



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: 7000 1670 0011 3315 1668**

October 21, 2014

Charles Lloyd, Administrator  
Mountain View Center For Geriatric Psychiatry  
500 Polk Street East  
Kimberly, ID 83341

RE: Mountain View Center For Geriatric Psychiatry, Provider #134014

Dear Mr. Lloyd:

This is to notify you that we are recommending to the Centers for Medicare/Medicaid Services (CMS) that it terminate its Medicare provider agreement with your Hospital based on the findings of the Follow Up and Complaint survey completed on October 6, 2014.

We have notified CMS that the following Condition of Participation is not met:

- 42 CFR 482.13          Patient Rights**
- 42 CFR 482.23          Nursing Services**
- 42 CFR 482.42          Infection Control**

In addition, we have informed CMS that substantial noncompliance representing an immediate and serious threat to patient health and safety has been identified. The deficiency that represents an immediate and serious threat to patients is:

**42 CFR 482.13 (c) (2) Patient Rights: Care in Safe Setting**

This deficiency was discussed with you and/or your staff during the exit conference. You were also informed in a letter dated October 7, 2014. The Statement of Deficiencies is enclosed for

Charles Lloyd, Administrator  
October 21, 2014  
Page 2 of 2

you reference.

This recommendation was accepted by CMS and they sent you a formal notice of termination dated October 10, 2014. The notice included information about appeal rights, the time schedule for termination and the steps you can take to halt the termination action.

I would like to extend a thank you to you and your staff for the courtesies and assistance provided to us during the investigation. If you have any questions, or if we can be of assistance to you, please contact me at (208) 334-6626 option 4.

Sincerely,

A handwritten signature in cursive script, appearing to read "Sylvia Creswell".

SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

SC/pt

Enclosures

cc: Kate Mitchell, CMS Region X Office  
Debra Ransom, R.N., R.H.I.T., Bureau Chief

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Western Division of Survey and Certification  
Seattle Regional Office  
701 Fifth Avenue, Suite 1600  
Seattle, WA 98104



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**IMPORTANT NOTICE – PLEASE READ CAREFULLY**

October 10, 2014

Charles Lloyd, Jr., Administrator  
Mountain View Center for Geriatric Psychiatry  
500 Polk Street East  
Kimberly, ID 83341

CMS Certification Number: 13-4014

Re: Complaint survey completed 10/06/2014  
Immediate Jeopardy (IJ) at Patient Rights – IJ not abated  
Placed on 23-day termination track starting 10/06/2014

Dear Mr. Lloyd:

After careful review of the facts, the Centers for Medicare and Medicaid Services (CMS) has determined that Mountain View Center for Geriatric Psychiatry no longer meets the requirements for participation as a provider of services in the Medicare program established under Title XVIII of the Social Security Act. Mountain View Center for Geriatric Psychiatry is now placed on a 23-day termination track. This is to notify you that effective **October 29, 2014** the Secretary of the Department of Health and Human Services intends to terminate its provider agreement with Mountain View Center for Geriatric Psychiatry. We will publish a legal notice in the local newspaper 15 days prior to the termination date.

**I. BACKGROUND**

To participate as a provider of services in the Medicare and Medicaid Programs, a psychiatric hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services. When a psychiatric hospital is found to be out of compliance with the Medicare Conditions of Participation, the facility no longer meets the requirements for participation as a provider of services in the Medicare program.

The Social Security Act Section 1866(b) authorizes the Secretary to terminate a psychiatric hospital's Medicare provider agreement if the psychiatric hospital no longer meets the regulatory requirements for a psychiatric hospital. Regulations at 42 CFR § 489.53 authorize the Centers for Medicare and Medicaid Services to terminate Medicare provider agreements when a provider, such as Mountain View Center for Geriatric Psychiatry, no longer meets the Conditions of Participation.

On October 6, 2014, the Idaho Bureau of Facility Standards (State survey agency) completed a complaint survey at your facility and notified you about an Immediate Jeopardy finding regarding the Medicare Condition of Participation (Cop) Patient Rights (42 CFR § 482.13). Briefly, the psychiatric hospital failed to ensure comprehensive patient assessments were conducted by the medical, psychiatric, and nursing staff upon admission and throughout patients' hospitalization. The Immediate Jeopardy was not removed by the end of the survey. The following CoPs are not met:

42 CFR § 482.13 Patient Rights (Immediate Jeopardy – Not Abated)

42 CFR § 482.23 Nursing Services

These deficiencies limit the capacity of Mountain View Center for Geriatric Psychiatry to furnish services of an adequate level and quality. The details of the above deficiencies were sent to you by the State survey agency.

## II. PUBLIC NOTICE OF TERMINATION AND OPPORTUNITY TO CORRECT

In accordance with 42 CFR § 489.53(d), legal notice of our action will be published in the local newspaper 15 days before the termination date.

Mountain View Center for Geriatric Psychiatry can avoid the 23-day termination action by submitting an abatement plan for the Immediate Jeopardy deficiencies prior to the effective date of the termination. CMS and the State survey agency must receive and approve a credible allegation of compliance, in sufficient time to verify, with an unannounced revisit by the State survey agency, that the immediacy of the deficiency has been removed. Complete and submit your abatement plan as soon as practicable to the State survey agency and to:

**CMS – Division of Survey and Certification**  
**Attention: Kate Mitchell (Mail Stop 400)**  
**701 Fifth Avenue, Suite 1600**  
**Seattle, WA 98104**  
**Fax: (206) 615-2088**  
**Email: [Catherine.mitchell@cms.hhs.gov](mailto:Catherine.mitchell@cms.hhs.gov)**

## III. APPEAL RIGHTS

Mountain View Center for Geriatric Psychiatry has the right to appeal this determination by requesting a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR § 498.40 et seq. A written request for a hearing must be filed not later than 60 days after the date you receive this letter. Such a request may be made to:

Page 3 – Mr. Lloyd

Chief, Civil Remedies Division  
Departmental Appeals Board  
MS 6132  
Cohen Building, Room 637-D  
330 Independence Avenue, SW  
Washington, D.C. 20201

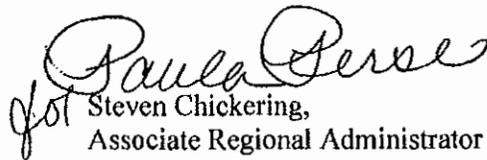
**Please also send a copy to:**

Chief Counsel  
Office of General Counsel, DHHS  
701 Fifth Avenue, Suite 1600  
Seattle, WA 98104

A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which Mountain View Center for Geriatric Psychiatry disagrees. The request should also specify the basis for contending that the findings and conclusions are incorrect. Evidence and arguments may be presented at the hearing and you may be represented by legal counsel at your own expense.

If you have any questions, please contact Kate Mitchell of my staff at (206) 615-2432 or by email at [Catherine.mitchell@cms.hhs.gov](mailto:Catherine.mitchell@cms.hhs.gov).

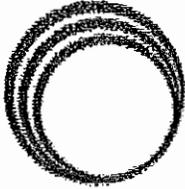
Sincerely,

Handwritten signature of Paula Perse in cursive script.

for Steven Chickering,  
Associate Regional Administrator  
Western Division of Survey & Certification

Enclosure

cc: Idaho Bureau of Facility Standards  
Office of General Counsel, DHHS



# MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY

*A BRP Health Management Care Center*

November 4th, 2014

Sylvia Creswell  
Co-Supervisor  
Non-Long Term Care  
Bureau of Facility Standards  
3232 Elder Street  
Boise, ID 83720-0036

RECEIVED  
NOV 04 2014

FACILITY STANDARDS

Dear Ms. Creswell:

Enclosed is the Plan of Correction for the follow-up and compliant survey that was conducted by the Bureau of Facility Standards on October 6, 2014.

If you have any questions please do not hesitate to call me at (208) 736-1050.

Respectfully submitted,

Charles D. Lloyd, Jr., MBA/HCM, LNHA, NCPT  
Administrator

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

PRINTED: 10/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  134014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 10/06/2014
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NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY	STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341
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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)	(X6) COMPLETION DATE
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{A 000}	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the follow up and complaint investigation survey at your hospital from 9/29/14 through 10/06/14. Surveyors conducting the survey were:</p> <p>Susan Costa, RN, HFS Team Leader Nancy Bax, BSN, HFS Laura Thompson, BSN, HFS Sylvia Creswell, LSW, QIDP, HFS</p> <p>During the survey it was determined that deficient practices at CFR 482.13, Condition of Participation of Patient's Rights, placed the health and safety of one (1) of six (6) sample patients in immediate jeopardy of serious harm, impairment, or death and had the potential to impact all patients receiving services at the facility. The facility administrator was verbally notified of the immediate jeopardy during the exit conference on 10/06/14 at 4:45 PM, and in a letter dated 10/07/14.</p> <p>Acronyms used in this report include: ADL - Activities of Daily Living ALF - Assisted Living Facility BHT - Behavioral Health Technician CDC - Centers for Disease Control C-Diff - Clostridium Difficile, a life threatening diarrhea cm - centimeter CNA - Certified Nursing Assistant DON - Director of Nursing DPOA - Durable Power of Attorney EHR - electronic health record H&amp;P - History and Physical examination IC - Infection Control IDG - Inter-disciplinary Group</p>	{A 000}	<p>Please refer to our plan of corrections at A130, A131, A144, A160, A164 and our IJ abatement plan as indicated below. The IJ was abated on 10/27/2014.</p> <p><b>I. Systems / Processes and training</b></p> <p>1. <b>Comprehensive Assessments of all current patients</b></p> <p>A comprehensive nursing assessment tool was immediately developed and utilized to reassess 100% of all current patients. The tool covers the following areas and is attached as Attachment A:</p> <ul style="list-style-type: none"> <li>• Cognition</li> <li>• Communication</li> <li>• Functional abilities</li> <li>• Cardio-vascular and Respiratory status</li> <li>• Gastro-intestinal and Genitourinary</li> <li>• Pain</li> <li>• Safety</li> <li>• Fall Risk factors</li> <li>• Elopement risk and additional Safety Issues</li> <li>• Psychosocial</li> <li>• Skin</li> <li>• Nutrition</li> </ul> <p>If issues were identified in specific areas, further and more in-depth assessments were completed by the</p>	<p>A115 11/2/14</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">RECEIVED NOV 04 2014 FACILITY STANDARDS</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X8) DATE 11/4/14
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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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{A 000}	Continued From page 1 IM - Intramuscular IV - Intravenous LPN - Licensed Practical Nurse LMSW - Licensed Medical Social Worker LTC - Long Term Care MAR - Medication Administration Record MD - Medical Doctor mg - milligrams MRSA - Methicillin Resistant Staph Aureus NCPT - Nationally Certified Psychiatric Technician NP - Nurse Practitioner OT - Occupational Therapy PICC - Percutaneous Inserted Central Catheter POST - Physician Orders for Scope of Treatment prn - as needed PT - Physical Therapy Pt - Patient QAPI - Quality Assessment Performance Improvement RD - Registered Dietician RN - Registered Nurse SBA - Stand by assist ST - Speech Therapy URI - Upper Respiratory Infection UTI - Urinary Tract Infection wt - weight	{A 000}	team.  In addition, the following team members conducted assessments pertinent to their area of expertise: Medical and Pharmacy staff have conducted an extensive review of psychopharmacological medication use and made recommendations. A Gradual Dose Reduction has been completed on patients who were found to have a primary diagnosis of Dementia and had medications (i.e. antipsychotics) above the BEERS criteria.  All patients have History and Physicals. Medical staff felt it was not necessary to complete new History and Physicals at this time as the History and Physicals contain all necessary information to develop a plan of care for each patient.		
{A 115}	482.13 PATIENT RIGHTS  A hospital must protect and promote each patient's rights.  This CONDITION is not met as evidenced by: Based on observation, patient and staff interview, and review of medical records, and facility policies, it was determined the facility failed to ensure patients' rights were protected and promoted. The facility failed to identify, and respond to, patients' initial and ongoing needs.	{A 115}	Physical Therapy and Occupational Therapy have conducted an assessment of each resident's functional status, including Mobility, Use of Devices, Range of Motion, ADL's and Activity Status and a plan for therapeutic interventions. We called in Speech Therapy for any issues identified on the nursing assessment related to swallowing and/or communication.		

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{A 115}	<p>Continued From page 2</p> <p>This resulted in the use of chemical restraints to treat anticipated aggression and negative behaviors and the rapid decline of mobility, verbal ability, and physical status of one patient. A determination of immediate jeopardy was identified at A144 for the failure of the facility to protect Patient #2 from physical and mental deterioration, and unnecessary medication. This systemic failure had the potential to result in serious harm or death to all patients receiving services at the facility. Findings include:</p> <ol style="list-style-type: none"> <li>1. Refer to A130 as it relates to the facility's failure to include the patient and/or family in the development and implementation of the plan of care.</li> <li>2. Refer to A131 as it relates to the facility's failure to ensure patients and/or family were afforded the right to request or refuse treatment.</li> <li>3. Refer to A144 as it relates to the facility's failure to ensure Patient #2's health and safety was not placed in immediate jeopardy and that all patients were provided care in a safe setting.</li> <li>4. Refer to A160 as it relates to the failure of the facility to identify the use of chemical restraints.</li> <li>5. Refer to A164 as it relates to the failure of the facility to use less restrictive interventions before implementing chemical restraints.</li> </ol> <p>The cumulative effect of these negative systemic practices impeded the facility's ability to ensure patients were protected from serious harm and provided care in a safe and effective manner.</p> <p>The administrator of the facility was verbally</p>	{A 115}	<p>Dietary staff performed an assessment for needs, preferences, ADL needs, and any specific issues related to weight loss and nutritional status including medication use. The Registered Dietician (RD) or a member of the Dietary Department will be involved in the weekly treatment team meeting currently held on Tuesdays. If the RD is unavailable to attend, the Dietary Department representative will report and discuss noted issues with the RD.</p> <p>Social Services assessed factors related to quality of life and psychosocial issues related to coping. A Social Service snapshot was developed and added to the Nurses alert charting book and Behavioral Health book for improved communication between departments.</p> <p>II. <u>Comprehensive Care Plans</u></p> <p>Once the team completed all the assessments, interdisciplinary care plan meetings were held that involved all the disciplines, IDT documentation was placed in the clinical record and the care plan updated with specific patient centered information. The plan of care meetings will be held once a</p>		

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<p>{A 115}</p> <p>A 130</p>	<p>Continued From page 3 notified of the Immediate Jeopardy to patients' health and safety on 10/06/14 at 4:45 PM, and in writing on 10/07/14.</p> <p>482.13(b)(1) PATIENT RIGHTS: PARTICIPATION IN CARE PLANNING</p> <p>The patient has the right to participate in the development and implementation of his or her plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records and interviews with family members and staff, it was determined the hospital failed to include the patient, or designated representative, in the development, implementation, and revision of the patient's plan of care for 1 of 6 patients (#2) whose records were reviewed. This resulted in the provision of care that was not individualized to meet the patient's needs. Findings include:</p> <p>1. Patient #2 was a 65 year old male admitted to the facility on 7/11/14, with diagnoses of dementia with behavioral changes, and psychosis. Patient #2's record indicated he had been admitted from his home where he was cared for by his wife. Additionally, his record indicated his wife was his DPOA, and authorized to make medical decisions for him.</p> <p>a. Patient #2's record included a "Nursing Admission Progress Note" completed and signed by Staff O, an RN, on 7/11/14 at 3:45 AM, and an "Initial Assessment History" completed and signed by Staff O, on 7/11/14 at 4:00 AM. The assessment indicated the information was obtained from an H &amp; P (History and Physical), however, the only H &amp; P in his record was from a</p>	<p>{A 115}</p> <p>A 130</p>	<p>week (minimum) with patient and/or the patient's representative participation in person or via telephone conference. The patient and/or patient representation will be documented on the IDT plan of care related to the development and implementation of the patients' plan of care.</p> <p><b>III. Staff Training</b></p> <p>All Licensed Nurses, Nursing Assistants, Certified Nursing Assistants, and Nationally Certified Psychiatric Technicians have been educated on the components related to communication – reporting changes, assessments and care planning.</p> <p><b>IV. Review of CFR 42 CFR § 482.13</b></p> <p>In collaboration with our consultant staff we have reviewed all policies and processes related to conditions of participation, Patient's Rights including, Notification of Rights, Grievances, Exercise of Rights, Privacy and Safety, and Restraint Use / Seclusion.</p> <p><b>V. Admission Policies and Processes</b></p> <p>Mountain View Center for Geriatric Psychiatry has not admitted and will not admit any patients until the</p>	
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A 130	<p>Continued From page 4 hospitalization at a critical access hospital, 6/04/14 to 6/05/14, 5 weeks prior to his admission to the facility.</p> <p>The progress note further stated Patient #2 did not know what day it was, where he was, or why he was in the facility. It also stated no family or guardian was present during the admission process. There was no documentation to indicate Patient #2's wife was contacted by phone to provide information about his recent history.</p> <p>The Initial Assessment History included sections related to social habits, sleep habits, activities of daily living, and history of falls in the last week. The sections were completed, however, it was unclear how the information was obtained, as it was not included in the H &amp; P. The Nursing Admission Progress Note stated care plans were activated.</p> <p>During an interview on 10/03/14 at 12:45 PM, Patient #2's wife stated the facility sent her a packet of forms to sign, but she did not recall them calling her to obtain information about his social habits, sleep habits, activities of daily living, and history of falls.</p> <p>During an interview on 10/02/14 at 2:50 PM, the DON confirmed Patient #2's record did not contain documentation to indicate his wife was contacted at the time of admission to obtain information regarding his recent history, or to participate in the development of his plan of care.</p> <p>Patient #2's plan of care was developed without input from his wife, who was his designated representative.</p>	A 130	<p>Immediate Jeopardy is abated by the Bureau of Facility Standards. Mountain View will continue to not admit patients until the new admission process has been reviewed and accepted by the Bureau of Facility Standards. These policies and procedures were sent to the Bureau on November 3, 2014. The new admission process will include processes for, obtaining information pre-admission, criteria for determining the appropriateness of the admission, and IDT assessment and care planning (nursing, dietary, physician, social services, activities, rehabilitation), and ongoing monitoring.</p> <p>VI. <u>Psychopharmacological Medications</u></p> <p>Mountain View Center for Geriatric Psychiatry will discuss with and inform patients and/or their representatives about proposed medications prior to implementation specifically anti-psychotic medications. The conversation will include but not limited to risk versus benefits, possible side effects of medications, and Black Box warnings issued by the FDA. This conversation will be conducted and documented by the Psychiatric Providers and/or Registered Nurse.</p>		

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A 130	<p>Continued From page 5</p> <p>b. Patient #2's record included a progress note completed by Staff H, an LPN on 9/07/14 at 11:04 PM. The note stated Patient #2's wife called to request he be given a bath as he had a history of disliking showers.</p> <p>Patient #2's record included a progress note completed by Staff O, an RN on 9/14/14 at 6:30 AM. The note stated Patient #2's wife called the previous night and provided information that he got aggressive with showers and preferred to take baths instead.</p> <p>Patient #2's record included a progress note completed by Staff G, an RN, on 09/14/14 at 9:30 PM. The note stated Patient #2's wife called and again informed the staff that he preferred baths. She requested they be offered, as she believed it would decrease his agitation.</p> <p>During an interview on 10/01/14 at 3:55 PM, Staff P, a CNA, stated patients were given showers every other day. She also stated there was a care plan binder for each hall, and the nurse's aides would check the binders for updates on the patients, including any special requests.</p> <p>A binder, labeled BHT (Behavioral Health Technician), and containing a care plan for Patient #2, was reviewed on 10/02/14. Patient #2's care plan did not indicate he was to be offered a bath instead of a shower.</p> <p>During an interview on 10/02/14 at 11:15 AM, Staff F, an NCPT, stated her assignment for the day was to provide patient showers. She stated she had given Patient #2 a shower many times, and was scheduled to provide his shower that day. Staff F stated she had not given Patient #2</p>	A 130	<p>Medications will no longer be discontinued on admission. The Hospital will implement a policy of observation for a certain time period in order to help establish each patient's baseline behavior and functional status. The length of the observation period will be patient specific and may vary from patient to patient depending the types and nature of the behaviors exhibited. During this time period, patients will be evaluated and non-pharmacological interventions will be implemented to decrease any behaviors.</p> <p>Mountain View's policy and procedures will no longer permit the initiation of high doses of psychopharmacological medications for perceived behaviors. The use of any psychopharmacological medication will only be entertained after all non-pharmacological interventions have been exhausted. Consistent with CMS guidelines (i.e. Beers criteria) the lowest possible doses will be utilized. Dosages of psychopharmacological medications going above the guidelines will have sound clinical documentation discussing all non-pharmacological interventions that were tried prior to going above the acceptable dosing. The policy and procedure will identify that Mountain View uses this as a LAST RESORT if the patients' safety or other patient's safety is at risk. Furthermore, the Administrator, Director of Nursing and/or Director of</p>	

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A 130	Continued From page 6 a bath in the past, and had not been informed he should be offered a bath instead of a shower. She confirmed his care plan in the BHT binder did not indicate he preferred baths.  During an interview on 10/02/14 at 2:50 PM, the DON reviewed Patient #2's record and stated his wife's request for a bath should have been added to his care plan in the BHT book. She confirmed his care plan had not been updated to direct the staff to offer him a bath instead of a shower.  Patient #2's plan of care was not updated as requested by his wife, who was his designated representative.	A 130	Social Services (LCSW) must be notified prior to implementation to ensure all options have been exhausted.  <b>VII. <u>Quality Measures</u></b>  As part of the plan of correction for our statement of deficiencies (SOD), we will outline established quality assurance and performance improvement measures in the following areas:	
A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT  The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care.  The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.  This STANDARD is not met as evidenced by: Based on medical record review, policy review and interviews with family members and staff, it was determined the hospital failed to ensure the patient, or designated representative, was given the information necessary to make informed decisions regarding care, for 1 of 6 patients (#2) whose records were reviewed. This interfered	A 131	<ul style="list-style-type: none"> <li>• Comprehensiveness of admission data and assessments</li> <li>• Comprehensiveness of care plans</li> <li>• Implementation of care plan interventions</li> <li>• Declines in status</li> <li>• Patient behaviors</li> <li>• Weight loss</li> <li>• Psychopharmacological medication use, assessments related to use and dose guidelines</li> <li>• Monitoring of adverse consequences related to medication use</li> </ul>	

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A 131	<p>Continued From page 7</p> <p>with the patient's or designated representative's ability to be involved in the plan of care. Findings include:</p> <p>1. Patient #2 was a 65 year old male admitted to the facility on 7/11/14, with diagnoses of dementia with behavioral changes, and psychosis. Patient #2's record indicated he had been admitted from his home where he was cared for by his wife. Patient #2's record listed his wife and his son as responsible parties.</p> <p>a. The facility's policy, titled "SECLUSION AND RESTRAINT-USE", revised 8/11, included, "The use or possible use of seclusion and/or restraint is discussed with the patient and/or family. Every effort is made to encourage the family's participation in the care process in order to limit or halt the use of restraint."</p> <p>The policy defined a drug used as a restraint as a medication used to control behavior or to restrict the patient's freedom of movement.</p> <p>Patient #2's record included a physician's order, written and signed by the Psychiatric NP on 7/11/14 at 8:40 AM, and cosigned by the Medical Director. The order was for Haldol 10 mg to be given 3 times a day with the first dose to be given immediately. The order indicated the Haldol was prescribed for psychotic agitation with verbal aggression. However, Patient #2's record did not include documentation of agitation or aggression prior to the time the order was written, or documentation of other interventions attempted prior to the implementation of Haldol.</p> <p>During an interview on 10/06/14 at 9:30 AM, the Medical Director stated Patient #2 was started on</p>	A 131	<p><b>A130</b></p> <p>Patient 2 is discharged.</p> <p>All plans of care are reviewed with the patient and/or the patient's representative. Information is provided such that a patient and/or patient representative can make an informed consent.</p> <p>We have implemented new processes for communicating plans of care including care plan and treatment changes. In addition, the team meets weekly to discuss treatment plans as well as discharge plans and the patient and patient representative are invited to attend. Patient customary routines and preferences will be considered. If attendance is not possible the treatment plan is discussed with family on the phone and/or mailed. Staff has been educated on the new processes by Administrator and Director of Nursing by November 12, 2014.</p> <p>Evidence of participation will be found documented in the clinical record. We will perform clinical record audits to determine processes are being followed. The RN Administrative Nursing Staff is responsible for compliance.</p> <p>The clinical record audits will be reported to Q.A.P.I. and Medical</p>	11/12/14	

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A 131	<p>Continued From page 8</p> <p>a high dose of Haldol to treat anticipated violent behaviors. He stated he was anticipating violent behavior based on his past history of alcohol use. The Medical Director confirmed he did not know the details of Patient #2's alcohol consumption. Additionally, he confirmed Patient #2 had not displayed violent or aggressive behaviors. The Medical Director stated the Haldol was prescribed as a chemical restraint, to ensure Patient #2 was under control.</p> <p>During an interview on 10/03/14 at 5:05 PM, Patient #2's son stated he was not consulted regarding the use of Haldol as a chemical restraint. He stated he was a clinical pharmacist and he knew Haldol was used for severe agitation but stated that wasn't the case with his father. He stated the nurses described his father as friendly and cooperative at the time of admission, but he declined rapidly after admission.</p> <p>During an interview on 10/03/14 at 12:45 PM, Patient #2's wife stated she was not consulted regarding the use of Haldol as a chemical restraint.</p> <p>Patient #2's responsible parties were not included in the decision to chemically restrain him.</p> <p>b. Patient #2's record included a progress note completed by Staff C, an LPN on 8/16/14 at 7:32 PM. The note stated Patient #2's son, who was a clinical pharmacist, called to request that 2 medications, Benadryl and Tegretol, be discontinued. The Medical Director was contacted and both medications were discontinued.</p> <p>Patient #2's record included a progress note</p>	A 131	<p>Executive Committee.</p> <p><b>A-131</b></p> <p>Patient 2 is discharged.</p> <p>All plans of care are reviewed with the patient and/or the patient's representative. Information is provided such that a patient and/or a patient representative can make an informed consent.</p> <p>We have updated all policies related to restraint use, seclusion and chemical restraints to provide for informed consent. The process includes oral notification of the risks and benefits of treatment plans especially related to medication use.</p>	11/12/14	

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A 131	<p>Continued From page 9</p> <p>completed by Staff M, an LPN on 8/19/14 at 6:50 PM. The note stated, "Pt received a one time dose of Benadryl 50 mg now and is to have Benadryl for the next two days."</p> <p>During an interview on 10/02/14 at 12:10 PM, Staff M stated he gave a one time dose of Benadryl to Patient #2 on 8/19/14. He stated there was no indication in Patient #2's record that Benadryl should not be given. He stated the family's request should have been communicated in nursing reports between shifts.</p> <p>A medication was administered to Patient #2 after his responsible party requested the medication be discontinued.</p> <p>c. Patient #2's record included a progress note completed by Staff O, an RN on 8/31/14 at 11:55 PM. The note stated, "Wife has asked that any and all med [medication] changes be reported to pt's son...".</p> <p>Patient #2's record included medication changes after 8/31/14, as follows:</p> <ul style="list-style-type: none"> <li>-9/01/14 Discontinue Fentanyl and Clonidine patches, give Claritin 10 mg now</li> <li>-9/01/14 Discontinue Rocephin 1 gram</li> <li>-9/02/14 Clonidine Patch 0.2 mg every week</li> <li>-9/05/14 Flomax 0.4 mg every day</li> <li>-9/06/14 Increase Clonidine Patch to 0.3 mg every 5 days</li> <li>-9/07/14 Ativan 2 mg now</li> <li>-9/07/14 Zyprexa 10 mg 2 times per day</li> <li>-9/16/14 Miralax 17 gm 2 times per day and Senakot-S 2 times per day</li> <li>-9/23/14 Increase Clonidine Patch to 0.4 mg every week</li> </ul>	A 131	<p>We have implemented new processes for communicating plans of care including care plan and treatment changes. In addition, the team meets weekly to discuss treatment plans as well as discharge plans and the patient and patient representative are invited to attend. Patient customary routines and preferences will be considered. If attendance is not possible the treatment plan is discussed with patient representative on the phone and/or mailed. Staff has been educated on the new processes by Administrator and/or Director of Nursing by November 12, 2014.</p> <p>Evidence of participation will be found documented in the clinical record. We will perform clinical record audits to determine processes are being followed. The RN Administrative Nurses are responsible for compliance.</p>		

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A 131	Continued From page 10  However, Patient #2's record did not include documentation to indicate the medication changes were reported to his son.  During an interview on 10/03/14 at 5:05 PM, Patient #2's son stated he was not contacted by the facility regarding medication changes. He stated he or his mother became aware of the changes when they called the facility to inquire about Patient #2's status.  During an interview on 10/02/14 at 2:50 PM, the DON stated the family's request to be notified of medication changes should have been communicated in nursing reports and posted on his medical record. She confirmed the requests were not posted on his medical record, and could not determine if they were communicated in nursing reports.  Patient #2's responsible parties were not notified of changes in his plan of care as they requested.	A 131		
{A 144}	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING  The patient has the right to receive care in a safe setting.  This STANDARD is not met as evidenced by: Based on observation, review of medical records, facility policies, accident and incident reports, and interviews with family members and staff, it was determined the hospital failed to ensure care was provided in a safe setting for 3 of 6 patients (#1, #2 and #3) whose records were reviewed. Lack of initial and ongoing assessments, and lack of appropriate	{A 144}	All cited patients are discharged.  All current patients have been reassessed by the Interdisciplinary Team (IDT) in order to identify changes in status and the care plans have been updated.  In regards to admission and collection of current information, we are implementing a comprehensive admission process that will include the following:	11/10/14

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{A 144}	<p>Continued From page 11</p> <p>Implementation and updates to plans of care resulted in significant decline in physical and mental status. This was manifested by profound weight loss, deterioration of motor skills and substantially decreased verbal skills, which placed the health and safety of Patient #2 in immediate jeopardy. This also resulted in the potential for all patients receiving services at the facility to experience serious harm, injury, or death. Findings include:</p> <p>1. Patient #2 was a 65 year old male admitted to the facility on 7/11/14, with diagnoses of dementia with behavioral changes, and psychosis. Patient #2's record indicated he was admitted from his home where he was cared for by his wife. Additionally, his record indicated his wife was his DPOA, and authorized to make medical decisions for him.</p> <p>a. Patient #2's initial medical, psychiatric, nursing and social assessments were not accurate and comprehensive. Examples include:</p> <p>i. Patient #2's record included a "Nursing Admission Progress Note" completed and signed by Staff O, an RN on 7/11/14 at 3:45 AM, which stated Patient #2 did not know what day it was, where he was, or why he was in the facility. It also stated no family or guardian was present during the admission process.</p> <p>Patient #2's record also included an "Initial Assessment History" completed and signed by Staff O, an RN on 7/11/14 at 4:00 AM. It indicated the information was obtained from an H &amp; P, however, the only an H &amp; P in his record was from a hospitalization at a critical access hospital on 6/04/14 to 6/05/14, 5 weeks prior to his</p>	{A 144}	<ul style="list-style-type: none"> <li>Preadmission screening to begin the collection of data to assist with determining care needs and our capacity and capability to provide care. This includes obtaining a recent history and physical and additional information the patient's diagnoses and comorbidities, current medications, behaviors and other psychosocial factors.</li> <li>Comprehensive assessments by the entire IDT. Nursing within the first 6 hours of admission and the development of an initial plan of care and treatment plan. The plan of care will include patient preferences, customary routines and be individualized with a person-centered focus. Other team members to complete assessments within 72 hours of admission. The physician or provider within 24 hours of admission for the History and Physical.</li> </ul>		

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{A 144}	<p>Continued From page 12 admission to the facility. The assessment history included sections related to social habits, sleep habits, activities of daily living, and history of falls in the last week. The sections were completed, however, it was unclear how the information was obtained, as it was not included in the H &amp; P, and there was no documentation to indicate Patient #2's wife was contacted by phone to provide information about his recent history.</p> <p>During an interview on 10/02/14 at 2:50 PM, the DON reviewed Patient #2's record and was unable to determine how the history documented by the RN was obtained, and stated it probably came from the records related to his hospitalization 5 weeks prior to his admission.</p> <p>ii. Patient #2's record included an H &amp; P, dated 7/11/14, signed by the psychiatric NP and cosigned by the Medical Director. It stated the information, which included his chief complaint, history of present illness, past psychiatric history, social history and current medications, was obtained from medical records from his acute care hospital admission 5 weeks earlier, and from staff during the admission process to this facility. The last paragraph of the H &amp; P stated, "I have asked staff to try and obtain additional records that may provide some additional insight into his alcohol use hx [history], family and social history." However, Patient #2's record did not include documentation to indicate additional information was obtained.</p> <p>Patient #2's record included a Progress Note, dated 7/11/14, signed by the psychiatric NP and cosigned by the Medical Director. It included admitting diagnoses of dementia with behavioral changes, psychosis manifested by physical and</p>	{A 144}	<ul style="list-style-type: none"> <li>An IDT meeting with input from the patient and/or patient representative in order to provide information relating to patient customary routines and preferences and obtain informed consent relating to treatment plans. The initial IDT meeting will occur on Mondays, Tuesdays, and Fridays.</li> <li>The entire IDT has been involved in the development of these processes and educated on their roles and responsibilities by Administrator and Director of Nursing by October 17, 2014.</li> </ul> <p>In regards to changes of status, we implemented a new I.D.T. format for our weekly treatment team that includes the following:</p> <ul style="list-style-type: none"> <li>Psychiatric Provider update, Nursing, Occupational Therapy, Nutrition, Medical Provider, Pharmacy, Social Services, Behavior Tracking, Group, Short and Long Term goals, and barriers to discharge. Any changes will result in referrals to IDT members with expertise and assessments conducted.</li> <li>Care plans will be updated with</li> </ul>		

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(A 144)	<p>Continued From page 13</p> <p>verbal aggression with wife, and chronic alcohol overuse. It was unclear how the diagnoses, including the behavioral changes and alcohol overuse, were determined, as there was no documentation of contact with Patient #2's wife.</p> <p>During an interview on 10/03/14 at 10:10 AM, the psychiatric NP confirmed she did not speak with Patient #2's wife at the time of his admission. She stated she was unable to recall where she obtained the information documented in her initial progress note.</p> <p>iii. Patient #2's record included a Social History and Discharge Planning Assessment, completed and signed by Staff L, an LMSW on 7/11/14 at 10:00 AM. The assessment documented his admission behaviors as physically aggressive, verbally aggressive, irritability/agitation, non-redirectable, trespassing and elopement risk. It was unclear how these behaviors were determined as there was no documentation in Patient #2's record of negative behaviors on 7/11/14, and no indication his wife was questioned about his recent behavior.</p> <p>The Social History and Discharge Planning Assessment included a section related to alcohol and drug use. The documentation indicated Patient #2 had a life long use of chewing tobacco. It stated he drank alcohol socially until retirement and heavily after forced retirement. However, it did not state what type of alcohol he was drinking, in what quantity, or for how long.</p> <p>During an interview on 10/02/14 at 1:50 PM, Staff L, an LMSW stated she spoke with Patient #2's wife on 7/11/14, regarding his alcohol and tobacco use. She confirmed she did not obtain</p>	(A 144)	<p>the focus on safety, dignity, choice and highest practicable well being.</p> <ul style="list-style-type: none"> <li>The entire IDT has been involved in the development of these processes and educated on their roles and responsibilities by Director of Nursing by October 17, 2014</li> </ul> <p>In regards to PICC line care and services, we have reviewed our policies and procedures and updated the policy. The policy now clearly states that only a Registered Nurse (R.N.) can provide PICC line care and services at Mountain View. All nurses were in-serviced on this new policy by October 17, 2014 by the Director of Nursing Services.</p> <p>In regards to our policies for 1:1 supervision, we have reviewed and updated the policies. All Nursing Staff (Licensed and Non-licensed) have been educated on the 1:1 supervision policy and procedure. This was conducted on October 7 and 15, 2014 by the Director of Nursing Services.</p> <p>To provide for ongoing compliance in this area, clinical record reviews are conducted on Mondays, Tuesdays, and Fridays through IDT. All declines</p>		

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{A 144}	<p>Continued From page 14</p> <p>specific information about his alcohol and tobacco use. Additionally, she confirmed the admission behaviors she documented were based on a review of his record, including nurse's note and information from his hospitalization at a critical access hospital 5 weeks prior to admission. She stated she did not obtain behavioral history from Patient #2's wife.</p> <p>During an interview on 10/03/14 at 12:45 PM, Patient #2's wife stated she was his caregiver prior to his hospitalization. She stated he was transferred by ambulance to the hospital because of the distance (approximately 6 hour driving time). She stated he walked to the ambulance without assistance, and was talking and joking with the driver. She stated Patient #2 was not physically aggressive but would display agitation at times. She stated he was not wandering outside their home. Additionally, she stated he was not doing badly at home but she had developed health issues and required medical treatment that made it impossible for her to care for her husband at home.</p> <p>Patient #2's wife stated she did not recall hospital staff calling her to obtain information about his recent behavior, social habits, sleep habits, activities of daily living, or history of falls.</p> <p>Care was provided to Patient #2 without full knowledge of his status and needs.</p> <p>b. Patient #2's initial plan of care was developed on 7/11/14, signed by the psychiatric NP and cosigned by the Medical Director. However, it was developed without accurate and comprehensive assessments, which resulted in a plan of care that was not individualized to meet</p>	{A 144}	<p>in status will be documented, measured, trended and analyzed; and provided as a Quality report to our QAPI committee. Measures have been set in weight loss and functional declines. All licensed staff competencies will be tested on hire and annually. Any accidents that occur with patients receiving 1:1 supervision will be carefully analyzed to identify cause(s) and preventive measures; appropriate actions with the employee and/or interventions will be implemented based on cause(s) identified.</p> <p>RN Administrative Staff are responsible for compliance.</p>		

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{A 144}	<p>Continued From page 15 his needs. Examples include:</p> <p>i. Patient #2's plan of care included discontinuing his current medications and beginning a new medication, Haldol, an antipsychotic medicine that works by changing the actions of chemicals in the brain.</p> <p>The Nursing 2015 Drug Handbook includes a black box warning related to Haldol, which states, "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 U.S. Food and Drug Administration's definition of Boxed Warnings states, "Drugs that have special problems, particularly ones that may lead to death or serious injury, may have this warning information displayed within a box in the prescribing information. This is often referred to as a "boxed" or "black box" warning."</p> <p>The Nursing 2015 Drug Handbook contains dosing information for Haldol, and states elderly and debilitated patients should be started on 0.5 to 2 mg by mouth, 2 to 3 times a day, increasing the dose gradually as needed. However, Patient #2's plan of care included Haldol 10 mg, to be given by mouth 3 times a day.</p> <p>ii. The Nursing 2015 Drug Handbook contains the following alert for patients on a high dose of Haldol:</p> <p>Monitor ECG (electrocardiogram) when the drug is given in high doses because of the increased risk of QT-interval prolongation (a heart rhythm</p>	{A 144}			

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{A 144}	<p>Continued From page 16</p> <p>disorder that can potentially cause fast, chaotic heartbeats that may trigger a sudden fainting spell or seizure) and torsades de pointes (a condition of the heart that exhibits distinct characteristics on the ECG).</p> <p>However, Patient #2's plan of care did not include an order for an ECG.</p> <p>During an interview on 10/06/14 at 9:30 AM, the Medical Director stated that when patients are admitted to the facility, the assumption is made they can not be treated elsewhere due to their negative behaviors. Therefore, the high dose of Haldol was ordered to treat Patient #2's behaviors, not his dementia. He stated he was treating anticipated behaviors and had to be sure Patient #2 was under control, as he expected him to exhibit violent behaviors due to his history of severe alcoholism. He stated, "We have to ensure this patient with history of alcohol intake will not be a threat. We have to treat to the milieu, so we make assumptions and will continue to do that." However, the Medical Director confirmed he did not know Patient #2's alcohol history and stated he could not explain how he determined it was severe.</p> <p>iii. Patient #2's Social History and Discharge Planning Assessment documented he had a life long use of chewing tobacco.</p> <p>During an interview on 10/03/14 at 12:45 PM, Patient #2's wife stated he chewed tobacco. She said when she spoke with someone at the hospital prior to his admission she asked if she could send his tobacco with him. She was told not to send any tobacco.</p>	{A 144}			

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{A 144}	<p>Continued From page 17</p> <p>Patient #2's plan of care did not include interventions to address nicotine withdrawal.</p> <p>During an interview on 10/03/14 at 10:30 AM, the psychiatric NP confirmed she developed Patient #2's plan of care and it did not include interventions to address nicotine withdrawal.</p> <p>Patient #2's plan of care was not individualized to meet his needs and protect his health and safety.</p> <p>c. Patient #2's plan of care was not updated to address his changing status and needs, as follows:</p> <p>i. Information regarding Patient #2's motor skills at the time of his admission to the hospital was obtained from interviews with his family and his hospital record, as follows:</p> <p>-During an interview on 10/03/14 at 12:45 PM, Patient #2's wife stated she was his primary caregiver prior to his hospitalization. She stated he was walking independently in his home prior to transfer to the hospital. Additionally, she stated on the day he was taken to the hospital he walked out of the house and to the ambulance without assistance.</p> <p>-During an interview on 10/03/14 at 5:05 PM, Patient #2's son stated he was able to walk independently prior to his admission to the hospital.</p> <p>- A "Nursing Admission Progress Note" completed and signed by Staff O, an RN on 7/11/14 at 3:45 AM, stated, "Pt ambulates w/ [with] slow steady gait, bears own wt w/o [without] difficulty.</p>	{A 144}			

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{A 144}	<p>Continued From page 18</p> <p>-A Social History and Discharge Planning Assessment completed and signed by Staff L, an LMSW on 7/11/14 at 10:00 AM, lists Patient #2's strengths as mobility, intelligence and family support.</p> <p>-A progress note, completed and signed by Staff J, an RN on 7/11/14 at 11:11 AM, stated, "Pt about unit at will with steady gait."</p> <p>-An OT assessment, completed and signed by the Occupational Therapist on 7/11/14, lists Patient #2's strengths as ambulatory and able to make needs known.</p> <p>-A progress note, completed and signed by Staff K on 7/14/14 at 6:11 PM, stated, "Spent most of the shift pacing and wandering the unit."</p> <p>-A progress note, completed and signed by Staff C, an LPN on 7/18/14 at 3:59 PM, stated, "Has been quietly ambulating around unit with steady gait t/o [throughout] the day."</p> <p>-A progress note, completed and signed by Staff O, an RN on 7/20/14 at 3:07 AM, stated, "He continues to enjoy walking in the halls and remains fairly independent."</p> <p>-A progress note, completed and signed by Staff O, an RN on 7/22/14 at 5:05 AM, stated, "Pt has been ambulating halls most of shift."</p> <p>Patient #2's record indicated a decline in his motor skills beginning approximately 2 weeks after his admission as follows:</p> <p>-A progress note, completed and signed by Staff M, an LPN on 7/26/14 at 11:06 AM, stated, "Pt</p>	{A 144}		

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{A 144}	<p>Continued From page 19 requires SBA [stand by assist] with transfers d/t [due to] unsteady gait"</p> <p>-A progress note, completed and signed by Staff Q, an RN on 7/27/14 at 2:51 AM, stated, "Pt remains unsteady on his feet with ambulation..."</p> <p>-A progress note, completed and signed by Staff Q, an RN on 7/28/14 at 12:16 AM, stated, "Patient unable to walk and transfers with 2 person assist."</p> <p>-A progress note, completed and signed by Staff E, an RN on 7/30/14 at 6:29 PM, stated, "WC [wheelchair] for mobility."</p> <p>-A progress note, completed and signed by Staff D, an LPN on 9/16/14 at 5:10 PM, stated, "Patient is a 2 person assist often and 1-2 with ambulating."</p> <p>-A progress note, completed and signed by Staff M, an LPN on 9/19/14 at 6:44 PM, stated, "Pt in broda chair throughout most of shift."</p> <p>On 9/29/14 at approximately 2:55 PM, the DON was asked if Patient #2 could walk. She stated he could walk with 3-4 person assist.</p> <p>On 9/29/14 at approximately 3:00 PM, Patient #2 was observed seated in a broda chair (specialized reclining wheelchair) in the dining room. He was also observed being taken to his room by Staff R, a NCPT, for toileting. Staff R was unable to transfer him to the toilet by herself and called for additional assistance. Staff K, an RN, came to assist. He was transferred to the toilet with the assistance of the 2 staff members.</p>	{A 144}			

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{A 144}	<p>Continued From page 20</p> <p>On 9/30/14 Patient #2 was observed from 8:51 AM - 9:20 AM. Patient #2 was in the dining area when Staff S, a CNA, attempted to push Patient #2 to his room in his specialized wheelchair. Staff S asked Patient #2 repeatedly to lift up his feet so she could push him, however, he did not do so. Staff S then tried to push him to his room anyway, but was unsuccessful. Staff S then requested the assistance of Staff T, a CNA. Walking backward, Staff T held Patient #2's feet up while Staff S pushed the wheelchair to Patient #2's bedroom. The 2 CNAs then assisted Patient #2 to utilize the bathroom. When done Patient #2 was returned to his wheelchair and Staff T left the room. Staff S then requested Staff T's assistance to return Patient #2 to the dining room. After brief discussion of the options, Staff T suggested walking Patient #2 to the dining room. Patient #2 was assisted by Staff S and Staff T back to the dining area. When asked, both staff stated Patient #2 required two staff to assist him to walk.</p> <p>During an Interdisciplinary team meeting on 9/30/14 beginning at 1:00 PM, Patient #2's mobility was discussed. The Medical Director stated it took 4 to 5 staff members to assist Patient #2 to walk safely.</p> <p>Staff responsible for Patient #2's treatment and services did not have a clear and common understanding of his mobility needs.</p> <p>Patient #2's record contained nursing care plans to address identified problems or potential problems. The care plans included interventions to address the problems, as well as short and long terms goals related to resolution of the problems. However, Patient #2's record did not contain a nursing care plan related to motor skills.</p>	{A 144}		
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{A 144}	<p>Continued From page 21</p> <p>Therefore, interventions were not developed to address his decline in motor skills and his loss of ability to ambulate.</p> <p>Patient #2's record included physician orders written to update his plan of care. However, no physician orders were written to address his decline in motor skills, such as a physical therapy evaluation or exercise program to maintain his strength.</p> <p>During an interview on 10/02/14 at 2:50 PM, the DON confirmed Patient #2 had a significant decline in mobility. She stated it was observed by facility staff, but it was up to the providers (physicians and NP's) to order physical therapy. She confirmed there was no documentation of a discussion between facility staff and providers regarding Patient #2's physical decline.</p> <p>During an interview on 10/06/14 at 9:30 AM, the DON confirmed Patient #2 did not receive a comprehensive functional assessment at the time of admission, as it is not required in the hospital setting.</p> <p>Patient #2's plan of care was not updated to address the significant decrease in his motor skills.</p> <p>ii. Information regarding Patient #2's verbal skills at the time of his admission to the hospital was obtained by surveyors from interviews with his family and his hospital record, as follows:</p> <p>-During an interview on 10/03/14 at 12:45 PM, Patient #2's wife stated she was his primary caregiver prior to his hospitalization. She stated on the day he was taken to the hospital he was</p>	{A 144}		

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{A 144}	<p>Continued From page 22</p> <p>talking and laughing with the driver. Additionally, she stated she was able to talk to him by phone at the beginning of his admission but he was no longer able to talk to her.</p> <p>-During an interview on 10/03/14 at 5:05 PM, Patient #2's son stated he was able to talk to his father on the phone frequently prior to his hospital admission, and although Patient #2 exhibited some confusion, he was able to carry on a conversation. Additionally, he stated he visited his father 2 to 3 weeks after his admission and at that time his father was not able to speak to him.</p> <p>-A Progress Note, dated 7/11/14, signed by the psychiatric NP and cosigned by the Medical Director, lists Patient #2's assets as good verbal skills, intelligent, and supportive family.</p> <p>-An OT assessment, completed and signed by the Occupational Therapist on 7/11/14, lists Patient #2's strengths as ambulatory and able to make needs known.</p> <p>-A progress note, completed and signed by Staff K, an RN on 7/14/14 at 10:44 AM, stated, "Received a phone call from his wife this morning, and appeared to have a very appropriate and lucid conversation with her. Phrases he used on the phone were: I love you, I'm ok...I just want to be home with you...there isn't much to do here...and ...alright honey, talk to you soon."</p> <p>-A progress note, completed and signed by Staff C, an LPN on 7/18/14 at 3:59 PM, stated, "Pt did have a brief phone conversation with his wife after lunch, seemed to enjoy."</p>	{A 144}			

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{A 144}	Continued From page 23 Patient #2's record indicated a decline in his verbal skills approximately 10 days after his admission as follows:  -A progress note, completed and signed by Staff G, an RN on 7/21/14 at 12:51 PM, stated, "Pt does not answer questions...."  -A progress note, completed and signed by Staff I, an RN on 7/24/14 at 10:49 AM, stated, "Unable to follow simple commands or answer questions."  -A progress note, completed and signed by Staff M, an LPN on 7/27/14 at 2:12 PM, stated, "Pt is unable to make needs known."  -A progress note, completed and signed by Staff I, an RN on 8/6/14 at 11:15 AM, stated, "Unable to answer questions or follow simple commands."  -A progress note, completed and signed by Staff C, an LPN on 8/11/14 at 10:19 AM, stated, "Pt is unable to make needs known at this time."  -A progress note, completed and signed by Staff I, an RN on 8/21/14 at 10:48 AM, stated, "...1 word statements and nonverbal sounds."  -A progress note, completed and signed by Staff K, an RN on 9/4/14 at 1:24 PM, stated, "...does not have any clarity or make sense."  -A progress note, completed and signed by a social worker on 9/24/14 at 9:13 AM, stated, "Patients [sic] verbal interactions with social services staff are minimal at best due to profound expressive and receptive aphasia." Aphasia is the loss of ability to understand or express speech.	{A 144}			

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{A 144}	Continued From page 24  Patient #2's record contained nursing care plans to address identified problems or potential problems. The care plans included interventions to address the problems, as well as short and long terms goals related to resolution of the problems. Patient #2's record contained a care plan titled Altered Thought Process. The care plan did not indicate the date it was implemented, although the first update to the care plan was dated 7/19/14. The interventions listed on the care plan included a referral to PT, ST, OT or dietary as needed. However, Patient #2's record did not include a referral to ST to address his decline in verbal skills and loss of ability to communicate.  Patient #2's record included physician orders written to update his plan of care. However, no physician orders were written to address his decline in verbal skills, such as an ST evaluation to maintain his ability to communicate.  Patient #2's plan of care was not updated to address the significant decrease in his verbal skills.  iii. Patient #2 experienced a weight loss of 44 pounds during his hospitalization, however interventions were not implemented in a timely manner to address his nutrition needs. Examples include:  Patient #2's record included a log of his weights, as follows: -7/13/14 208 pounds -7/20/14 205 pounds -8/03/14 187 pounds -8/10/14 183 pounds	{A 144}			

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{A 144}	<p>Continued From page 25</p> <p>-8/20/14 171 pounds -8/24/14 168 pounds -8/31/14 165 pounds -9/09/14 170 pounds -9/21/14 170 pounds -9/28/14 164 pounds</p> <p>On 9/29/14 at approximately 12:00 PM, Patient #2 was observed seated in a specialized reclining wheelchair in the facility dining room. The food on his meal tray was in liquid form and he was being fed the liquids by a staff member.</p> <p>Patient #2's record included OT weekly progress notes dated 7/14/14 to 7/18/14, and 7/21/14 to 7/25/14. The area to record his response to interventions on both notes stated, "Patient [sic] responds well to the progressive cueing. He does well with finger foods." The updated plan/goals section of both notes stated, "Patient will eat 75% of meal with intiation [sic] cue and finger foods as possible." However, there was no indication in Patient #2's record that he was offered finger foods for his meals.</p> <p>Patient #2's record included a nutritional risk assessment completed and signed by the registered dietician on 7/14/14. The form included a section to note food/meal preferences. The form indicated the source of information was the patient. It also documented he did not answer many of the questions, including questions about his favorite foods or meats he did not like to eat. There was no indication his wife was contacted to provide information about his food preferences.</p> <p>The dietary note also indicated Patient #2's meal intakes averaged 23%, meeting 20% of his</p>	{A 144}		

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{A 144}	<p>Continued From page 26 estimated needs. It stated "At high risk for unintended weight loss and malnutrition with current intakes."</p> <p>The next dietary note in Patient #2's record was dated 8/04/14. It indicated his diet order was changed to mechanical soft on 7/31/14. The note stated, "Patient with significant unintended weight loss since admission. Weight is down 21# or 10% in 24 days. Weight loss directly related to inadequate oral intake stemming from psychological issues and medication changes. Weight loss likely to continue with current intakes."</p> <p>Patient #2's record also included a dietary note dated 8/11/14. It stated, "Patient with significant unintended weight loss in a month related to inadequate oral intake. Diet changed to puree last week with no improvement in intakes.... Weight loss will continue with current intakes." The intervention included, "Alert MD to weight loss and inadequate oral intake; as Idaho POST form indicates tube feeding is desired." However, there was no documentation in Patient #2's record to indicate his physician or the Medical Director were alerted to his significant weight loss, or that they contacted his family about a feeding tube. During an interview on 10/02/14 at 2:50 PM, the DON stated Patient #2's medical physician was notified of his weight loss and possible need for a feeding tube, however, she did not know if his family was contacted. She confirmed there was no documentation of contact with Patient #2's family.</p> <p>Patient #2's record included a nursing care plan to address imbalanced nutrition. However, the care plan was implemented on 9/09/14, 62 days</p>	{A 144}			

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{A 144}	<p>Continued From page 27</p> <p>after his admission. On 9/09/14, Patient #2's weight was recorded as 170 pounds, indicating a 38 pound weight loss from his admission weight of 208 pounds.</p> <p>During an interview on 10/02/14 at 11:55 AM, Staff I, an RN confirmed there was a gap between the dietician's identification of Patient #2's high risk nutritional status and the implementation of a nursing care plan to address his nutritional needs. She stated that to her knowledge, the dietician's risk assessment was not communicated to the nursing staff.</p> <p>During an interview on 10/03/14 at 12:45 PM, Patient #2's wife stated she was his primary caregiver prior to his hospitalization. She stated he was feeding himself when he was at home. Additionally she stated he had not lost any weight prior to his admission to the hospital.</p> <p>During an interview on 10/06/14 beginning at 9:30 AM, the DON stated they did not collect information regarding food preferences from family members as there was not a regulation that required that. She stated the facility abided by the diet ordered by the physician.</p> <p>Patient #2's weight loss and risk of malnutrition were not addressed by the medical and nursing staff.</p> <p>Patient #2's significant decline in physical and mental status placed him at risk of further serious harm, injury, or death, and created the potential for all patients to experience similar serious adverse outcomes.</p> <p>2. Patient #1 was a 55 year old female admitted</p>	{A 144}			

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{A 144}	<p>Continued From page 28</p> <p>on 7/15/14 at 2:00 PM. Her diagnoses included dementia and psychosis NOS. Patient #1's record documented her refusal to eat or drink, and she received IV hydration. A PICC was placed on 7/25/14 in her left forearm. (The acronym PICC describes a peripherally inserted central catheter, in which the tip of the catheter rests in a large vein close to the entrance of the heart. It allows a higher concentration of medications or IV fluids to be administered, whereas smaller veins could not tolerate the higher osmolarity of the solutions). According to Lippincott Manual of Nursing Practice, eighth edition, a PICC is considered a central line, and extra vigilance must be used to protect the integrity of the line and dressing. If the dressing has become dislodged, or the line has been pulled at any point, the placement must be confirmed, and a sterile dressing change must take place.</p> <p>The facility policy for PICC line care, revised 12/11, indicated: "If PICC line is found to be torn, loose, damp, soiled or raised, the nurse should complete a sterile dressing change." The policy also stated the nurse was to document findings and actions, and alert the PICC line team of findings. The policy noted the dressing was first changed 24 hours after insertion and every 7 days if intact.</p> <p>During an interview on 10/02/14 beginning at 2:00 PM, the DON stated PICC line dressings are to be monitored and changed by the RN and not LPNs.</p> <p>In a nursing note 7/29/14 at 1:45 PM, the LPN noted "Patient has PICC line patent to left forearm, it was noticed during lab draw that</p>	{A 144}			

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{A 144}	<p>Continued From page 29</p> <p>patient has lifted the dressing and pulled some of the line out. Patient is to have daily dressing changes, securing displaced line and monitoring for S/S infection."</p> <p>A verbal order, written by the above LPN, and signed by a physician, was dated 7/29/14 at 1:15 PM. The order noted "PICC line dressing to be changed daily. Watch for S/S (signs or symptoms) infection, monitor line placement."</p> <p>In a nursing note 7/29/14 at 7:09 PM, the LPN wrote "PICC line dressing change secondary to covering entire line to prevent further displacement. When this nurse removed prior dressing it was discovered the insertion site is approximately 8-10 cm from Y connection suture site."</p> <p>A social service progress note on 7/30/14 at 4:50 PM, noted that Patient #1 had a PICC line to receive fluids which was not secure, and the nursing staff was monitoring closely.</p> <p>A verbal order to discontinue the PICC line was dated 7/30/14 at 8:45 AM. The order, written by an RN, included instructions to send the tip to be cultured and to start antibiotics for possible infection of the site.</p> <p>In an RN progress note on 7/30/14 at 5:39 PM, the nurse wrote that Patient #1's PICC line site had redness surrounding the entire elbow area down the forearm, and it was tender to touch. She noted that the medical physician was notified, and the PICC line was removed and the tip sent for culture.</p> <p>A lab result in the record noted the cultured PICC</p>	{A 144}			

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{A 144}	<p>Continued From page 30</p> <p>tip was positive for MRSA, and the facility was notified of the results on 8/01/14 at 3:01 PM. The report was reviewed and initialed by the medical physician and it was noted on the report that Patient #1's antibiotics were changed to treat the cellulitis (swelling, redness, and tenderness) and MRSA infection.</p> <p>During an interview on 10/02/14 beginning at 2:00 PM, the DON reviewed Patient #1's record and stated she was called in to see the loose dressing on 7/29/14 around 1:30 PM. She stated the LPN did not perform a sterile dressing change, but applied an occlusive dressing over the line that had been disrupted. The DON stated she instructed the LPN to contact the physician for orders. The DON confirmed that RN's have been instructed to change the PICC dressings, and it was not included as an LPN's duties at this facility. Further, the DON confirmed there was no X-Ray or verification the PICC line remained in good placement for the delivery of IV fluids and medication administration.</p> <p>During the time that Patient #1's care was provided by an LPN, her PICC line and dressing became dislodged, a sterile dressing change was not performed, and placement was not determined, which resulted in cellulitis and a MRSA infection.</p> <p>3. Patient #3 was a 61 year old male admitted to the facility on 9/04/14. His diagnoses include dementia, psychosis, multiple falls, multiple fractures, chronic pain, frequent night time urination, and an enlarged prostate. His H&amp;P documented he was transferred from an ALF for</p>	{A 144}		

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{A 144}	Continued From page 31 Increasing agitation, verbal and physical aggression, and frequent falls.  Patient #3's record included an H&P completed by the psychiatric NP. The H&P included his history of multiple falls and fractures. Also included was information from a recent admission to an acute care hospital on 8/08/14, where he was evaluated for acute fractures related to multiple falls. The psychiatric NP also documented Patient #3 wore a splint on his left lower leg which prevented him from ambulating.  Fall Scene Investigation Reports, dated 9/15/14, 9/16/14, 9/21/14, 9/24/14, and 9/28/14 documented Patient #3 had 5 falls in a 2 week period. The incident reports documented the following:  -The incident report dated 9/15/14 documented Patient #3 was on 1:1 supervision by a CNA when he fell. Patient #3 was reported to lose balance when he was transferring from his wheelchair into the bathroom. He received two cuts to his left eye from his glasses and swelling to the left cheek. He was started on neurological checks per the facility protocol for the injuries.  - The incident report dated 9/16/14 documented Patient #3 was on 1:1 supervision by a CNA and being assisted to the bathroom, when he fell forward out of his wheelchair. Staff documented he was within arm's length when the fall occurred.  - The incident report dated 9/21/14 documented Patient #3 was on 1:1 supervision when he was reaching for something and fell out of his wheelchair. The report stated his wheelchair brakes were not locked.	{A 144}			

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{A 144}	Continued From page 32  - The incident report dated 9/24/14 documented Patient #3 was on 1:1 supervision by a CNA when he slipped out of his wheelchair and onto the floor. The CNA was not within arm's reach of Patient #3 when the fall occurred.  - The incident report dated 9/28/14 documented Patient #3 fell from his bed to the floor and sustained abrasions to his right shoulder from the fall. Patient #3 was supposed to be on 1:1 supervision while awake. The CNA documented he was asleep when she left the room.  A form, titled Fall Risk Assessment, was in Patient #3's record as part of the admission process. The assessment used eight clinical condition parameters, in which the patient is assigned a score from the column that best describes the patient, and the scores are then added up. If the total number is 10 or greater, the patient is considered at high risk for potential falls. Patient #3 was given a total score of 24 on 9/04/14 and 9/18/14.  A form, titled Mountain View Hospital for Geriatric Psychiatry Nursing Care Plan, was also in Patient #3's record related to risk for falls. It documented a patient specific plan was started for history of frequent falls and impulsive behavior. The care plan had a short term goal which stated for every shift, "Patient will be free from injury." There was also a long term goal, "Patient will have no preventable falls through hospital stay." Some of the interventions listed included:  - Fall risk assessment on admission and every week - Review history of prior falls associated with	{A 144}			

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{A 144}	Continued From page 33 immobility, weakness prolonged bed rest, sedentary lifestyle (changes in body due to disuse) - 1:1 while awake due to history of frequent falls - Low bed due to history of falling out of the bed  A job description for 1:1 staff stated it was the responsibility of the staff assigned to this duty to remain within arm's length and have eyes on the patient at all times. It also stated that staff assigned to the patient are to read the patient's care plans.  During an interview on 10/01/14 beginning at 4:05 PM, the administrator and DON reviewed the Fall Incident Report logs and process. Both stated that the reporting process for falls was recently changed to include a new report form. The form included statements from staff that witnessed the fall, a root cause analysis, group huddle, and summary of the huddle. The DON stated they may also include policies, if they were not followed, and job descriptions if staff needed to review responsibilities.	{A 144}			
A 160	The facility failed to provide a safe environment for Patient #3 during his admission. 482.13(e)(1)(i)(B) PATIENT RIGHTS: RESTRAINT OR SECLUSION  [A restraint is-]  (B) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.	A 160	Patient 2 has been discharged.  All current patients' drug regimen has been reviewed and is within standards.	11/12/14	

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A 160	Continued From page 34 This STANDARD is not met as evidenced by: Based on review of hospital policy, record review and staff interview, it was determined the facility failed to ensure restraints were used only when necessary to ensure the immediate physical safety of the patient or others, for 1 of 6 patients (#2) whose records were reviewed. The failure resulted in patients being subjected to unnecessary chemical restraints. Findings include:  The facility's policy, titled "SECLUSION AND RESTRAINT-USE", revised 8/11, included, "Seclusion and/or restraint should be the selected intervention only when used as an emergency measure to control a patient's unanticipated, severely aggressive or destructive behavior which places the patient or others in imminent danger and all less restrictive measures have been determined to be ineffective."	A 160	As part of our IJ abatement plan we implemented new policies with regards to psychoactive medication use as documented in A115. In addition, we have updated processes to include behavioral tracking that will be analyzed at our weekly IDT treatment plan meetings in order to identify the best possible non-pharmacological interventions.  We have set a Quality measure for psychoactive medication use that will be discussed at our monthly Q.A.P.I. and our quarterly Medical Executive Committee meetings.  RN Administrative Staff are responsible for compliance.	
	The policy defined a drug used as a restraint as a medication used to control behavior or to restrict the patient's freedom of movement.  The policy stated a physician, psychologist or RN must document they observed the patient's threat of harm to self or others, as well as the less restrictive interventions attempted prior to the use of restraint.  Patient #2 was a 65 year old male admitted to the facility on 7/11/14, with diagnoses of dementia with behavioral changes, and psychosis. Patient #2's record indicated he had been admitted from his home where he was cared for by his wife.  A "Nursing Admission Progress Note" completed and signed by Staff O, an RN on 7/11/14 at 3:45			

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A 160	<p>Continued From page 35</p> <p>AM, indicated Patient #2 arrived at the facility at 2:15 AM on 7/11/14. The note stated, "Pt ambulates w/ [with] slow steady gait, bears own wt w/o [without] difficulty. Pt is giggly, polite, cooperative, though confusion is noted."</p> <p>Behavioral and Physical Assessment logs were completed on each shift to document negative behaviors including physical aggression, verbal aggression, agitation, non-redirectable behavior, trespassing and elopement risk. Patient #2's log indicated none of these behaviors were noted for the first 13 days of his hospitalization.</p> <p>Patient #2's record included a physician's order, written and signed by the Psychiatric NP on 7/11/14 at 8:40 AM, and cosigned by the Medical Director. The order was for Haldol 10 mg to be given 3 times a day with the first dose to be given immediately. The order indicated the Haldol was</p>	A 160		
	<p>prescribed for psychotic agitation with verbal aggression. However, Patient #2's record did not include documentation of agitation or aggression prior to the time the order was written, or documentation of other interventions attempted prior to the implementation of Haldol.</p> <p>The Nursing 2015 Drug Handbook contains dosing information for Haldol, and states elderly and debilitated patients should be started on 0.5 to 2 mg by mouth, 2 to 3 times a day, increasing the dose gradually as needed. However, Patient #2's initial plan of care on 7/11/14, included Haldol 10 mg, to be given by mouth 3 times a day, beginning on the day of admission.</p> <p>The Nursing 2015 Drug Handbook includes a black box warning related to Haldol, which states, "Elderly patients with dementia-related psychosis</p>			

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A 160	Continued From page 36 treated with atypical or conventional antipsychotics are at increased risk for death. Antipsychotics aren't approved for the treatment of dementia-related psychosis."  The U.S. Food and Drug Administration's definition of Boxed Warnings states, "Drugs that have special problems, particularly ones that may lead to death or serious injury, may have this warning information displayed within a box in the prescribing information. This is often referred to as a "boxed" or "black box" warning."  During an interview on 10/06/14 at 9:30 AM, the Medical Director stated Patient #2 was started on a high dose of Haldol to treat anticipated violent behaviors. He stated he was anticipating violent behavior based on the history of alcohol use. The Medical Director confirmed he did not know the details of Patient #2's alcohol consumption. Additionally, he confirmed Patient #2 had not displayed violent or aggressive behaviors. The Medical Director stated the Haldol was prescribed as a chemical restraint, to ensure Patient #2 was under control.	A 160			
A 164	482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION  Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.  This STANDARD is not met as evidenced by:	A 164	Please refer to A160 for our plan of correction.	11/12/14	

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NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY	STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341
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A 164	Continued From page 37 Based on review of hospital policy, record review and staff interview, it was determined the facility failed to ensure the use of chemical restraint was appropriately utilized and implemented only after other interventions were proven to be ineffective, for 1 of 6 patients (#2) whose records were reviewed. The failure resulted in patients being subjected to unnecessary chemical restraints. Findings include:  The facility's policy, titled "SECLUSION AND RESTRAINT-USE", revised 8/11, included, "Seclusion and/or restraint should be the selected intervention only when used as an emergency measure to control a patient's unanticipated, severely aggressive or destructive behavior which places the patient or others in imminent danger and all less restrictive measures have been determined to be ineffective."	A 164		
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	The policy defined a drug used as a restraint as a medication used to control behavior or to restrict the patient's freedom of movement.  The policy stated a physician, psychologist or RN must document they observed the patient's threat of harm to self or others, as well as the less restrictive interventions attempted prior to the use of restraint.  Patient #2 was a 65 year old male admitted to the facility on 7/11/14, with diagnoses of dementia with behavioral changes, and psychosis. Patient #2's record indicated he had been admitted from his home where he was cared for by his wife.  Patient #2's record included a physician's order, written and signed by the Psychiatric NP on 7/11/14 at 8:40 AM, and cosigned by the Medical			
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A 164	Continued From page 38 Director. The order was for Haldol 10 mg to be given 3 times a day with the first dose to be given immediately. The order indicated the Haldol was prescribed for psychotic agitation with verbal aggression. However, Patient #2's record did not include documentation of agitation or aggression prior to the time the order was written, or documentation of other interventions attempted prior to the implementation of Haldol.  During an interview on 10/06/14 at 9:30 AM, the Medical Director stated Patient #2 was started on a high dose of Haldol to treat anticipated violent behaviors. He stated he was anticipating violent behavior based on the history of alcohol use. The Medical Director confirmed he did not know the details of Patient #2's alcohol consumption. Additionally, he confirmed Patient #2 had not displayed violent or aggressive behaviors. The Medical Director stated the Haldol was prescribed as a chemical restraint, to ensure Patient #2 was under control.	A 164			
A 385	482.23 NURSING SERVICES Patient #2 was placed on chemical restraints without determining whether less restrictive interventions would be effective. The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.  This CONDITION is not met as evidenced by: Based on staff interview, review of patients' clinical records, facility policies, and observations, it was determined the hospital failed to ensure nursing services were organized to effectively	A 385	Please refer to A395, A397, and A405.	11/12/14	

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A 385	Continued From page 39 meet the health care needs of psychiatric patients who had additional medical conditions and needed specialized monitoring of their ongoing health status. This resulted in the failure of the facility to identify patients' initial and ongoing health care needs and provide safe and effective care. The findings include:  1. Refer to A395 as it relates to the failure of the facility to ensure a registered nurse provided each patient with initial and ongoing evaluation of his/her health care needs and supervised the delivery of nursing services.  2. Refer to A396 as it relates to the failure to ensure that patients' care plans were individualized and kept current in order to consistently meet the needs of the patients.  3. Refer to A397 as it relates to the failure to ensure nursing staff was assigned to patients based on competency and patient needs.	A 385			
A 395	4. Refer to A405 as it relates to the failure of the facility to ensure safe medication administration.  The cumulative effect of these negative systemic facility practices placed the health and safety of patients with underlying medical needs at risk. 482.23(b)(3) RN SUPERVISION OF NURSING CARE  A registered nurse must supervise and evaluate the nursing care for each patient.  This STANDARD is not met as evidenced by: Based on review of clinical records and hospital policies, observations, and staff interviews, it was	A 395	All patients cited have been discharged.  All current patients have individualized care plans.  Relating to care plans we have updated our admission process and treatment meeting plan process as described in A144:	11/2/14	

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A 395	Continued From page 40 determined the hospital failed to ensure an RN provided adequate supervision and oversight necessary to ensure appropriate patient care was provided to 3 of 6 patients (#1, #2, and #5) whose records were reviewed. This resulted in deterioration in patients' medical conditions without interventions. Findings include:  1. The facility did not ensure that RN's reassessed patients to determine if nursing care and interventions were appropriate.  a. Patient #2 was a 65 year old male admitted to the facility on 7/11/14, with diagnoses of dementia with behavioral changes, and psychosis. Patient #2's record indicated he had been admitted from his home where he was cared for by his wife. Additionally, his record indicated his wife was his DPOA, and authorized to make medical decisions for him.	A 395	<ul style="list-style-type: none"> <li>Comprehensive assessments by the entire IDT. Nursing within the first 6 hours of admission and the development of an initial plan of care and treatment plan. The plan of care will include patient preferences, customary routines with an individualized person-centered focus. Other team members to complete assessments within 72 hours of admission. The physician or provider within 24 hours of admission for the History and Physical.</li> <li>An IDT meeting with input from the patient and/or patient representative in order to provide information relating to patient customary routines and preferences and obtain informed consent relating to treatment plans. The initial IDT meeting will occur on Mondays, Tuesdays, or Fridays. The entire IDT has been involved in the development of these processes and educated on their roles and responsibilities.</li> </ul> <p>In regards to changes of status, we implemented a new I.D.T. format for our weekly treatment team that includes the following:</p>	
	i. Patient #2's record included a "Nursing Admission Progress Note" completed and signed by Staff O, an RN on 7/11/14 at 3:45 AM, which stated Patient #2 did not know what day it was, where he was, or why he was in the facility. It also stated no family or guardian was present during the admission process.  Patient #2's record also included an "Initial Assessment History" completed and signed by Staff O, an RN on 7/11/14 at 4:00 AM. It indicated the information was obtained from a history and physical, however, the only history and physical in his record was from a critical access hospital on 6/04/14 to 6/05/14, 5 weeks prior to his admission to the facility. The assessment history included sections related to social habits, sleep habits, activities of daily living,			

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A 395	Continued From page 41 and history of falls in the last week. The sections were completed, however, it was unclear how the information was obtained, as it was not included in the H & P, and there was no documentation to indicate Patient #2's wife was contacted by phone to provide information about his recent history.  During an interview on 10/02/14 at 2:50 PM, the DON reviewed Patient #2's record and was unable to determine how the history documented by the RN was obtained, and stated it probably came from the records related to his hospitalization 5 weeks prior to his admission.  Patient #2's initial nursing assessment was not accurate and comprehensive to determine his needs.  ii. Patient #2's plan of care was not updated to address his changing status and needs, as follows:	A 395	<ul style="list-style-type: none"> <li>Psychiatric Provider update, Nursing, Occupational Therapy, Nutrition, Medical Provider, Pharmacy, Social Services, Behavior Tracking, Group, Short and Long Term goals, and barriers to discharge. Any changes will result in referrals to IDT members with expertise and assessments conducted.</li> <li>Care plans will be updated with the focus on safety, dignity, choice and highest practicable well being. <ul style="list-style-type: none"> <li>The entire IDT has been involved in the development of these processes and educated on their roles and responsibilities by Director of Nursing by October 17, 2014</li> </ul> </li> </ul> <p>In regards to PICC line care and services, we have reviewed our policies and procedures and updated the policy. The policy now clearly states that only a Registered Nurse (R.N.) can provide PICC line care and services at Mountain View. All nurses were in-serviced on this new policy by October 17, 2014 by the Director of Nursing Services.</p>		
	<p>- Information regarding Patient #2's motor skills at the time of his admission to the hospital was obtained from interviews with his family and his hospital record, as follows:</p> <p>-During an interview on 10/03/14 at 12:45 PM, Patient #2's wife stated she was his primary caregiver prior to his hospitalization. She stated he was walking independently in his home prior to transfer to the hospital. Additionally, she stated on the day he was taken to the hospital he walked out of the house and to the ambulance without assistance.</p> <p>-During an interview on 10/03/14 at 5:05 PM, Patient #2's son stated he was able to walk independently prior to his admission to the</p>				

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A 395	Continued From page 42 hospital.  - A "Nursing Admission Progress Note" completed and signed by Staff O, an RN on 7/11/14 at 3:45 AM, stated, "Pt ambulates w/ [with] slow steady gait, bears own wt w/o [without] difficulty."  -A progress note, completed and signed by Staff J, an RN on 7/11/14 at 11:11 AM, stated, "Pt about unit at will with steady gait."  -A progress note, completed and signed by Staff K, an RN on 7/14/14 at 6:11 PM, stated, "Spent most of the shift pacing and wandering the unit."  -A progress note, completed and signed by Staff C, an LPN on 7/18/14 at 3:59 PM, stated, "Has been quietly ambulating around unit with steady gait t/o [throughout] the day."	A 395	In regards to lab levels, the Medical Director implemented a lab tracking log to ensure labs were collected, results were obtained, providers notified, and the providers' recommendations for treatment. The weekly treatment plan meetings will review lab results and discuss further labs that may be required.  Please refer to A144 for admission assessments per our new admission processes.	
	-A progress note, completed and signed by Staff O, an RN on 7/20/14 at 3:07 AM, stated, "He continues to enjoy walking in the halls and remains fairly independent."  -A progress note, completed and signed by Staff O, an RN on 7/22/14 at 5:05 AM, stated, "Pt has been ambulating halls most of shift."  Patient #2's record indicated a decline in his motor skills beginning approximately 2 weeks after his admission, as follows:  -A progress note, completed and signed by Staff M, an LPN on 7/26/14 at 11:06 AM, stated, "Pt requires SBA [stand by assist] with transfers d/t [due to] unsteady gait"  -A progress note, completed and signed by Staff			

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A 395	Continued From page 43 Q, an RN on 7/27/14 at 2:51 AM, stated, "Pt remains unsteady on his feet with ambulation..."  -A progress note, completed and signed by Staff Q, an RN on 7/28/14 at 12:16 AM, stated, "Patient unable to walk and transfers with 2 person assist."  -A progress note, completed and signed by Staff E, an RN on 7/30/14 at 6:29 PM, stated, "WC [wheelchair] for mobility."  -A progress note, completed and signed by Staff D, an LPN on 9/16/14 at 5:10 PM, stated, "Patient is a 2 person assist often and 1-2 with ambulating."  -A progress note, completed and signed by Staff M, an LPN on 9/19/14 at 6:44 PM, stated, "Pt in broda chair throughout most of shift."	A 395			
	On 9/29/14 at approximately 2:55 PM, the DON was asked if Patient #2 could walk. She stated he could walk with 3-4 person assist.  On 9/29/14 at approximately 3:00 PM, Patient #2 was observed seated in a broda chair (specialized reclining wheelchair) in the dining room. He was also observed being taken to his room by Staff R, a NCPT, for toileting. Staff R was unable to transfer him to the toilet by herself and called for additional assistance. Staff K, an RN, came to assist. He was transferred to the toilet with the assistance of the 2 staff members.  On 9/30/14 Patient #2 was observed from 8:51 AM - 9:20 AM. Patient #2 was in the dining area when Staff S, a CNA, attempted to push Patient #2 to his room in his specialized wheelchair.				

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A 395	<p>Continued From page 44</p> <p>Staff S asked Patient #2 repeatedly to lift up his feet so she could push him, however, he did not do so. Staff S then tried to push him to his room anyway, but was unsuccessful. Staff S then requested the assistance of Staff T, a CNA. Walking backward, Staff T held Patient #2's feet up while Staff S pushed the wheelchair to Patient #2's bedroom. The 2 CNAs then assisted Patient #2 to utilize the bathroom. When done Patient #2 was returned to his wheelchair and Staff T left the room. Staff S then requested Staff T's assistance to return Patient #2 to the dining room. After brief discussion of the options, Staff T suggested walking Patient #2 to the dining room. Patient #2 was assisted by Staff S and Staff T back to the dining area. When asked, both staff stated Patient #2 required two staff to assist him to walk.</p> <p>During an interdisciplinary team meeting on 9/30/14 beginning at 1:00 PM, Patient #2's mobility was discussed. The Medical Director stated it took 4 to 5 staff members to assist Patient #2 to walk safely.</p> <p>Staff responsible for Patient #2's treatment and services did not have a clear and common understanding of his mobility needs.</p> <p>Patient #2's record contained nursing care plans to address identified problems or potential problems. The care plans included interventions to address the problems, as well as short and long terms goals related to resolution of the problems. However, Patient #2's record did not contain a nursing care plan related to motor skills. Therefore, nursing interventions were not developed to address his decline in motor skills and his loss of ability to ambulate.</p>	A 395		

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A 395	<p>Continued From page 45</p> <p>During an interview on 10/02/14 at 2:50 PM, the DON reviewed Patient #2's record and confirmed nursing interventions were not developed to address the decline in his motor skills.</p> <p>Patient #2's motor skills declined significantly, however, interventions were not developed to address his decline in motor skills and his loss of ability to ambulate.</p> <p>iii. Information regarding Patient #2's verbal skills at the time of his admission to the hospital was obtained from interviews with his family and his hospital record, as follows:</p> <p>-During an interview on 10/03/14 at 12:45 PM, Patient #2's wife stated she was his primary caregiver prior to his hospitalization. She stated on the day he was taken to the hospital he was talking and laughing with the driver. Additionally, she stated she was able to talk to him by phone at the beginning of his admission but he was no longer able to talk to her.</p> <p>-During an interview on 10/03/14 at 5:05 PM, Patient #2's son stated he was able to talk to his father on the phone frequently prior to his hospital admission, and although Patient #2 exhibited some confusion, he was able to carry on a conversation. Additionally, he stated he visited his father 2 to 3 weeks after his admission and at that time his father was not able to speak to him.</p> <p>-A Progress Note, dated 7/11/14, signed by the psychiatric NP and cosigned by the Medical Director, listed Patient #2's assets as good verbal skills, intelligent, and supportive family.</p> <p>-A progress note, completed and signed by Staff</p>	A 395			

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A 395	<p>Continued From page 46</p> <p>K, an RN on 7/14/14 at 10:44 AM, stated, "Received a phone call from his wife this morning, and appeared to have a very appropriate and lucid conversation with her. Phrases he used on the phone were: I love you, I'm ok...I just want to be home with you...there isn't much to do here...and ...alright honey, talk to you soon."</p> <p>-A progress note, completed and signed by Staff C, an LPN on 7/18/14 at 3:59 PM, stated, "Pt did have a brief phone conversation with his wife after lunch, seemed to enjoy."</p> <p>Patient #2's record indicated a decline in his verbal skills approximately 10 days after his admission as follows:</p> <p>-A progress note, completed and signed by Staff G, an RN on 7/21/14 at 12:51 PM, stated, "Pt does not answer questions...."</p>	A 395		
	<p>-A progress note, completed and signed by Staff I, an RN on 7/24/14 at 10:49 AM, stated, "Unable to follow simple commands or answer questions."</p> <p>-A progress note, completed and signed by Staff M, an LPN on 7/27/14 at 2:12 PM, stated, "Pt is unable to make needs known."</p> <p>-A progress note, completed and signed by Staff I, an RN on 8/6/14 at 11:15 AM, stated, "Unable to answer questions or follow simple commands."</p> <p>-A progress note, completed and signed by Staff C, an LPN on 8/11/14 at 10:19 AM, stated, "Pt is unable to make needs known at this time."</p> <p>-A progress note, completed and signed by Staff</p>			

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A 395	Continued From page 47 I, an RN on 8/21/14 at 10:48 AM, stated, "... 1 word statements and nonverbal sounds."  -A progress note, completed and signed by Staff K, an RN on 9/4/14 at 1:24 PM, stated, "...does not have any clarity or make sense."  -A progress note, completed and signed by a social worker on 9/24/14 at 9:13 AM, stated, "Patients [sic] verbal interactions with social services staff are minimal at best due to profound expressive and receptive aphasia." Aphasia is the loss of ability to understand or express speech.  Patient #2's record contained a nursing care plan titled "Altered Thought Process". The care plan did not indicate the date it was implemented, although the first update to the care plan was dated 7/19/14. The interventions listed on the care plan included a referral to PT, ST, OT or dietary as needed. However, Patient #2's record did not include a referral to ST to address his decline in verbal skills and loss of ability to communicate.  Patient #2's verbal skills declined significantly, however, his nursing care plan was not followed to initiate a referral to ST to address his decline in verbal skills and his loss of ability to communicate.  iv. Patient #2 experienced a weight loss of 44 pounds during his hospitalization, however interventions were not implemented in a timely manner to address his nutrition needs. Examples include:  Patient #2's record included a log of his weights,	A 395			

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A 395	<p>Continued From page 48 as follows: -7/13/14 208 pounds -7/20/14 205 pounds -8/03/14 187 pounds -8/10/14 183 pounds -8/20/14 171 pounds -8/24/14 168 pounds -8/31/14 165 pounds -9/09/14 170 pounds -9/21/14 170 pounds -9/28/14 164 pounds</p> <p>Patient #2's record included OT weekly progress notes dated 7/14/14 to 7/18/14, and 7/21/14 to 7/25/14. The area to record his response to interventions on both notes stated, "Paitent [sic] responds well to the progressive cueing. He does well with finger foods." The updated plan/goals section of both notes stated, "Patient will eat 75% of meal with intiation [sic] cue and finger foods as possible." However, there is no indication in Patient #2's record that he was offered finger foods for his meals.</p> <p>Patient #2's record included a nursing care plan to address imbalanced nutrition. However, the care plan was not implemented until 9/09/14, 62 days after his admission. On 9/09/14, Patient #2's weight was recorded as 170 pounds, indicating a 38 pound weight loss from his admission weight of 208 pounds.</p> <p>During an interview on 10/02/14 at 11:55 AM, Staff I, an RN confirmed a nursing care plan to address Patient #2's nutritional needs should have been developed earlier.</p> <p>During an interview on 10/06/14 beginning at 9:30 AM, the DON stated they do not collect</p>	A 395			

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A 395	<p>Continued From page 49</p> <p>information regarding food preferences from family members as there is not a regulation requiring this. She stated they abided by the diet ordered by the physician.</p> <p>Patient #2's weight loss and risk of malnutrition were not addressed by the nursing staff. An RN did not provide sufficient oversight of Patient #2's care.</p> <p>b. Patient #1 was admitted on 7/15/14 at 2:00 PM. Her flow sheet indicated she had one incontinent urine output that day. On 7/16/14, the flow sheet documented she did not void for 24 hours. On 7/17/14 at 5:13 PM, the nursing progress note documented a foley catheter was inserted and her urine output for 24 hours was 400 ml. (The National Institute of Health defines decreased urine output as less than 500 ml in 24 hours. It includes causes such as kidney failure and dehydration.)</p> <p>The psychiatric NP wrote an order to place a urinary catheter on 7/17/14 at 1:15 PM.</p> <p>Patient #1's record included a nursing progress note dated 7/17/14 at 3:13 PM. The LPN noted "Patient had not voided in over 24 hours so I got an order for catheter."</p> <p>During an interview on 10/02/14 beginning at 2:00 PM, the DON reviewed Patient #1's record and confirmed there was one documented incontinent void over a period of 48 hours since her admission. She was unable to find documentation in Patient #1's record to indicate an RN was aware of the extended period of time without urine output. She confirmed that LPN staff were assigned to Patient #1 until 7/17/14</p>	A 395		

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A 395	Continued From page 50 beginning at 7:00 PM, when an RN assumed her care.  The RN did not evaluate Patient #1's inability to void for 2 days.  i. Patient #1's record documented her refusal to eat or drink, and she received IV hydration. A PICC was placed on 7/25/14 in her left forearm. (The acronym PICC describes a peripherally inserted central catheter, in which the tip of the catheter rests in a large vein close to the entrance of the heart. It allows a higher concentration of medications or IV fluids to be administered, whereas smaller veins could not tolerate the higher osmolarity of the solutions). According to Lippincott Manual of Nursing Practice, eighth edition, a PICC is considered a central line, and extra vigilance must be used to protect the integrity of the line and dressing. If the dressing has become dislodged, or the line	A 395			
	has been pulled at any point, the placement must be confirmed, and a sterile dressing change must take place.  The facility policy for PICC line care, revised 12/11, indicated: "If PICC line is found to be torn, loose, damp, soiled or raised, the nurse should complete a sterile dressing change." The policy also stated the nurse was to document findings and actions, and alert the PICC line team of findings. The policy noted the dressing was first changed 24 hours after insertion and every 7 days if intact.  During an interview on 10/02/14 beginning at 2:00 PM, the DON stated PICC line dressings are to be monitored and changed by the RN and not LPNs.				

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A 395	Continued From page 51  In a nursing note 7/29/14 at 1:45 PM, the LPN noted "Patient has PICC line patent to left forearm, it was noticed during lab draw that patient has lifted the dressing and pulled some of the line out. Patient is to have daily dressing changes, securing displaced line and monitoring for S/S infection."  A verbal order, written by the above LPN, and signed by a physician, was dated 7/29/14 at 1:15 PM. The order noted "PICC line dressing to be changed daily. Watch for S/S (signs or symptoms) infection, monitor line placement."  In a nursing note 7/29/14 at 7:09 PM, the LPN wrote "PICC line dressing change secondary to covering entire line to prevent further displacement. When this nurse removed prior dressing it was discovered the insertion site is approximately 8-10 cm from Y connection suture site."  A social service progress note on 7/30/14 at 4:50 PM, noted that Patient #1 had a PICC line to receive fluids which was not secure, and the nursing staff was monitoring closely.  A verbal order to discontinue the PICC line was dated 7/30/14 at 8:45 AM. The order, written by an RN, included instructions to send the tip to be cultured and to start antibiotics for possible infection of the site.  In an RN progress note on 7/30/14 at 5:39 PM, the nurse wrote that Patient #1's PICC line site had redness surrounding the entire elbow area down the forearm, and it was tender to touch. She noted that the medical physician was	A 395			

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A 395	<p>Continued From page 52 notified, and the PICC line was removed and the tip sent for culture.</p> <p>A lab result in the record noted the cultured PICC tip was positive for MRSA, and the facility was notified of the results on 8/01/14 at 3:01 PM. The report was reviewed and initialed by the medical physician and it was noted on the report that Patient #1's antibiotics were changed to treat the cellulitis (swelling, redness, and tenderness) and MRSA infection.</p> <p>During an interview on 10/02/14 beginning at 2:00 PM, the DON reviewed Patient #1's record and stated she was called in to see the loose dressing on 7/29/14 around 1:30 PM. She stated the LPN did not perform a sterile dressing change, but applied an occlusive dressing over the line that had been disrupted. The DON stated she instructed the LPN to contact the physician for orders. The DON confirmed that RN's have been instructed to change the PICC dressings, and it was not included as an LPN's duties at this facility. Further, the DON confirmed there was no X-Ray or verification the PICC line remained in good placement for the delivery of IV fluids and medication administration.</p> <p>During the time that Patient #1's care was provided by an LPN, her PICC line and dressing became dislodged, a sterile dressing change was not performed, and placement was not determined, which resulted in cellulitis and a MRSA infection. An RN did not provide appropriate care and oversight of Patient #1's medical needs.</p> <p>c. Patient #5 was a 61 year old male admitted to the facility on 9/11/14, with diagnoses of</p>	A 395			

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A 395	Continued From page 53 schizophrenia (a severe brain disorder in which people interpret reality abnormally), dementia (a decline in mental ability severe enough to interfere with daily life) with behavioral disturbance, and psychosis (a loss of contact with reality). Patient #5's record indicated he was transferred from an ALF due to aggressive behaviors.  Patient #5's admission orders dated 9/11/14, included Lasix. According to the Nursing 2014 Drug Handbook, "Lasix is a potent diuretic used to treat fluid retention and high blood pressure. It may cause excessive water loss through urination, causing serious electrolyte abnormalities or dehydration." The handbook advises to monitor the serum potassium level closely. Potassium is a chemical (electrolyte) that is critical to the proper functioning of nerve and muscles cells, particularly heart muscle cells.	A 395			
	Patient #5's record included a laboratory report, dated 9/15/14, with results from blood that was taken on 9/12/14. His potassium level was 3.3 meq/L, which was below the indicated reference range of 3.6 - 5.1 meq/L. On the report was written "9/15/14 faxed to [medical doctor's] office." The record did not include further documented communication regarding these test results between nursing and the physician.  On 9/16/14, orders were written by the psychiatric NP for multiple blood tests to be drawn on 9/22/14, however, she did not include orders to check Patient #5's potassium level.  During an interview on 9/30/14 beginning at 2:55 PM, the medical physician confirmed the laboratory results and Patient #5's low potassium				

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A 395	Continued From page 54 level. The physician stated the low potassium level should have been repeated, and it was an oversight the laboratory test was not ordered.  Patient #5's low potassium level was not repeated.  2. A facility policy titled "Admission Assessment," revised 12/08, noted each patient would be assessed by a licensed nurse and the RN would retain responsibility for interpreting the data and identifying patient care needs. The policy noted the patient assessment would include demographic data, past medical history, allergies, biophysical, psychosocial, environmental, self-care, education, and discharge planning needs.  Admission assessments were not performed by an RN as follows:	A 395			
	a. Patient #1 was a 55 year old female, admitted to the facility on 7/15/14. Her diagnoses included dementia with behavior disturbance and unspecified psychosis. Her record indicated she had been living at home with her husband, then was admitted to an assisted living facility for approximately a week prior to her admission to this facility. The record noted she had exhibited aggressive behavior towards other residents and staff at the assisted living facility, so she was transferred to the hospital.  Her record included three admission assessment forms, Initial Assessment History, Nursing Admission Progress Note, and Initial BHT Care Guide. The forms were signed by an LPN and dated 7/15/14 at 3:00 PM.				

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A 395	<p>Continued From page 55</p> <p>The Initial Assessment History noted information was obtained from Patient #1's husband. It documented behaviors leading to her admission included verbal and physical assault. In the sections of the assessment titled "Significant Medical History/Recent Hospitalizations/Procedures," and "Psychiatric History/Hospitalizations," the LPN had written "N/A," indicating not applicable. Additionally, the form noted Patient #1's ADLs required physical assistance. A comprehensive biophysical and psychosocial assessment with vital signs was not included.</p> <p>The Nursing Admission Progress Note included information of Patient #1's status upon admission as assessed by the LPN who completed the admission documentation. It noted she was oriented to her room, staff, meal schedule, and the unit. The note stated Patient #1 was unable to verbalize her reason for admission. The admitting LPN documented Patient #1 arrived on the unit with the ambulance crew and was sedated.</p>	A 395		
	<p>The Initial BHT Care Guide included categories which were marked with an "x" that indicated Patient #1's mental and behavioral status, toileting needs, ambulation, vision, hearing, bathing, diet, and grooming needs. The guide noted Patient #1 was able to walk with assistance, needed help with feeding and grooming.</p> <p>During an interview on 10/02/14 beginning at 2:00 PM, the DON reviewed Patient #1's medical record and confirmed the admission assessment was performed by an LPN. She confirmed the assessment was not reviewed or co-signed by an</p>			

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A 395	Continued From page 56 RN as the policy indicated. She confirmed the record did not indicate an RN provided care or entered notes in the record until 7/17/14 at 11:59 PM, which was greater than 48 hours after her admission.	A 395			
A 396	The facility did not ensure admission assessments were performed by RN's. 482.23(b)(4) NURSING CARE PLAN  The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan  This STANDARD is not met as evidenced by: Based on observation, medical record review, and staff interview it was determined the facility failed to ensure a comprehensive, individualized plan-of-care was developed, evaluated and revised as patients conditions changed, for 2 of 6 patients (#1 and #2) whose records were reviewed. This failed practice resulted in unaddressed patient care needs, and had the potential to negatively impact all patients receiving services in the facility. Findings include:  1. Patient #2 was a 65 year old male admitted to the facility on 7/11/14, with diagnoses of dementia with behavioral changes, and psychosis. Patient #2's record indicated he had been admitted from his home where he was cared for by his wife. Additionally, his record indicated his wife was his DPOA, and authorized to make medical decisions for him.  a. Patient #2's record indicated a decline in his motor skills beginning approximately 2 weeks	A 396	Please refer to A144 and A395 for our plan of correction.	11/12/14	

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A 396	Continued From page 57 after his admission, as follows:  -A "Nursing Admission Progress Note" completed and signed by Staff O, an RN on 7/11/14 at 3:45 AM, stated, "Pt ambulates w/ [with] slow steady gait, bears own wt w/o [without] difficulty."  -A progress note, completed and signed by Staff M, an LPN on 7/26/14 at 11:06 AM, stated, "Pt requires SBA [stand by assist] with transfers d/t [due to] unsteady gait"  -A progress note, completed and signed by Staff Q, an RN on 7/27/14 at 2:51 AM, stated, "Pt remains unsteady on his feet with ambulation..."  -A progress note, completed and signed by Staff Q, an RN on 7/28/14 at 12:16 AM, stated, "Patient unable to walk and transfers with 2 person assist."	A 396			
	-A progress note, completed and signed by Staff E, an RN on 7/30/14 at 6:29 PM, stated, "WC [wheelchair] for mobility."  -A progress note, completed and signed by Staff D, an LPN on 9/16/14 at 5:10 PM, stated, "Patient is a 2 person assist often and 1-2 with ambulating."  -A progress note, completed and signed by Staff M, an LPN on 9/19/14 at 6:44 PM, stated, "Pt in broda chair throughout most of shift."  On 9/29/14 at approximately 2:55 PM, the DON was asked if Patient #2 could walk. She stated he could walk with 3-4 person assist.  On 9/29/14 at approximately 3:00 PM, Patient #2				

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A 396	<p>Continued From page 58</p> <p>was observed seated in a broda chair (specialized reclining wheelchair) in the dining room. He was also observed being taken to his room by Staff R, a NCPT, for toileting. Staff R was unable to transfer him to the toilet by herself and called for additional assistance. Staff K, an RN, came to assist. He was transferred to the toilet with the assistance of the 2 staff members.</p> <p>On 9/30/14 Patient #2 was observed from 8:51 AM - 9:20 AM. Patient #2 was in the dining area when Staff S, a CNA, attempted to push Patient #2 to his room in his specialized wheelchair. Staff S asked Patient #2 repeatedly to lift up his feet so she could push him, however, he did not do so. Staff S then tried to push him to his room anyway, but was unsuccessful. Staff S then requested the assistance of Staff T, a CNA. Walking backward, Staff T held Patient #2's feet up while Staff S pushed the wheelchair to Patient #2's bedroom. The 2 CNAs then assisted Patient #2 to utilize the bathroom. When done Patient #2 was returned to his wheelchair and Staff T left the room. Staff S then requested Staff T's assistance to return Patient #2 to the dining room. After brief discussion of the options, Staff T suggested walking Patient #2 to the dining room. Patient #2 was assisted by Staff S and Staff T back to the dining area. When asked, both staff stated Patient #2 required two staff to assist him to walk.</p> <p>During an interdisciplinary team meeting on 9/30/14 beginning at 1:00 PM, Patient #2's mobility was discussed. The Medical Director stated it took 4 to 5 staff members to assist Patient #2 to walk safely.</p> <p>Staff responsible for Patient #2's treatment and services did not have a clear and common</p>	A 396			

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A 396	Continued From page 59 understanding of his mobility needs.  Patient #2's record contained nursing care plans to address identified problems or potential problems. The care plans included interventions to address the problems, as well as short and long terms goals related to resolution of the problems. However, Patient #2's record did not contain a nursing care plan related to motor skills. Therefore, interventions were not developed to address his decline in motor skills and his loss of ability to ambulate.  Patient #2's nursing plan of care did not identify, or include interventions, to address the significant decline in his motor skills.  b. Patient #2's record indicated a decline in his verbal skills during his hospitalization, as follows:	A 396		
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	-A Progress Note, dated 7/11/14, signed by the psychiatric NP and cosigned by the Medical Director, listed Patient #2's assets as good verbal skills, intelligent, and supportive family.  -A progress note, completed and signed by Staff K, an RN on 7/14/14 at 10:44 AM, stated, "Received a phone call from his wife this morning, and appeared to have a very appropriate and lucid conversation with her. Phrases he used on the phone were: I love you, I'm ok...I just want to be home with you...there isn't much to do here...and ...alright honey, talk to you soon."  -A progress note, completed and signed by Staff G, an RN on 7/21/14 at 12:51 PM, stated, "Pt does not answer questions...."			
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A 396	Continued From page 60 -A progress note, completed and signed by Staff I, an RN on 7/24/14 at 10:49 AM, stated, "Unable to follow simple commands or answer questions."  -A progress note, completed and signed by Staff M, an LPN on 7/27/14 at 2:12 PM, stated, "Pt is unable to make needs known."  -A progress note, completed and signed by Staff I, an RN on 8/6/14 at 11:15 AM, stated, "Unable to answer questions or follow simple commands."  -A progress note, completed and signed by Staff C, an LPN on 8/11/14 at 10:19 AM, stated, "Pt is unable to make needs known at this time."  -A progress note, completed and signed by Staff I, an RN on 8/21/14 at 10:48 AM, stated, "... 1 word statements and nonverbal sounds."  -A progress note, completed and signed by Staff K, an RN on 9/4/14 at 1:24 PM, stated, "...does not have any clarity or make sense."  -A progress note, completed and signed by a social worker on 9/24/14 at 9:13 AM, stated, "Patients [sic] verbal interactions with social services staff are minimal at best due to profound expressive and receptive aphasia." Aphasia is the loss of ability to understand or express speech.  Patient #2's record contained nursing care plans to address identified problems or potential problems. The care plans included interventions to address the problems, as well as short and long terms goals related to resolution of the problems. Patient #2's record contained a care plan titled Altered Thought Process. The care	A 396			

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A 396	Continued From page 61 plan did not indicate the date it was implemented, although the first update to the care plan was dated 7/19/14. The interventions listed on the care plan included a referral to PT, ST, OT or dietary as needed. However, Patient #2's record did not include a referral to ST to address his decline in verbal skills and loss of ability to communicate.  Patient #2's nursing plan of care did not identify, or include interventions, to address the significant decline in his motor skills.  c. Patient #2 experienced a weight loss of 44 pounds during his hospitalization, however a nursing care plan was not implemented in a timely manner to address his nutrition needs. Examples include:  Patient #2's record included a log of his weights, as follows: -7/13/14 208 pounds -7/20/14 205 pounds -8/03/14 187 pounds -8/10/14 183 pounds -8/20/14 171 pounds -8/24/14 168 pounds -8/31/14 165 pounds -9/09/14 170 pounds -9/21/14 170 pounds -9/28/14 164 pounds  Patient #2's record included a nutritional risk assessment completed and signed by the registered dietician on 7/14/14. The form included a section to note food/meal preferences. The form indicated the source of information was the patient. It also documented he did not answer many of the questions, including	A 396			

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A 396	<p>Continued From page 62</p> <p>questions about his favorite foods or meats he did not like to eat. There was no indication his wife was contacted to provide information about his food preferences.</p> <p>The dietary note also indicated Patient #2's meal intakes averaged 23%, meeting 20% of his estimated needs. It stated "At high risk for unintended weight loss and malnutrition with current intakes."</p> <p>Patient #2's record included a nursing care plan to address imbalanced nutrition. However, the care plan was implemented on 9/09/14, 62 days after his admission. On 9/09/14, Patient #2's weight was recorded as 170 pounds, indicating a 38 pound weight loss from his admission weight of 208 pounds.</p> <p>On 9/29/14 at approximately 12:00 PM, Patient #2 was observed seated in a specialized reclining wheelchair in the facility dining room. The food on his meal tray was in liquid form and he was being fed the liquids by a staff member.</p> <p>During an interview on 10/02/14 at 11:55 AM, Staff I, an RN confirmed there was a gap between the dietician's identification of Patient #2's high risk nutritional status and the implementation of a nursing care plan to address his nutritional needs. She stated that to her knowledge, the dietician's risk assessment was not communicated to the nursing staff.</p> <p>During an interview on 10/06/14 beginning at 9:30 AM, the DON stated they do not collect information regarding food preferences from family members as there is not a regulation requiring this. She stated they abided by the diet</p>	A 396			

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A 396	<p>Continued From page 63 ordered by the physician.</p> <p>A nursing care plan to address Patient #2's nutritional needs was not implemented in a timely manner to prevent significant weight loss and malnutrition.</p> <p>2. Patient #1's medical record documented a 55 year old female, admitted to the facility on 7/15/14. Diagnosis included dementia, Alzheimer's type, hypothyroidism and a urinary tract infection (UTI.) She was discharged to a long term care facility during the survey on 9/30/14. Patient #1's nursing plan of care was not adequately developed or revised as follows:</p> <p>Patient #1's record included physician orders for the following changes in her treatment plan:</p> <p>a. 7/17/14 at 1:15 PM - a psychiatric NP entered an order for placement of a Foley catheter related to urinary retention.</p> <p>7/25/14 at 6:00 PM - the treating psychiatrist entered an order that included "PICC line dressing per policy."</p> <p>7/29/14 at 1:15 PM - a verbal order from an MD was entered that included "PICC (peripherally inserted central catheter) line dressing to be changed daily. Watch for s/s infection, monitor line placement."</p> <p>8/25/14 at 9:00 AM - the psychiatric NP entered an order for a medication, Cogentin, 1 mg, to treat "neck dystonia" (Neck/cervical dystonia is a painful condition in which the neck muscles contract involuntarily, causing the head to twist or turn to one side.)</p>	A 396			

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A 396	Continued From page 64  9/18/14 at 4:30 PM - the psychiatric NP entered an order to change the Foley catheter the evening of 9/18/14 and monthly thereafter. The order included directions to flush the catheter as needed, with sterile water, using sterile irrigation tray, for the purpose of clearing sediment.  The nursing plan of care for Patient #1 did not identify, or include interventions, to address ongoing management of a patient with a Foley catheter or ongoing management of a PICC line. Additionally, the plan of care failed to include interventions to address or monitor the condition, neck dystonia.  b. Patient #1's nursing progress notes dated 7/27/14 at 7:41 AM, documented Patient #1 was placed on contact isolation precautions related to frequent loose stools. According to the nursing notes, she remained in contact isolation until 9/13/14 at 11:45 PM.  The nursing progress notes dated dated 7/27/14 at 6:56 PM, stated lab results for Patient #1 indicated a positive test for clostridium difficile (C. Diff.) (C. Diff is an intestinal bacteria causing infectious diarrhea.)  The nursing care plan for Patient #1 failed to provide a plan or interventions for a patient found positive for C. Diff. and placed on contact isolation precautions.  c. A progress note, by the medical physician, dated 9/22/14 and untimed, documented " She does have a left foot contracture that might benefit from therapies ... "	A 396			

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A 396	Continued From page 65 The nursing plan of care for Patient #1 did not identify or include interventions for contracture of the left foot.  d. Patient #1's record also included a "Nutritional Care Plan" form, undated and untimed, initiated by a registered dietician (RD.) She recommended that Patient #1 receive a regular diet, PRN snacks and a dietary supplement if meals were refused. The form also documented the following goals for Patient #1: "...consume 75% of meals and maintain a weight between 98-132 pounds." Directions to obtain weekly weights were included as well.  Patient #1's nursing plan of care did not identify, or include interventions, to address nutritional needs.  During an interview on 10/02/14 beginning at 2:00 PM, the DON reviewed Patient #1's record and confirmed the care plans were not updated to include her changing needs and changes in treatment goals.	A 396		
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A 397	482.23(b)(5) PATIENT CARE ASSIGNMENTS  A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available.  This STANDARD is not met as evidenced by: Based on record review, policy review, and staff	A 397	Please refer to A144 and A395 for P.O.C.	11/12/14
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A 397	<p>Continued From page 66</p> <p>interview, it was determined the facility failed to ensure nursing assignments were based on staff competency and patients' needs for 1 of 6 patients (#1) whose record was reviewed. This failure resulted in the failure to ensure a sterile dressing change was performed, inadequate assessment, and poor patient outcome. Findings include:</p> <p>1. Patient #1 was a 55 year old female admitted to the facility on 7/15/14, with the diagnoses of dementia with behavioral disturbance and unspecified psychosis.</p> <p>Patient #1's record documented her refusal to eat or drink, and she received IV hydration. A PICC was placed on 7/25/14 in her left forearm. (The acronym PICC describes a peripherally inserted central catheter, in which the tip of the catheter rests in a large vein close to the entrance of the heart. It allows a higher concentration of medications or IV fluids to be administered, whereas smaller veins could not tolerate the higher osmolarity of the solutions). According to Lippincott Manual of Nursing Practice, eighth edition, a PICC is considered a central line, and extra vigilance must be used to protect the integrity of the line and dressing. If the dressing has become dislodged, or the line has been pulled at any point, the placement must be confirmed, and a sterile dressing change must take place.</p> <p>The facility policy for PICC line care, revised 12/11, stated: "If PICC line is found to be torn, loose, damp, soiled or raised, the nurse should..." and further describes a sterile dressing change. The policy also stated the nurse was to document findings and actions, and alert the PICC line team</p>	A 397			

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A 397	<p>Continued From page 67 of findings. The policy noted the dressing is to be changed 24 hours after insertion and every 7 days if intact.</p> <p>During the time that Patient #1's care was provided by an LPN, her PICC line and dressing became dislodged, a sterile dressing change was not performed, placement was not determined, which resulted in cellulitis and a MRSA infection.</p> <p>In a nursing note 7/29/14 at 1:45 PM, Staff N, an LPN noted "Patient has PICC line patent to left forearm, it was noticed during lab draw that patient has lifted the dressing and pulled some of the line out."</p> <p>A verbal order, written by the above LPN, and signed by a physician, was dated 7/29/14 at 1:15 PM. The order noted "PICC line dressing to be changed daily. Watch for S/S (signs or symptoms) infection, monitor line placement."</p> <p>In a nursing note 7/29/14 at 7:09 PM, Staff N, the LPN, documented that when she removed the loose dressing, the PICC line was pulled out approximately 8-10 cm, and she covered the entire line that was exposed.</p> <p>In an RN progress note on 7/30/14 at 5:39 PM, the nurse wrote that Patient #1's left arm had redness surrounding the entire elbow area down the forearm, and it was tender to touch. She noted that the medical physician was notified, the PICC was removed, and the tip of the catheter was sent for culture.</p> <p>A lab result in the record noted the cultured PICC tip was positive for MRSA, and the facility was notified of the results on 8/01/14 at 3:01 PM. The</p>	A 397			

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A 397	Continued From page 68 report was reviewed and initialed by the medical physician and it was noted on the report that Patient #1's antibiotics were changed to treat the cellulitis and MRSA infection.  During an interview on 10/02/14 beginning at 2:00 PM, the DON reviewed Patient #1's record and stated she was called in to see the loose dressing on 7/29/14 around 1:30 PM. She stated the LPN did not perform a sterile dressing change, but applied an occlusive dressing over the line that had been disrupted. The DON stated she instructed the LPN to contact the physician for orders. The DON stated the policy of the facility is that PICC line dressings are to be monitored and changed by the RNs and not LPNs. Further, the DON confirmed an X-Ray was not performed for verification the PICC line was positioned properly before resuming IV fluids and medication administration.	A 397	We have reviewed our policies and procedures in the area of drug administration and made the following updates:		
{A 405}	The facility failed to ensure an RN performed a sterile dressing change when Patient #1's PICC line and dressing was disrupted. 482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS  (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice.  (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State	{A 405}	<ul style="list-style-type: none"> <li>• Wrist bands have been implemented that include the patient identifying information (i.e. Name, Date of Birth, and Allergies) for patient identification prior to medication administration.</li> <li>• The pharmacy will be responsible for splitting pills and packaging.</li> <li>• All nurses will be observed passing medications and competency tested on hire and annually.</li> <li>• Results of competency testing and medication error rates will be provided to the QAPI committee.</li> </ul> RN Administrative Nurses are responsible for compliance.	11/12/14	

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{A 405}	Continued From page 69 law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations.  (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.  This STANDARD is not met as evidenced by: Based on staff interview, policy review, and observation, it was determined the facility failed to ensure medications were properly dispensed and stored for 2 of 6 patients (#1 and #4) whose records were reviewed and medication administrations were observed. This failed practice resulted in the potential for errors in dosage, medication delivery, and possible adverse reactions. Findings include:  The National Institute of Health online resource defines the 5 rights of Safe Medication Administration as: 1. Right individual 2. Right medication 3. Right dose 4. Right time 5. Right route  The facility failed to follow the "5 Rights of Safe Medication Administration", as follows:  1. During an observation of medication administration on 9/29/14 beginning at 4:15 PM, the nurses were observed preparing and administering medications. The medication room	{A 405}			

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{A 405}	Continued From page 70 was located just off the main room of the unit. There was a binder for each patient that also included the MAR. Most of the binders included a black and white picture of the patient taped to the inside front cover of the binder. When the medications were ready to be administered, each nurse then left the medication room to give the medications to the patients.  Three nurses were observed to prepare and administer medications. Staff D, an LPN, was the only nurse observed that removed the patient binder, with the patient picture, from the medication room upon leaving. The 2 remaining nurses were observed leaving the medication room without a binder or a picture of the patient in their possession. Staff J and Staff K, both RN's, approached patients, stated their name, and gave the medications without verification of the identity of the patients.	{A 405}			
	During an interview on 10/02/14 beginning at 3:20 PM, the DON stated wristbands with patient name and information were not used in the facility. She stated some patients wore yellow wristbands, but they did not include allergy information or patient information, they were to indicate fall risk.  A hospital policy titled "Administration of Medications," revised September 2014, stated a picture of the patient must be placed in the MAR to ensure proper identification. However, the policy excluded patients who have refused to have their photo taken.  During an interview on 10/02/14 beginning at 3:20 PM, the DON reviewed and confirmed the medication administration policy. She stated				

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{A 405}	Continued From page 71 many of the patients have been at the facility for an extended period of time, and confirmed the nursing staff should, but do not always, take the patient binder and photo out when dispensing medications. When questioned about another method to identify the patient prior to administration of medications, she stated the policy did not include further options. The DON stated wristbands with patient name and information were not currently used in the facility. She stated some patients wore yellow wristbands, but they did not include allergy information or patient information, they were to indicate fall risk.  The facility failed to ensure the proper identity of the patient prior to administering medication.  2. Nursing staff halved and stored open medications to be dispensed at a later time.	{A 405}		
	Six patients' MARs were reviewed along with their medical records. The MARs of Patients #2 and #4 were noted to include documentation of medication ordered that was 1/2 of the amount of the medication that was supplied. The documentation by the nursing staff noted the medications were split and stored in an open container to be used at a later time.  During an interview on 9/30/14 at 11:15 AM, Staff D, an LPN, stated "Sometimes staff will half the pills and save the rest for the next dose." The LPN stated the broken medication would be returned to the open original packaging, stored in a dispenser cup, and placed in the patient's medication bin.  a. Patient #4 was a 66 year old male admitted to the facility on 8/14/14. His MAR was reviewed			

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{A 405}	<p>Continued From page 72 and the following was noted:</p> <p>- Spironolactone 12.5 mg twice daily. It was ordered upon his admission 8/14/14, and he was on the same dose during the time of the survey.</p> <p>The back of each MAR indicated the medications were opened, broken in half, and either stored to be administered later or discarded. Entries on the back of the MAR included such comments as "1/2 saved for next dose," "1/2 used, 1/2 wasted," "1/2 of above given," "used 1/2 tab found in med cart," and "1/2 used at 8:00 and 1/2 used at 5:00."</p> <p>Between 8/14/14 and 9/29/14, the MAR showed 58 entries in which the partial tablet of aldactone was wasted, stored for later use, or given.</p> <p>- Glyburide 2.5 mg daily. It was ordered upon his admission 8/14/14, and he was on the same dose during the time of the survey.</p>	{A 405}			
	<p>The back of the MAR indicated Glyburide 5 mg tablets were broken to administer a dose of 2.5 mg. The MAR included 35 entries between 8/14/14 and 9/29/14, where the Glyburide broken tablets were stored, administered, or discarded.</p> <p>During an interview on 9/30/14 at 3:30 PM, the Pharmacist stated "There are a few occasions when the pharmacy supplies medications in a particular dose, and the nurse must split the medications. They can split them and use the remaining dose at a later time. This most often occurs when I am off for the weekend, or on vacation, never more that a couple of days." He further stated that when he notices the medications are supplied in a dose other than what has been prescribed, he will go ahead and</p>				

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{A 405}	Continued From page 73 split the doses and repackage them. He reviewed Patient #4's record and confirmed the two drugs that were supplied in a larger dose and split by the nursing staff had occurred for greater than a month. He stated that was an acceptable practice.  According to the Institute for Safe Medication Practices online resource, "... some medications should not be split because they are specially coated to be long-acting or to protect the stomach. Also, if the tablets aren't split evenly, the patient might not be getting the exact dose."  During an interview on 10/02/14 beginning at 2:00 PM, the DON stated medications are to be discarded once they were opened and halved. She stated the staff has been instructed to discard the medication, and not save the remainder for another dose. She reviewed Patient #4's MAR and confirmed the 58 entries of Aldactone that was wasted, stored, or given. She then confirmed the 35 entries of Glyburide that was wasted, stored, or given.  b. Patient #1 was a 55 year old female admitted on 7/15/14. Her MAR was reviewed and the following was noted:  Flagyl 250 mg three times daily for 10 days was ordered on 7/28/14 for a diagnosis of C-Diff infection. The drug was supplied in 500 mg tablets. Her MAR documented on 15 occasions between 7/28/14 and 8/06/14, Flagyl was split, stored in the drawer for administration at a later time, wasted, or pulled from the drawer to be given.  During an interview on 10/02/14 beginning at 2:00	{A 405}			

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{A 405}	Continued From page 74 PM, the DON reviewed Patient #1's MAR and confirmed the doses of Flagyl were split and saved to be administered later. She stated she did not know this practice was still occurring, and did not see that when she audited patient records. The DON stated the policy for medication administration did not include direction for splitting medications and using the remainder at a later time.	{A 405}		
{A 454}	The facility did not follow safe medication delivery practices with administration and storage. 482.24(c)(1) CONTENT OF RECORD: ORDERS DATED & SIGNED  All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.  This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview it was determined the facility failed to ensure medication and treatment orders were signed, dated, and authorized by practitioners in a timely manner. This resulted in the potential for medication and treatment being provided to patients without the order of a practitioner.  1. Patient #5 was a 61 year old male admitted to the facility on 9/11/14, with diagnoses of schizophrenia, dementia with behavioral disturbance, and psychosis. Patient #5's record indicated he was transferred from an ALF due to	{A 454}	We have reviewed our policies relating to medication orders. The policy now states that all verbal orders obtained by an R.N. from a provider must be read back to the provider and verified to ensure the verbal order is correct. The verbal order written on the physician (green) sheet with state "read and verified" or "R & V." Verbal orders with R & V need to be signed by the Provider within 30 days from the last date of service. Orders that are identified as not having R & V must be verified and signed by the provider within two business days. Nursing and Medical staff have been educated as to their roles and responsibilities relating to these processes on November 4, 10, and 11, 2014 by Administrator, Director of Nursing, or R.H.I.T.  Medical records will conduct ongoing audits to ensure policies and processes are followed. These audits will be presented and reviewed in the monthly Q.A.P.I. meeting and quarterly at Medical Executive Committee.  RN Administrative Staff and RHIT are responsible for compliance.	11/2/14

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{A 454}	Continued From page 75 frequent falls and aggressive behaviors.  Patient #5's record was reviewed which contained a form Doctor's Orders and Progress Notes, on which several verbal and telephone orders were documented. The orders were written by the licensed staff at the time they received the order. The verbal and telephone orders were not signed, dated, and timed by the prescribers on the following dates: 9/17/14, 9/18/14, 9/19/14, 9/20/14, 9/26/14, and 9/27/14.  The facility's Administration of Medications policy, revised September 2014, stated that verbal/telephone orders were to be authenticated, dated, and timed by the prescriber within 48 hours in accordance with the medical staff rules and regulations.  During an interview on 10/02/14 beginning at 3:20 PM, the DON confirmed the frequency of the verbal and telephone orders. She also confirmed the verbal and telephone orders were not signed within 48 hours per the policy.	{A 454}		
A 467	The facility failed to ensure verbal and telephone orders were signed, dated, and authenticated in a timely manner per their policy. 482.24(c)(2)(vi) CONTENT OF RECORD: ORDERS, NOTES, REPORTS  [All records must document the following, as appropriate:] All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.	A 467	Patient 5 is discharged.  We have reviewed our policies with regards to documentation and no changes are required. However, we have reinforced our policies with education by Director of Nursing by October 15, 2014.  We are currently conducting audits to ensure documentation and providing educational encounters to ensure compliance with this citation.  RN Administrative Staff is responsible for compliance.	11/2/14

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A 467	Continued From page 76  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure documentation was accurate and included in the record for 1 of 6 patients (#5) whose records were reviewed. This resulted in the lack of ability for those providing care, to properly monitor the patient's changing condition and needs. Findings include:  Patient #5 was a 61 year old male admitted to the facility on 9/11/14, with diagnoses of schizophrenia, dementia with behavioral disturbance, and psychosis. Patient #5's record indicated he was transferred from an ALF due to aggressive behaviors.  Patient #5's record was reviewed and contained a form for snack/meal/fluid output, which was used for a one week period that began on Tuesday and ended on Monday. This form had areas for daily monitoring of weight, food consumption, fluid intake and output, bowel movements, showering, and total hours of sleep.  The first form, for Patient #5, began Thursday 9/11/14 on the date of his admission. A total of 5 days were completed for that week ending 9/15/14, the following Monday. On the second week of his admission, the same form was completed for the first 2 days, 9/16/14 Tuesday and 9/17/14 Wednesday. However, no data was documented for the remainder of the week. A request was made to the RHIT director to copy these forms in Patient #5's record on 9/30/14. On 10/01/14 at 3:00 PM, Patient #5's record was reviewed again. The form with dates beginning	A 467			

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A 467	Continued From page 77 9/16/14, was completed for the remainder of that week  Additionally, on 10/01/14 Patient #5's record included completed forms for the following two weeks, 9/23/14 - 9/29/14 and 9/30/14 - 10/06/14. The form for the current week, starting 9/30/14, had information completed for 9/30/14 and 10/01/14. These forms and data were not present in Patient #5's record on 9/30/14 when copies were originally requested.  During an interview on 10/02/14 beginning at 2:45 PM with the DON, the record was reviewed. She confirmed the original copies of the form obtained on 9/30/14 and compared them to the forms that were in the record. The DON said she could not explain how all of the forms were not originally in the record. She also could not explain how the form dated 9/16/14 to 9/22/14 was completed in the preceding two days, after the original copies were made.	A 467			
A 747	Patient #5's information was not documented in his record appropriately in order to monitor his condition. <b>482.42 INFECTION CONTROL</b>  The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.  This CONDITION is not met as evidenced by: Based on observation, staff interview, review of medical records, and infection control logs, it was	A 747	Please refer to A748 and A749 for our plan of correction.	11/12/14	

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A 747	Continued From page 78 determined the hospital failed to ensure a trained IC officer provided oversight of the IC program, and that an active program was in place to track, trend, and analyze infections and infection control practices in the facility. This had the potential for patients to develop infections that could have been prevented. Findings include:  1. Refer to A748 as it relates to the lack of program oversight and direction by a trained IC officer.  2. Refer to A749 as it relates to the failure to investigate, identify trends, and educate staff regarding infection control practices.  The cumulative result of these systemic deficient practices resulted in increased opportunities for patients to acquire infections.	A 747	Mountain View Center for Geriatric Psychiatry has contracted with a trained Infection Control Officer to provide oversight of the Infection Control program and to give guidance in developing a comprehensive Infection Control program. This will be ongoing until Mountain View has a certified Infection Control Officer. Part of the Contracted Infection Control Officer oversight will be to help investigate, identify trends for infection(s), and provide Infection Control education.  With the guidance of the contracted trained Infection Control Officer, policies and procedures governing the control of infections and	11/12/14	
A 748	482.42(a) INFECTION CONTROL OFFICER(S)  A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases.  This STANDARD is not met as evidenced by: Based on staff interview, and review of hospital policies, and IC logs, it was determined the hospital failed to ensure the appointment of a trained Infection Control Officer. This resulted in the failure of the facility to perform surveillance activities, an inability to evaluate and trend results of infections occurring in the facility, and implement education and training to staff. Findings include:	A 748	communicable diseases will be updated. Policies and Infection Control logs will be put in place to perform weekly surveillance activities and evaluate trends in infections within the hospital.  The contracted trained Infection Control Officer will help update policies and procedures that are evidence based and follow the guidelines from the Association for Professionals in Infection Control and Epidemiology (A.P.I.C.) and The Centers for Disease Control and Prevention (C.D.C.). A Registered Nurse (R.N.) from Mountain View has		

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A 748	Continued From page 79 During a phone interview on 10/07/14 at 3:00 PM, the DON introduced an RN as the Staff Educator and Infection Control Officer. Initially, the DON said the facility did not follow national guidelines for infection control. She referred to a policy initiated by the Long Term Care facility the hospital was affiliated with, and stated the policy for infection control was developed with CMS and LTC guidelines in 2010. When questioned further, the DON stated the facility used CDC guidelines. The DON and IC Officer stated they did not have formal infection control training, and the corporate level of the organization had recently paid for a self study course. They stated the self study course had not yet been taken, and a test was required afterwards to obtain credit. The DON confirmed the facility did not have a trained infection control practitioner.  The facility did not have a trained infection control officer.	A 748	been named as the Infection Control Officer and is in the process of becoming a credentialed Infection Control Officer. The R.N. once completed will obtain a Certification in Infection Prevention and Control or (C.I.C.) credential. Once this credential has been obtained the Mountain View Infection Control Officer will function independently with guidance and oversight from the contracted trained Infection Control Officer as needed.  Infection Control logs have been developed to trend and identify infections upon admissions and those that are acquired in the hospital. The Infection Control logs will identify the site of the infection (such as cellulitis right foot, MRSA site, Foley catheter, PICC, etc). Further, the hospital will track Foley catheter days, Foley catheter days related to infections, and identify central line/blood stream infections. Communicable diseases as defined by the C.D.C. and the Local Health Department will be investigated and reported to South Central Community Health.	
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM  The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.  This STANDARD is not met as evidenced by: Based on observation, staff interview, review of patient medical records, and IC logs, it was determined the hospital failed to ensure an active program was in place for the prevention, control, and investigation of infections and communicable diseases. This resulted in the failure to investigate, identify trends, and educate staff	A 749	Audits will be conducted on all charts within 72 hours of admission to determine whether or not an infection	11/12/14

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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
A 749	Continued From page 80 regarding infection control practices. Findings include:  The IC logs for June, July and August were reviewed. The logs included patient names, dates of admission, type of infection, when it occurred, type of medication ordered, and if the patient was placed in isolation. The following data was obtained from the IC logs:  June 2014: 16 infections, (2 skin, 10 UTI, 2 URI, 1 eye, 1 other), with 500 patient days. The IC log noted the percentage of nosocomial infections was noted as 1.4%.  July 2014: 11 infections, (2 skin, 5 UTI, 1 URI, 3 other), with 497 patient days. The IC log noted the percentage of nosocomial infections was noted as 1.2%.  August 2014: 16 infections (4 skin, 7 UTI, 2 URI, 3 other), with 510 patient days. The IC log noted the percentage of nosocomial infections was noted as 1.2%.  The logs did not include information regarding the site of the infection (such as cellulitis right foot, MRSA cultured from wound on face, foley, PICC line, etc).  During a phone interview on 10/07/14 beginning at 3:00 PM, the DON reviewed the IC logs and confirmed there was no indication if the 22 UTI's were related to catheter insertion or other means. She confirmed the site of infection was not identified. She described her method of obtaining the percentage rates, and stated the facility historically had a low infection rate. The DON stated that after the infections have been	A 749	was present upon admission.  The hospital will investigate infections that are hospital acquired. This process includes an initial assessment by the R.N. identifying signs and symptoms of an infection. The R.N. will fill out an Infection Control Report that gathers specific information pertaining to a suspected infection in a patient. This information is then shared with the provider to ensure appropriate treatment is provided to the patient. The Infection Control Officer will gather and ensure appropriate follow-up (i.e. documentation on Infection Control Log, Diagnostic Tests completed, appropriateness of Antibiotic per results of diagnostic test, educate staff about potential trends, issues, or concerns in regard to infection control practices).  The Infection Control Officer will hold an Infection Control meeting on a monthly basis to ensure a comprehensive Infection Control Program.  The Infection Control Officer will be auditing in the following areas to ensure compliance: Infection Control Program Audit (monthly), Urinary Catheter Audit (weekly when one is present), Staff practices audit	

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A 749	Continued From page 81 recorded on the IC log, there was no causal analysis, or source tracking completed. She stated the facility did not monitor for foley catheter days related to infections, or identify central line/blood stream infections.  The DON stated the IC log information was discussed at QAPI meetings, and as the percentage rate of infections have been within acceptable range, no further investigation activities were conducted. She stated the established goal was for 10% or less of patients to develop nosocomial infections while hospitalized. The DON was unable to describe how the 10% goal was determined as acceptable for the facility.  These systemic problems resulted in the hospital's inability to ensure a process in which patients were protected from infections.	A 749	(weekly), Infection Control Program Documentation Audit (On admission and when a new infection is noted), Cleaning and Disinfection (two times a month unless a trend has been noted which would indicate to increase the frequency).  The Infection Control Officer will now track and trend employee illnesses to help identify, report, investigate, and control infections within Mountain View. Polices and Procedures have been developed and implemented that address and trend infection control issues related to employee illness.  Any trends that are identified the appropriate staff members and/or departments will be in-serviced by the Infection Control Officer about the deficient practice.  The outcomes of audits and reports from the Infection Control Officer will be reported to the Q.A.P.I Committee on a monthly basis and to the Medical Executive Committee on a Quarterly basis.  Infection Control Officer is responsible for compliance.		
A1132	482.66(b) DELIVERY OF SERVICES  Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws.  This STANDARD is not met as evidenced by: Based on review of records and staff interviews,	A1132			

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A1132	Continued From page 82 it was determined the facility failed to ensure OT services were provided under the orders of a practitioner responsible for the care of the patient, for 3 of 6 patients (#1-3) who received OT services. This had the potential to result in lack of physician input and unmet patient needs. Findings include:  1. Patient #2 was a 65 year old male admitted to the facility on 7/11/14, with diagnoses of dementia with behavioral changes, and psychosis. Patient #2's record indicated he had been admitted from his home where he was cared for by his wife.  Patient #2's record included physician admission orders written and signed by the admission nurse on 7/10/14, and signed by the Medical Director on 7/12/14. They included an order for OT to evaluate and treat.	A1132	Our policies have been updated to provide for therapy orders and treatment plans to be reviewed and authenticated by our physicians. The weekly treatment plan meeting will review these plans and orders.  Results of the audits and compliance will be presented to Q.A.P.I. on a monthly basis and quarterly to Medical Executive Committee.  RHIT and/or designee are responsible for compliance.	11/2/14	
	Patient #2's record also included an OT evaluation, completed and signed by the Occupational Therapist on 7/11/14. The evaluation included a plan of care with activities and goals. However, the plan of care was not signed by the physician and there was no documentation to indicate the plan of care was approved by the physician.  Patient #2's record included OT weekly progress notes for 10 weeks, however the evaluation stated OT services would be provided 4 times a week for 4 weeks.  During an interview on 10/02/14 at 9:10 AM, the Occupational Therapist stated the Medical Director usually signed the OT orders once they were placed in the record, however, it was not her practice to discuss the plan of care with the				

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A1132	<p>Continued From page 83</p> <p>physician. She stated she was in the process of revising the OT program for the hospital, and she was not aware of a regulation regarding physician orders for the OT plan of care.</p> <p>Patient #2's OT plan of care was not provided under the orders of a physician.</p> <p>2. Patient #3 was a 61 year old male admitted to the facility on 9/04/14. His diagnoses include dementia, psychosis, multiple falls, multiple fractures, chronic pain, frequent night time urination, and an enlarged prostate. His H&amp;P documented he was transferred from an ALF for increasing agitation, verbal and physical aggression, and frequent falls.</p> <p>a. Patient #3's record contained physician admission orders written and signed by the admission nurse on 9/03/14, and signed by the Medical Director on 9/06/14. They included an order for an Occupational Therapist to evaluate and treat.</p> <p>Patient #3's record also included an OT evaluation, completed and signed by the Occupational Therapist on 9/05/14. The evaluation included a plan of care with activities and goals. However, the plan of care was not signed by the physician and there was no documentation to indicate the plan of care was approved by the physician.</p> <p>The record included OT weekly progress evaluations for two weeks, however the evaluation stated OT services would be provided 4 times a week for 4 weeks.</p> <p>Patient #3's OT plan of care was not provided</p>	A1132			

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A1132	Continued From page 84 under the order of a physician.  b. Patient #3's record contained an order for a PT consult to assess his physical independence with cares, which was written and signed by the NP on 9/16/14.  The record included a PT evaluation, completed and signed by the Physical Therapist on 9/18/14. The evaluation included a plan of care with interventions, goals, and functional levels. The Physical Therapist also documented the goals and treatment plan were discussed with the patient, family, and staff. However, the plan of care was not signed by the physician or NP and it was not documented the plan of care was approved by the physician or NP. Patient #3's record included 2 additional visits documented by the Physical Therapist, on 9/19/14 and 9/22/14.	A1132			
	During an interview on 10/02/14 beginning at 9:55 AM the Occupational Therapist was on the phone with the Physical Therapist and the chart was reviewed. The Physical Therapist was unaware the plan of care was not signed by the physician or NP. She confirmed the plan of care was discussed with staff but not with the physician or NP.  Patient #3's PT plan of care was not provided under the care of a physician or NP.  3. Patient #1 was a 55 year old female admitted to the facility on 7/15/14, with diagnoses of dementia with behavioral disturbance, and unspecified psychosis. She was discharged to a long term care facility on 9/30/14.  Patient #1's record included physician admission				

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A1132	<p>Continued From page 85</p> <p>orders written and signed by the admission nurse on 7/15/14, and signed by the Medical Director on 7/19/14. They included an order for OT to evaluate and treat.</p> <p>Patient #1's record also included an OT evaluation, completed and signed by the Occupational Therapist on 7/15/14. The evaluation included a plan of care with activities and goals. However, the plan of care was not signed by the physician and there was no documentation to indicate the plan of care was approved by the physician.</p> <p>Patient #1's record included OT weekly progress notes for 7 weeks, however the evaluation stated OT services would be provided 4 times a week for 4 weeks.</p> <p>During an interview on 10/02/14 beginning at 9:10 AM, the Occupational Therapist stated the Medical Director usually signed the OT orders once they were placed in the record, however, it was not her practice to discuss the plan of care with the physician. She stated she was in the process of revising the OT program for the hospital, and she was not aware of a regulation regarding physician orders for the OT plan of care.</p> <p>Patient #1's OT plan of care was not provided under the orders of a physician.</p>	A1132			

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(B 000)	16.03.14 Initial Comments	(B 000)		
BB014	16.03.14.014 Drug Administration  An act in which a single dose of a prescribed drug or biological is given to a patient by an authorized person in accordance with laws and regulations governing such acts. The complete act of administration entails the removal of an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying the drug and dosage with the practitioner's orders, administering dose to the proper patient, and immediately recording the time and amount given. This Rule is not met as evidenced by: Refer to A405	BB014	Refer to A406	11/12/14
BB152	16.03.14.250.09 Medical Orders  09. Medical Orders. Written, verbal and telephone orders from persons authorized to give medical orders under Idaho law shall be accepted by those health care practitioners empowered to do so under Idaho law and written hospital policies and procedures. Verbal and telephone orders shall contain the name of the person giving the order, the first initial and last name and professional designation of the health care practitioners receiving the order. The order(s) shall be promptly signed or otherwise authenticated by the prescribing practitioner in a timely manner in accordance with the hospital's policy. (5-3-03)  This Rule is not met as evidenced by: Refer to A454	BB152	Refer to A454	11/12/14

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*[Signature]* WBA/HCM

TITLE  
Administrator

(X6) DATE  
11/4/14

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BB174 BB174	Continued From page 1 16.03.14.310.02 Records  02. Records. Nurses shall maintain records that document patient status, progress and care given using descriptive measurable data. This documentation shall include but not be limited to: (10-14-88)  a. Admission note; and (10-14-88)  b. Vital signs; and (10-14-88)  c. Medication record; and (10-14-88)  d. Rationale for and results of PRN drug administration; and (10-14-88)  e. Patient teaching; and (10-14-88)  f. Adverse drug or blood reaction; and (10-14-88)	BB174 BB174	Refer to A467	11/12/14
BB175	g. Discharge note. (10-14-88)  This Rule is not met as evidenced by: Refer to A467  16.03.14.310.03 Patient Care Plans  03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: (10-14-88)  a. Nursing care treatments required by the patient; and (10-14-88)  b. Medical treatment ordered for the patient; and (10-14-88)	BB175	Refer to A396	11/12/14

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BB175	Continued From page 2  c. A plan devised to include both short-term and long-term goals; and (10-14-88)  d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88)  e. A description of socio-psychological needs of the patient and a plan to meet those needs. (10-14-88)  This Rule is not met as evidenced by: Refer to A396	BB175		
BB226	16.03.14.330.06 Safe Handling of Drugs  06. Safe Handling of Drugs. In addition to the rules listed below, written policies and procedures which govern the safe dispensing and administration of drugs shall be developed by the pharmacy and therapeutics committee with the cooperation and the approval of the medical staff. (10-14-88)  a. The pharmacist shall review the prescriber's original order or a direct copy thereof; and (10-14-88)  b. The pharmacist shall develop a procedure for the safe mixture of parenteral products; and (10-14-88)  c. All medications shall be administered by trained personnel in accordance with accepted professional practices and any laws and regulations governing such acts; and (10-14-88)  d. Each dose of medication administered shall be properly recorded as soon as administered in the patient's medication record which is a separate	BB226	Refer to A405	11/02/14

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BB226	Continued From page 3 and distinct part of the patient's medical record; and (10-14-88)  e. Drug reactions and medication errors shall be reported to the attending physician and pharmacist in accordance with hospital policy. (10-14-88)  This Rule is not met as evidenced by: Refer to A405	BB226		
BB272	16.03.14.360.01 Medical Records Service, Facilities  360. MEDICAL RECORDS SERVICE. The hospital shall maintain medical records that are documented accurately and timely, and that are readily accessible and retrievable. (12-31-91)  01. Facilities. The hospital shall provide a medical record room, equipment, and facilities for the retention of medical records. Provision shall be made for the safe storage of medical records. (10-14-88)  This Rule is not met as evidenced by: Refer to A467	BB272	Refer to A467	11/12/14
BB455	16.03.14.470.02 Patient Treatment Plan  02. Patient Treatment Plan. Patient's records shall reflect that an individualized plan of treatment is developed for each patient which is specific and appropriate to individual problems and takes into consideration strengths as well as disabilities. The plan shall designate the persons responsible for each component of care and shall be reviewed, evaluated, and updated at regularly scheduled intervals by all professional personnel	BB455	Refer to A396	11/12/14

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BB455	Continued From page 4 involved in the patient's care. (10-14-88)  This Rule is not met as evidenced by: Refer to A396	BB455		
BB458	16.03.14.470.05 Patient's Rights  05. Patient's Rights. Written Policies and procedures shall be developed regarding patient's rights. (10-14-88)  a. Use of any form of physical restraint, forced treatment, chemical restraint or seclusion shall only occur in circumstances where there is established written policy and approved procedures to warrant such action and/ or is ordered by a physician; and (10-14-88)  b. Each patient shall be allowed to communicate with persons outside the facility, except where excluded or limited in accordance with his comprehensive treatment plan. (10-14-88)  c. Each patient shall be apprised of his rights. (10-14-88)  This Rule is not met as evidenced by: Refer to A115, A144, A160, and A164	BB458	Refer to A115, A144, A160 and A164	11/12/14
BB459	16.03.14.470.06 Records  06. Records. Adequate and comprehensive records shall be retained for assessment, evaluation and treatment purposes. Admitting and subsequent psychiatric diagnoses shall be recorded in currently accepted terminology; and (10-14-88)	BB459	Refer to A130 and A131	11/12/14

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BB459	<p>Continued From page 5</p> <p>a. The patient's psychiatric history and social evaluation shall provide information regarding the patient's background, the onset and development of the illness, including factors and precipitating circumstances that led to the patient's admission, and data useful for patient care and discharge planning; and (10-14-88)</p> <p>b. A properly executed consent form shall be obtained and incorporated into the record in any case of treatment approach that carries significant risks, and shows that the patient, his family, or other legally responsible person is informed of available alternative approaches; and (10-14-88)</p> <p>c. Documentation shall show that the patient, his family, or other legally responsible person is informed of the treatment to be given; and (10-14-88)</p>	BB459		
BB539	<p>d. Documentation shall show that planning for continued care and treatment in the community are coordinated with the patient's family and others in his social environment. (10-14-88)</p> <p>This Rule is not met as evidenced by: Refer to A130 and A131</p> <p>16.03.14.540.02 Infection Control Program</p> <p>02. Infection Control Program. The program shall include at least the following elements: (10-14-88)</p> <p>a. Definition of nosocomial infection, as opposed to community acquired infections; and (10-14-88)</p> <p>b. A procedure for hospital surveillance of and for</p>	BB539	Refer to A747	11/12/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>10/06/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>
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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
BB539	Continued From page 6 nosocomial infections; and (10-14-88)  c. A procedure for reporting and evaluating nosocomial infections. The procedure must enable the hospital to establish the following on at least a quarterly basis: (10-14-88)  i. Level or rate of nosocomial infections; and (10-14-88)  ii. Site of infection; and (10-14-88)  iii. Microorganism involved. (10-14-88)  This Rule is not met as evidenced by: Refer to A747	BB539		
BB541	16.03.14.540.04 Infection Control Committee Responsibilities  04. Infection Control Committee Responsibilities. The infection control committee shall be responsible for at least the following: (10-14-88)  a. Designate one (1) person to act as the surveillance officer; and (10-14-88)  b. Evaluating antibiotic susceptibility/resistance trends; and (10-14-88)  c. Review of all infection control procedures for all departments, including housekeeping and laundry procedures, at least annually; and (10-14-88)  d. Development of procedures for defining and controlling hazardous and infectious wastes; and (10-14-88)  e. Continuing education for all appropriate	BB541	Refer to A748	11/2/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  134014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  R-C 10/06/2014
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NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW CENTER FOR GERIATRIC PS	STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341
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BB541	Continued From page 7 personnel. (10-14-88)  This Rule is not met as evidenced by: Refer to A748	BB541		



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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December 10, 2014

Charles Lloyd, Administrator  
Mountain View Center For Geriatric Psychiatry  
500 Polk Street East  
Kimberly, ID 83341

Provider #134014

Dear Mr. Lloyd:

On **October 6, 2014**, a complaint survey was conducted at Mountain View Center For Geriatric Psychiatry. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00006668**

**Allegation #1:** Patients demonstrated rapid decline in motor and verbal skills after admission.

**Findings #1:** An unannounced visit was made to the hospital on 9/29/14-10/02/14. Six medical records were reviewed. Patients were observed. Staff were interviewed.

One medical record documented a 65 year old male who was admitted to the hospital on 7/11/14 with a diagnosis of dementia with behavioral changes and psychosis.

Documentation completed on the day of his admission, including an admission progress note and initial assessment history completed by an RN, indicated the patient was able to ambulate without assistance. Progress notes completed by the nursing staff during the first 2 weeks of his admission indicated he continued to walk around the unit. However, a decline in his motor skills was noted approximately 2 weeks after his admission. A progress note completed by an LPN on 7/26/14, stated he required assistance with transfers due to an unsteady gait. A progress note completed by an RN on 7/28/14, stated he was unable to walk. On 7/30/14, an RN documented he was using a wheelchair for mobility. The patient's record did not indicate interventions were initiated to address his decline in motor skills.

Documentation completed on the day of his admission, including an admission progress note completed by a Nurse Practitioner and an initial assessment completed by an Occupational Therapist, indicated the patient had good verbal skills and was able to make his needs known. Progress notes completed by nursing staff on 7/14/14 and 7/18/14, noted the patient had phone conversations with his wife. However, a decline in his verbal skills was noted beginning 10 days after his admission. Progress notes completed by nursing staff on 7/21/14 and 7/24/14, noted he was unable to answer questions or make his needs known. The patient's record did not indicate interventions were initiated to address his decline in verbal skills.

The Director of Nurses was interviewed on 10/02/14 at 2:50 PM. She stated the patient's decline was noticed by facility nursing staff but no physician orders were received to implement interventions to address his decline, or prevent further decline. She confirmed there was no documentation to indicate there was communication between the nursing staff and the physicians regarding his decline in motor and verbal skills.

The hospital did not take actions to protect the patient from rapid decline in motor and verbal skills. A deficiency was cited at 42 CFR Part 482.13 related to the failure of the hospital to keep the patient safe.

**Conclusion#1:** Substantiated. Federal and State deficiencies related to the allegation are cited.

**Allegation #2:** Patient had significant weight loss after hospital admission.

**Findings #2:** An unannounced visit was made to the hospital on 9/29/14-10/02/14. Six medical records were reviewed. Patients were observed. Staff were interviewed.

One medical record documented a 65 year old male who was admitted to the hospital on 7/11/14, with a diagnosis of dementia with behavioral changes and psychosis.

The patient experienced a weight loss of 44 pounds from 7/11/14 to 9/28/14. A nutritional risk assessment completed by the registered dietician on 7/14/14, stated he was at high risk for unintended weight loss and malnutrition based on his current intake. The next dietician note was dated 8/04/14, and indicated he had lost 21 pounds in 24 days. However, the patient's record did not indicate interventions had been initiated to address his weight loss.

The patient's record included a dietician note dated 8/11/14, stating she would alert his physician to his weight loss and inadequate intake. However, there was no documentation in his record to indicate his physician was notified of his weight loss.

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December 10, 2014  
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A nursing care plan to address imbalanced nutrition was not implemented until 9/09/14, 62 days after his admission. His weight recorded on that day indicated a 38 pound weight loss since his admission to the facility.

The hospital did not take actions to protect the patient from weight loss and malnutrition. A deficiency was cited at 42 CFR Part 482.13 related to the failure of the hospital to protect the patient from inadequate nutrition.

**Conclusion#2:** Substantiated. Federal and State deficiencies related to the allegation are cited.

**Allegation #3:** Patient was taken off all pre-admission medications and given Haldol.

**Findings #3:** An unannounced visit was made to the hospital on 9/29/14-10/02/14. Six medical records were reviewed. Patients were observed. Staff were interviewed.

One medical record documented a 65 year old male who was admitted to the hospital on 7/11/14, with a diagnosis of dementia with behavioral changes and psychosis.

The patient's initial plan of care included an order to discontinue all of his current medications and begin a new medication, Haldol, an antipsychotic medication that works by changing the actions of chemicals in the brain.

The Nursing 2015 Drug Handbook contains dosing information for Haldol, and states elderly and debilitated patients should be started on 0.5 to 2 mg by mouth, 2 to 3 times a day, increasing the dose gradually as needed. However, the patient's initial plan of care included Haldol 10 mg, to be given by mouth 3 times a day.

The Nursing 2015 Drug Handbook also states that patients on a high dose of Haldol should be monitored for heart problems due to the risk of a heart rhythm disorder that can be seen on an EKG. However, an EKG was not ordered for the patient.

The Medical Director was interviewed on 10/06/14 at 9:30 AM. He stated that it was his standard practice to stop current medications at the time of admission. He stated he gave the patient an antipsychotic medication to control any aggressive behaviors he might exhibit. He stated he was treating anticipated behaviors. However, the patient's medical record did not document aggressive behaviors at the time of admission.

The hospital did not ensure that patients were not given potentially harmful medications without indication of a need for them. A deficiency was cited at 42 CFR Part 482.13 related to the failure of the hospital to protect the patient from unnecessary medication.

**Conclusion#3:** Substantiated. Federal and State deficiencies related to the allegation are cited.

**Allegation #4:** The family's requests regarding the patient's care were not followed.

**Findings #4:** An unannounced visit was made to the hospital on 9/29/14-10/02/14. Six medical records were reviewed. Patients were observed. Staff were interviewed.

One medical record documented a 65 year old male who was admitted to the hospital on 7/11/14, with a diagnosis of dementia with behavioral changes and psychosis. His record indicated his wife was his Durable Power of Attorney, and authorized to make medical decisions for him.

The patient's record included an admission progress note and an initial assessment history that were completed by an RN on the day of his admission. The progress note stated the patient did not know what day it was, where he was, or why he was in the facility. It also stated no family or guardian was present during the admission process.

The assessment history included sections related to social habits, sleep habits, activities of daily living, and history of falls in the last week. The sections were completed, however, it was unclear how the information was obtained, as there was no documentation to indicate his wife was contacted by phone to provide information about his recent history.

The Director of Nursing was interviewed on 10/02/14 at 2:50 PM. She confirmed his wife was not contacted at the time of admission to obtain information regarding his recent history, or to participate in the development of his plan of care.

The patient's record included a progress note completed by an LPN on 9/07/14. The note stated his wife called to request he be given a bath as he had a history of disliking showers. A progress note completed by an RN on 9/14/14, stated his wife called the previous night and provided information that he preferred to take baths. Another progress note completed by an RN on 09/14/14, stated the patient's wife called and again informed the staff that he preferred baths. She requested they be offered, as she believed it would decrease his agitation. However, the patient's care plan did not indicate he was to be offered a bath instead of a shower.

A Certified Psychiatric Technician was interviewed on 10/02/14. She stated she had given the patient a shower many times, and was scheduled to provide his shower that day. She stated she had not given or offered the patient a bath and had not been informed he should be offered a bath instead of a shower.

The Director of Nursing was interviewed on 10/02/14. She stated his wife's request for a bath should have been added to his care plan. She confirmed his care plan had not been updated to direct the staff to offer him a bath instead of a shower.

The hospital did not ensure the patient's authorized representative was involved in his plan of care. A deficiency was cited at 42 CFR Part 482.13 related to the failure of the hospital to ensure the patient's representative was allowed to participate in his plan of care.

**Conclusion#4:** Substantiated. Federal and State deficiencies related to the allegation are cited.

**Allegation #5:** The patient developed cellulitis while in the facility.

**Findings #5:** An unannounced visit was made to the hospital on 9/29/14-10/02/14. Six medical records were reviewed. Patients were observed. Staff were interviewed.

One medical record documented a 65 year old male who was admitted to the hospital on 7/11/14, with a diagnosis of dementia with behavioral changes and psychosis.

The patient's record indicated he was treated for cellulitis during his hospitalization. The documentation indicated the cellulitis was observed by the nursing staff and reported to his physician. Orders were obtained for antibiotics to treat the cellulitis. The patient's progress was monitored and the cellulitis resolved with treatment.

The patient's cellulitis was monitored closely and treated appropriately. No deficiencies were cited.

**Conclusion#5:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #6:** The patient was sleeping on a mattress on the floor.

**Findings #6:** An unannounced visit was made to the hospital on 9/29/14-10/02/14. Six medical records were reviewed. Patients were observed. Staff were interviewed.

One medical record documented a 65 year old male who was admitted to the hospital on 7/11/14, with a diagnosis of dementia with behavioral changes and psychosis.

During an observation of the patient's room it was noted his mattress was on the floor and several mats were in the room. His record was reviewed and it indicated the patient was in danger of falling out of his bed due to confusion. His record indicated his mattress was placed on the floor, surrounded by mats to prevent injury if he rolled off the mattress. His record indicated he was observed frequently by nursing staff when he was in his room.

The patient's mattress was placed on the floor for his safety, and he was monitored closely by the nursing staff. No deficiencies were cited.

**Conclusion#6:** Unsubstantiated. Lack of sufficient evidence.

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December 10, 2014  
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Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626, option 4. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



SUSAN COSTA  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

SC/pmt