #5's "Idaho Physician Orders for Scope of Treatment (POST)," dated 10/19/11 by the resident and 10/21/11 by the Physician, documented the resident's desire to be a full code with medical interventions, artificial fluids and nutrition: IV fluid, antibiotics and blood products, and signatures from the resident and physician. However, the POST form was incomplete as the basis for the orders, and with whom the desires/orders were discussed with were both blank. On 9/25/13 at 6:22 p.m., the DON was informed of the incomplete POST form. However, no further information or documentation was provided that resolved the issue.	F 514			

Bureau of Facility Standards

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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 Bradley Perry, LSW, BSW Linda Kelly, RN Lauren Hoard, RN Debra Bernamonti, RN Survey Definitions:	C 000		10-31-13
C 325	02.107.08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F371 as it related to the sanitizing solution and non-food contact surfaces in the dietary department.	C 325	Please see POC for F371	
C 361	02.108.07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment	C 361	Please see POC for F253	

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OCT 24 2013
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OFFICE	DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bryan Lindsay</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>10-22-13</i>
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Bureau of Facility Standards

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C 361	Continued From page 1 shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Refer to F253 regarding paint coming off the wall in the shower rooms.	C 361		
C 389	02.120,03,d Sturdy Handrails on Both Sides of Halls d. Handrails of sturdy construction shall be provided on both sides of all corridors used by patients/ residents. This Rule is not met as evidenced by: Refer to F468 regarding missing handrails.	C 389	Please see POC for F468	
C 445	02.120,13,c Hot Water Temps 105-120 Degrees F c. The temperature of hot water at plumbing fixtures used by patients/residents shall be between one hundred five degrees (105F) and one hundred twenty degrees (120F) Fahrenheit. This Rule is not met as evidenced by: Based on observation, resident group interview and staff interview, it was determined the facility failed to ensure the temperature of hot water was between 105 degrees F (Fahrenheit) and 120 degrees F. This affected 1 of 3 (300 hallway shower) shower rooms tested for hot water. Findings included: On 9/24/13 at 2:00 PM during the resident group interview several residents indicated shower water temperatures were not hot enough.	C 445	C 445 SPECIFIC RESIDENT 10/11/13 – water in D-wing shower room was fixed and has shown above 105 degrees in each test reading since. OTHER RESIDENTS All other showers were monitored to ensure they were within the appropriate limits.	

Bureau of Facility Standards

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C 445	Continued From page 2 On 9/25/13 during the environmental tour between 4:05 and 5:15 PM with the Assistant Maintenance Director, the Housekeeping Director, and the Administrator, the water temperature in the 300 hallway shower room was recorded at 97.5 F. After the Assistant Maintenance Director made several attempts to increase the heat of the water, the Administrator asked LN #8 to demonstrate how the bath staff operated the faucet. LN #8 adjusted the faucet and stated, "That's as high as it will go." (Note: the temperature did not increase after LN#8 adjusted it.) The Assistant Maintenance Director readjusted the faucet for several more minutes with the recorded temperature still at 97.5 F and he stated, "It's not getting any hotter." He then tested the water in the adjoining bathroom sink, which was recorded at 108.5 F. He then said the shower faucet O ring may be the problem and may be sending too much cold water through the hose. When asked if he had been taking water temperatures in the shower rooms, he said he had only worked at the facility for a month and had not checked the hallway showers yet, but he had tested and worked on sinks and showers in resident rooms. No further information was provided.	C 445	SYSTEMIC CHANGES Daily water temperature checks are performed to ensure temperature ranges are within the 105-120 degree limits. These audits include both showers and sinks. MONITOR Audits will <u>continue daily</u> and turned in to the <u>executive director weekly</u> for <u>three weeks</u> then <u>monthly</u> for two months with results being brought to Quality Assurance team for further audit needs. Executive Director to ensure compliance. DATE OF COMPLIANCE 10/25/2013 C664 The infection control nurse will ensure that key personnel including: Facility medical director, administrator, Pharmacist, Dietary Supervisor, DNS, Housekeeping services, Maintenance supervisor attend the infection control meeting and will use a sign in log to track attendance.	
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by:	C 664		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001390	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/27/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COEUR D'ALENE	STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST AQUA AVENUE COEUR D ALENE, ID 83815
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C 664	<p>Continued From page 3</p> <p>Based on review of Infection Control Committee/Performance Improvement meeting attendance records and staff interview, it was determined the facility failed to ensure the pharmacist and a representative from the maintenance department attended Infection Control Committee meetings. The failure of key committee members to attend Infection Control Committee meetings created the potential for a negative affect for all residents, staff and visitors to the facility. Findings included:</p> <p>On 9/26/13 at 2:20 p.m., the Infection Preventionist (IP) was interviewed. The IP stated she had been the IP since February 2013. When asked for Infection Control Committee (ICC) meeting minutes and attendance records, the IP stated she had conducted only 2 ICC meetings, one in July 2013 and one in August 2013.</p> <p>On 9/26/13 at 5:45 p.m., the Administrator and DNS were informed of the interview with the IP. The Administrator and DNS both stated that ICC meetings were conducted during monthly Performance Improvement (PI) meetings. The DNS said she would provide attendance records for the meetings.</p> <p>On 9/27/13 at 10:45 a.m., the DNS provided attendance records for the ICC/PI meetings for February through August 2013. At that time, the DNS stated, "I know the pharmacist hasn't attended any of them."</p> <p>The ICC/PI attendance records, dated 2/19/13, 4/14/13, 5/21/13, 6/18/13, 7/23/13, and 8/20/13, revealed that not only the pharmacist but also a maintenance department representative had not attended any of the meetings during that 6 month time frame.</p>	C 664	<p>The ADNS will audit attendance of Infection Control committee quarterly and report findings to Quality Assurance team for further audit needs. The audit started on 10/23/2013. ADNS to ensure compliance.</p> <p>DATE OF COMPLIANCE 10/25/2013</p>	
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C 664	Continued From page 4 On 9/27/13 at about 11:10 a.m. during the Exit Conference with the Administrator, DNS, and numerous other staff, the Administrator stated he knew the pharmacist had not signed the attendance records; but, he also knew the pharmacist had attended the meetings and he would provide the documentation by facsimile (fax). However, no other information or documentation regarding ICC/PI meeting attendance was received from the facility.	C 664		
C 779	02.200,03,a,i Developed from Nursing Assessment i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Refer to F272 as it related to side rail safety assessments.	C 779	Please see POC for F272	
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F329 as it related to not considering a resident for a gradual dose reduction. Refer to F309 as it relates to following Physician orders.	C 784	Please see POC for F309 and F329	

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C 804 C 804	Continued From page 5 02.200,04,g Recorded on Medication Record g. Each patient's/resident's medication is properly recorded on his individual medication record by the person administering the medication. The record shall include: This Rule is not met as evidenced by: Please refer to F281 as it related to pre-signing medications.	C 804 C 804	Please see POC for F281	
C 879	02.203 PATIENT/RESIDENT RECORDS 203. PATIENT/RESIDENT RECORDS. The facility maintains medical records for all patients/residents in accordance with accepted professional standards and practices. This Rule is not met as evidenced by: Refer to F514 as it relates to inaccurate and incomplete medical records.	C 879	Please see POC for F514	