



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7012 3050 0001 2125 6027

October 29, 2014

Robin J. Leary, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Ms. Leary:

On , a Recertification, Complaint Investigation and State Licensure survey was conducted at Life Care Center of Post Falls by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be **ISOLATED** deficiencies and to constitute immediate jeopardy to residents' health and safety. You were informed of the immediate jeopardy situations in writing on **October 15, 2014**.

On **October 20, 2014**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the residents had been removed. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction. The most serious deficiency now constitutes actual harm that is not immediate jeopardy and that is isolated in scope, as evidenced by the Form CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health

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deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 12, 2014**. Failure to submit an acceptable PoC by **November 12, 2014**, may result in the imposition of additional civil monetary penalties by **December 1, 2014**.

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

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

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

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

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

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Based on the immediate jeopardy cited during this survey;

F281 -- S/S: J -- 42 CFR §483.20(k)(3)(i) -- Services Provided Meet Professional Standards

We are recommending to the Centers for Medicare & Medicaid Services (CMS) Regional Office that the following remedies be imposed:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

A 'per instance' civil money penalty of **5,000.00**.
*(THIS REMEDY IS GENERALLY RESERVED FOR SITUATIONS OF SERIOUS
NONCOMPLIANCE AS DESCRIBED AT §7510) (§488.430)*

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 14, 2015**, if substantial compliance is not achieved by that time.

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

If you believe the deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

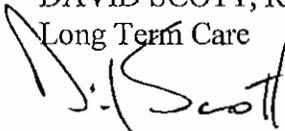
2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **November 12, 2014**. If your request for informal dispute resolution is received after **November 12, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

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

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

DS/dmj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/14/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF POST FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during an Annual Recerification and Complaint survey of your facility.</p> <p>This report reflects changes resulting from the December 18, 2014 Informal Dispute Resolution (IDR) process.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Becky Thomas, RN Linda Hukill Neil, RN Judy Atkinson, RN</p> <p>An IJ (Immediate Jeopardy) was identified at F281 and the facility was notified on 10/10/14 at 11:20 AM and during the exit conference on 10/14/2014. The facility submitted an acceptable Abatement Plan to the Bureau of Facility Standards on 10/20/14 at 9:38 AM. An onsite visit on 10/27/2014 confirmed the IJ was abated.</p> <p>The survey team entered the facility on 10/6/14 and exited on 10/14/14.</p> <p>Survey Definitions:</p> <p>ADLS = Activities of Daily Living BG = Blood Glucose and is used interchangeably with BS = Blood Sugar. c/o = complaint of CVA = Cerebrovascular Accident DNS = Director of Nursing Services ED = Executive Director FSBG = Finger Stick Blood Glucose HS = Bedtime snack LE = Lower Extremity</p>	F 000	<p>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p> <p style="text-align: right;">RECEIVED JAN 27 2015 FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

DATE (X6)

Robert Leary, Administrator

11-14-14 11/06/2014

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

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F 000	Continued From page 1 LUE = Left Upper Extremity mg/dl = milligrams per decaliter ORIF = Open Reduction Internal Fixation OT = Occupational Therapist Pt and pt = Patient PT = Physical Therapist PROM = Passive Range of Motion RNC = Regional Nurse Consultant r/t = related to Subq = Subcutaneous s/s = signs and symptoms TTWB = Toe Touch Weight Bearing	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of	F 164	F 164 SPECIFIC RESIDENTS Resident #16 and #26 MAR is kept closed when staff are not in attendance at the medication cart. OTHER RESIDENTS Residents who require assistance with medication administration will have their MAR's covered or closed when staff are not in attendance. SYSTEMIC CHANGES Licensed Nurses have been inserviced on ensuring medical record privacy. This included keeping the MAR's covered or closed when not in attendance at the medication cart.	11/14/14

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F 164	<p>Continued From page 2</p> <p>the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to maintain resident privacy and confidentiality of their personal information for 1 of 20 sampled residents (#16) and a Random Resident (#26). This failure created the potential for a negative effect on the residents' psychosocial well-being related to the need for privacy and confidentiality. Findings included:</p> <p>On 10/8/14 at 4:15 PM, LN #1 was observed to leave Resident #16's MAR on top of the medication cart in the 300 Hall in full view while she was in another resident's room. When LN #1 was asked about leaving the MAR open she stated, "I will fix it, I have been doing it for 30 years, nobody got me till now."</p> <p>On 10/9/14 at 10:55 AM, LN #2 was observed to leave Random Resident #26's MAR on top of the medication cart in the 300 Hall in full view and enter a resident's room. When LN #2 was asked about leaving the MAR open she stated, "I usually do like that (cover the MAR with a clipboard), I am sorry, I don't do good with people watching me."</p> <p>On 10/14/14 at 9:50 AM, the Administrator and DON were informed of the observation. No further information was provided regarding this issue.</p>	F 164	<p>MONITOR</p> <p>Medical Records Director and/or designee will perform direct observations of the medication books to ensure compliance. These observations will be completed weekly for a month, every other week for two months and monthly for three months.</p> <p>The results of the observations will be taken to the monthly QAPI meetings for analysis and action taken as indicated.</p>	

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F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined the facility did not ensure call lights were accessible for 1 of 20 sampled residents (#11) and 1 random resident (#27). Inability to access call lights placed the residents at risk to have unmet needs and a negative effect on their psychosocial well-being. Findings included:</p> <p>1. On 10/6/14 at 9:15 AM, during the initial tour of the facility with LN #3, Resident #27 was observed asleep, lying on her back, in her bed. The resident's call light was observed clipped to the call light wall mount. The surveyor asked LN #3 where the resident's call light was. The LN observed the call light's location and stated, "Not good."</p> <p>The surveyor asked LN #3 if the resident could reach her call light where it was clipped and/or if she could get out of bed to get to the call light. LN #3 stated, "No, [Resident's name] could not reach it and she can't get out of bed by herself."</p> <p>The LN removed the call light from the wall mount and clipped it on the bed within Resident #27's</p>	F 246	<p>F 246 SPECIFIC RESIDENTS</p> <p>Resident # 11 no longer resides at this facility.</p> <p>Resident #27's call light button is kept in a position accessible for her to call for assistance as needed.</p> <p>OTHER RESIDENTS</p> <p>Residents who utilize the call light to request help have it positioned so they have access to it.</p> <p>SYSTEMIC CHANGES</p> <p>Facility Staff was inserviced on the importance of assuring the call light button is accessible to the residents.</p> <p>Management staff will check call light placement during their floor rounds</p> <p>MONITOR</p> <p>Unit Mangers and/or designee will perform direct observations of call light placement to ensure compliance. The observations will be completed weekly for a month, every other week for two months and monthly for 3 months.</p>	11/14/14

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F 246	Continued From page 4 reach. 2. On 10/6/14 at 2:25 PM, Resident #11 was observed in her room, with her call light to the right side of the bed, in the dresser drawer. The surveyor interviewed CNA #4 regarding the call light location. CNA #4 indicated that the call light was on the resident. The CNA then stated, "It's in her drawer." The surveyor asked the CNA how Resident #11 would activate the call light if she needed help. CNA #4 stated, "It's my fault. I should have put it where she could reach it." On 10/8/14 at 6:25 PM, the Administrator and DON were informed of the concerns of the accessibility of call lights. No additional information was provided.	F 246	The results of observations will be taken to the monthly QAPI meeting for analysis and action taken as indicated	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280	F 280 SPECIFIC RESIDENTS Resident #10's care plan was updated to reflect current MD orders for catheter change. Resident # 16's care plan has been reviewed and up dated as indicated to ensure current fall prevention measures. OTHER RESIDENTS Residents that require the use of an indwelling catheter, care plan has been reviewed and up dated to match the specific physician orders.	11/14/14

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F 280	<p>Continued From page 5 each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to review and revise care plans for 2 of 13 sampled residents (#s 10 & 11). Resident #10's care plan did not contain accurate information of when to change the catheter. Resident #16's care plan was not revised after the resident fell and fractured her femur. This had the potential for harm if residents did not receive appropriate care due to lack of direction in the care plan. Findings included:</p> <p>1. Resident #10 was admitted to the facility on 5/29/14 with multiple diagnoses which included hemiplegia affecting non-dominant side (late effects of cerebrovascular disease).</p> <p>The October 2014 Physician Orders (recapitulation) documented, "Change s/p [suprapubic] cath every month and prn, non patency," with a start date of 5/30/14.</p> <p>The TAR (Treatment Administration Record) for the month of September 2014, documented to "change s/p cath every month and prn, non patency," with a start date of 5/30/14. The TAR documented the catheter was last changed on 9/17/14.</p> <p>Resident #10's Urinary Catheter Care Plan, dated 5/29/14, documented an approach to "change catheter per policy...MD prefers catheter [sic]"</p>	F 280	<p>Residents that are at risk for falls have specific fall prevention intervention care planned.</p> <hr/> <p>SYSTEMIC CHANGES</p> <p>Root causes revealed:</p> <ol style="list-style-type: none"> 1. No specific nurse has been assigned to keep care plans up-dated 2. Nurses do not feel comfortable updating or changing the care plans 3. Lack of training on how to update the care plan. <p>Corrective Actions</p> <ol style="list-style-type: none"> 1. Nurse Managers have been assigned to keep the care plans up to date. 2. Nurse Managers and floor staff have been inserviced on updating the care plan and in recognizing when the care plan needs updated. 3. Care plans will be up dated when new orders are received by the nurse managers. 		

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	<p>Continued From page 6 change weekly...refer to MD order."</p> <p>On 10/9/14 at 5:25 PM, the RCM #14 was shown the Urinary Catheter Care Plan and stated, "That isn't right, our order isn't to change weekly. The order is to change monthly."</p> <p>On 10/14/14 at 9:50 AM, the Administrator and DON were made aware of the Urinary Catheter Care Plan concern. No further information was provided by the facility.</p> <p>2. Resident # 16 was admitted to the facility on 9/2/14 and re-admitted on 9/16/14 with diagnoses of pelvic fracture, femur fracture, and generalized pain.</p> <p>The resident's Fall Care Plan, dated 9/8/14, documented the following interventions: - Assist of one for transfers, ambulating, and toileting. - Glasses on prior to getting out of bed.</p> <p>On 9/14/14, Resident #16 was transported to a local hospital where the Operative report documented the resident had a comminuted left intertrochanteric/sub-trochanteric hip fracture (left femur) which required surgical intervention with open reduction internal fixation.</p> <p>The resident was re-admitted to the facility on 9/16/14 .</p> <p>The resident's Fall Care Plan, dated 9/16/14, documented the following interventions: - Educate resident/family on call light use. - Assist of one for transfers, ambulating, and toileting.</p>		<p>MONITOR</p> <p>MDS Coordinator and/or designee will perform audits of the care plans of residents requiring indwelling catheters These audits will be done weekly for a month, every other week for two months and monthly <u>for three months.</u></p> <p>Unit Managers and/or designee will perform audits on those that have had recent falls. Those audits will done weekly for a month, every other week for two months and monthly for 3 months</p> <p>The results of audits will be taken to the monthly QAPI meeting for analysis and action taken as indicated</p>	

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F 280	Continued From page 7 On 10/10/14 at 8:55 AM RCM #5 was asked why the 9/16/14 Fall Care Plan had not been reviewed and revised to address the resident's need for increased supervision. RCM #5 said the resident was placed on "frequent checks" and the Falling Leaf Program on 9/30/14. The RCM confirmed the above interventions were added two weeks after the resident was re-admitted. No further information was provided to resolve this concern.	F 280		
F 281 SS=J	On 10/13/14 at 9:40 AM the ED and DNS were notified of the concern, no further information was provided to resolve this concern. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide care and services in accordance with professional standards for 1 of 4 (#11) residents sampled for diabetic management. The facility failed to measure blood glucose as ordered by the physician, failed to provide prompt interventions for critically low blood glucose levels, and failed to provide care according to facility policy and protocol regarding monitoring food intake and reporting abnormal blood glucose measurements. The facility administered injectable insulin to Resident #11 without physician orders. Resident #11 required hospitalization in response to an altered level of consciousness secondary to hypoglycemia and urinary tract infection. The	F 281	F 281 SPECIFIC RESIDENTS Resident #11 was assessed for signs and symptoms of hypo/hyperglycemia at time of finding with no presence of symptoms. The physician was notified with personal contact of the patient's blood sugar results since admission, additional orders received. On the identified unit, blood glucose machines and test strips codes were verified and were validated as being correct. The testing solutions were verified and not expired. The calibration was reviewed and within normal range.	11/14/14

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F 281	<p>Continued From page 8</p> <p>facility failure to ensure and implement a coordinated system to monitor blood glucose, monitor food intake, administer medications as ordered by the physician, and provide appropriate and timely interventions for critically low blood glucose levels placed Resident #11 and 26 residents in the facility who required care for diabetes mellitus in immediate jeopardy and at risk of serious injury or death.</p> <p>On 10/10/14 at 11:20 AM, the Administrator, DNS, and Regional Nurse Consultant were notified of the Immediate Jeopardy involving the facility 's three conflicting diabetic management policies, its lack of interventions for critically low blood glucose readings, and its practice of nurses writing orders outside their professional scope of practice for - and then administering insulin injections without prior physician order.</p> <p>The facility submitted an acceptable Abatement Plan to the Bureau of Facility Standards on 10/20/14 at 9:38 AM and included: The facility would not accept a new referral with a diabetic diagnosis for residents who have not previously or currently resided at the facility; revisions were made to the facility's Hypoglycemic Protocol and Diabetic Management; diabetic education was provided to all nursing staff and will be provided in the orientation program; verification of admission orders by two nurses; and ensuring physician involvement occurs on every patient admitted with diabetic management needs. The abatement plan was verified by an on-site follow-up by surveyors on 10/27/14.</p> <p>The American Diabetes Association's (ADA) Standards of Medical Care in Diabetes, January 2010, defines hypoglycemia as a glucose level</p>	F 281	<p>OTHER RESIDENTS</p> <p>On October 15, 2014, 24 diabetic patient records were audited for abnormal (outside parameter) blood sugars for the past 2 weeks, assessed by licensed nurse for signs and symptoms of hypo/hyperglycemia, and physicians notified of any abnormal findings that were outside of parameters.</p> <p>All other units, blood glucose machines and test strips codes were verified and were correct. The testing solutions were verified and not expired. The calibration was reviewed and within normal range.</p> <p>Admission orders-all residents admitted in the last 30 days have been audited to ensure that discharge orders from the hospital and admission orders are consistent, have physician involvement and clarification as needed.</p> <p>SYSTEMIC CHANGES</p> <p>Effective 10-15-14, the facility will no longer accept a new referral with a diabetic diagnosis for residents who have not previously or currently resided a LCC of Post Falls with a subsequent <u>hospitalization requiring</u></p>	

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F 281	<p>Continued From page 9</p> <p>less than 70 mg/dl [milligrams per decaliter]. The ADA [http://www.diabetes.org], which documented, "Severe hypoglycemia has the potential to cause accidents, injuries, coma, and death," described initial "treatment" for hypoglycemia to include:</p> <ul style="list-style-type: none"> · "Consume 15-20 grams of glucose or simple carbohydrates · Recheck ... blood glucose after 15 minutes · If hypoglycemia continues, repeat · Once blood glucose returns to normal, eat a small snack if [the] next planned meal or snack is more than an hour or two away." <p>Review of the history and physical showed Resident #11 admitted to the facility on 9/5/14 with diagnoses that included diabetes mellitus for which she was prescribed Glimepiride 4 mg [milligrams] oral twice daily and Metformin 250 mg oral twice daily. The resident discharged to the hospital on 9/16/14, and was re-admitted to the facility on 9/20/14 with diagnoses that included dysphagia, diabetes mellitus, and Urinary Tract Infection (UTI).</p> <p>A Physician Telephone Order, dated 9/6/14, documented, "Per family check FSBG [finger stick blood sugars] [at] AC/HS [before meals, and at bedtime]."</p> <p>The resident's blood glucose record, however, revealed staff did not measure the resident's BG level from admission on 9/5/14 until 9/7/14 at 5:30 PM.</p> <p>On 9/7/14 an electronic Physician Order for insulin documented, "Novolog 100 unit/mL subcutaneous solution. Subq [subcutaneous] before meals and at bedtime insulin sensitive</p>	F 281	<p>readmission until this issue is abated. The issue was abated on 10-20-2014.</p> <p>On 10-10-2014 the license nurses were provided inservice education on clinical assessment of a diabetic patient, including but not limited to:</p> <ul style="list-style-type: none"> • Signs and symptoms of hypo/hyperglycemia • Blood sugar protocols • Physician notification • Diabetic medication orders <p>On 10-16-2014, the license nurses were provided inservice education on:</p> <ul style="list-style-type: none"> • Diabetic protocol, following the parameters, assessment & documentation • Assessment of hypo/hyperglycemia & potential contributing factors to include, PO intake, Medications, infections • Verification of physician orders to include 2 nurses, & ensuring that the physician involvement occurs on every patient admitted with diabetic 	

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F 281	<p>Continued From page 10 sliding scale."</p> <p>Prior to her 9/16/14 discharge to the hospital, Resident #11's Sliding Scale Insulin [SSI] flow sheet documented the following blood glucose [BG] levels:</p> <ul style="list-style-type: none"> · 9/11/14 - 40 mg/dl · 9/12/14 - 46 mg/dl · 9/13/14 - 48 mg/dl · 9/14/14 - 37 mg/dl <p>The Diabetic Treatment Administration Record, dated 9/11/14 through 9/14/14, documented the resident did not receive any intervention or monitoring for the identified low BG levels, except for 9/14/14, when she was given orange juice.</p> <p>The Nurse Progress Notes dated 9/11 through 9/13 did not document whether the resident exhibited signs and symptoms of hypoglycemia, blood glucose values, interventions administered, resident response to interventions, or whether the physician/family had been notified.</p> <p>The SSI flow sheet, dated September 2014, however, documented the resident received HS [bedtime] insulin on 9/10, 9/11, 9/12, and 9/13.</p> <p>A telephone order, dated 9/12/14, documented, "Nursing to assure resident receives HS snack due to [decreased/low] AM BG." A telephone order dated 9/13/14 documented, "Offer 1 cookie [with] 2% milk for HS snack."</p> <p>The MAR dated September 202014, documented the resident did not receive or refused HS snacks on 9/12/14 through 9/14/14.</p> <p>Additionally, the September 2014 Meal Monitor</p>	F 281	<p>management needs.</p> <ul style="list-style-type: none"> • Nurse practice act including implementing orders for medications and treatment issued by authorized prescriber. • Physician notification in person or by phone for blood sugars results outside parameters including to notify the Medical Director if unable to reach residents primary physician. • Competencies were performed to the license nurses on diabetic management. • Policy on diabetic care, chapter 3 related to hypoglycemic reaction will be discontinued in facility and implementation of protocols with diabetic management will be followed in a consistent manner. 	

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F 281	<p>Continued From page 11</p> <p>record documented the resident refused or was not offered dinner on 9/9, 9/10, 9/12, and 9/14; ate twenty five percent or less of dinner on 9/7 and 9/11; and refused or was not offered PM and HS snacks on 9/5 through 9/14.</p> <p>The facility's Guidelines for Nursing Care of a Resident with Diabetes Mellitus, documented the dietician, nurse, and physician would assess the resident's nutritional needs and determine food preferences. Additionally, the facility would provide appropriate diagnostic testing to determine nutritional status, identify dietary needs, complications, and risk factors.</p> <p>There was nothing documented in the resident's record to indicate the CNAs reported the resident's lack of food intake to the Licensed Nurse (LN) and the LN documented the resident received HS snacks daily from 9/12/14 through 9/15/14.</p> <p>A Nurse Progress Note, dated 9/14/14, documented, "Blood sugar was low this AM, orange juice given and resident had breakfast, came up adequately. Sliding scale [insulin] administered per MAR today."</p> <p>The 9/14/14 Nurse Note did not document whether the resident exhibited signs and/or symptoms of hypoglycemia, BG level 15 minutes after the intervention, whether the intervention was repeated, or whether the physician and family had been notified.</p> <p>A SBAR (Situation, Background, Assessment, Request) Communication Form, dated 9/16/14 at 5:35 PM, documented a FSBS measurement of 148 mg/dl with the resident exhibiting body</p>	F 281	<ul style="list-style-type: none"> Diabetic management protocols were updated to include patients who were on PO medications & insulin dependent & specifically when physician notification will be made for patients. Inservice & training completed to license nurses on protocols & the facilities consistent approach. <p>Any licensed nurse not in attendance at the above inservice will be provided the education & pass competency prior to their next shift worked.</p> <p>The C.N.A's were provided inservice education on the following:</p> <ul style="list-style-type: none"> Observing diabetic patients for signs & symptoms of hypo/hyperglycemia Reporting patients with signs & symptoms of hypo/hyperglycemia to the nurse immediately Documentation of meal intake & HS snacks 	

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F 281	<p>Continued From page 12</p> <p>jerking, unfocused eyes, increased confusion, unfocused thoughts, and other signs of delirium.</p> <p>On 9/16/14, Resident #11 discharged to the hospital, where an Emergency Room Report documented a BG of 70 mg/dl. The resident was admitted with altered mental status related to hypoglycemia and urinary tract infection.</p> <p>The resident's Hospital Progress Note, dated 9/19/14, documented "Altered consciousness due to urinary tract infection and diabetes with hypoglycemia now off Metformin."</p> <p>The resident's Hospital Discharge Medication Orders, which also served as the facility's admission orders, dated 9/20/14, documented: - "Insulin Lispro: 0 units SUBCUTANEOUS Before Meals Per sliding scale And At Bedtime." - Discontinue Metformin 250 mg twice daily. - Discontinue tramadol 250mg twice daily. - Discontinue Gabapentin 1200 mg at bedtime. - Discontinue Metolazone 5 mg by mouth every Monday and Thursday.</p> <p>The resident's Hospital Discharge Medication Orders, dated 9/20/14, did not include an order for Glimepiride 4 mg po twice daily or Premarin 0.625 mg one tablet by mouth daily.</p> <p>On 9/20/14, facility nursing staff - without prior consultation with the resident's physician - wrote the following Admission Orders: - Novolog 100 unit/ml. subcutaneous solution: Subq (subcutaneous) before meals and at bedtime insulin sensitive sliding scale. - Metformin 500 mg tablet, give 1/2 tablet (250 mg) by mouth twice daily. - Tramadol 50 mg tablet, give 1 tablet by mouth</p>	F 281	<ul style="list-style-type: none"> Reporting to LN's resident who do not consume meal and/or refuse HS snack <p>Effectively immediately, diabetic education has been included in the orientation program for license nurses and C.N.A.'s.</p> <p>Review current license nurses staffing patterns during blood sugar times & adjustments made to AM staffing schedule to include the charge nurse on 200 hall where there is higher acuity residents reside, to complete blood sugars, assessment, following protocol, MD notification & documentation.</p>	

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F 281	<p>Continued From page 13</p> <p>as needed - four times a day every 6 hrs as needed for pain 1-5.</p> <ul style="list-style-type: none"> - Gabapentin 600 mg tablet five 2 tabs (1200 mg) by mouth at bedtime. - Metolazone 5 mg 1 tablet by mouth two times per week. - Glimepiride 4 mg tablet twice daily. - Premarin 0.625 mg one tablet by mouth daily. <p>The Nursing Home Admission Orders were not signed by the physician until 9/22/14, when, at 4:00 PM, a Physician Telephone Order documented, "Med[ication] clarifications. D/C glimepiride and Metformin!!!"</p> <p>Review of the resident's morning blood glucose levels after her return to the facility revealed the following:</p> <ul style="list-style-type: none"> • 9/17/14 - 50 mg/dl • 9/18/14 - 63 mg/dl • 9/22/14 - 49 mg/dl • 9/23/14 - 48 mg/dl • 10/1/14 - 60 mg/dl • 10/8/14 - 51 mg/dl <p>The Diabetic Treatment Administration Record did not document the resident received any interventions for the identified low BG levels on 9/22/14, 9/23/14, or 10/8/14.</p> <p>Nurse Progress Notes documented the following:</p> <ul style="list-style-type: none"> • 9/22/14 - " Blood sugars have been 49 this am [morning] and 280 at 11 am. Covered per MAR ... " • 9/23/14 - " Low blood sugars today. 48 at breakfast and 61 at lunch ... " • 10/8/14 - " This morning her BG was 51, gave OJ. BG came up to WNL [within normal limits] quickly. " 	F 281	<p>MONITOR</p> <p>Unit Managers and/or designee will audit diabetic patient's accuchecks daily times 4 weeks, then weekly times 4 weeks, then bimonthly times 2 months, then monthly thereafter. The audit will identify patients, with abnormal (outside parameters) blood sugars, to ensure proper assessment, monitoring, MD notification at the time of occurrence, protocol followed and documentation.</p> <p>The DON and/or designee will monitor all admissions & readmissions records to validate the "Two Nurse Check", and orders verified & clarified as needed with physician</p> <p>The audit findings will be reviewed by the DON and/or designee during daily clinical meetings for follow-up.</p> <p>The ED will ensure audit results will be analyzed monthly in the QAPI committee for 3 months, with changes made as indicated.</p>	

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F 281	<p>Continued From page 14</p> <p>The Nurses Notes for these three days did not document whether the resident had signs or symptoms of hypoglycemia, blood glucose level 15 minutes after the intervention, whether the intervention was repeated more than once, the resident ' s response to the intervention, or whether the physician and family had been notified.</p> <p>Three facility procedures and policies - the Hypoglycemic Reaction Policy (HRP), Hypoglycemic Protocol (HP), and the Insulin Sensitive Sliding Scale (ISSS) - instructed staff to document in the disciplinary notes and nurses notes all signs and/or symptoms, resident assessment, blood glucose values, attempts to give oral carbohydrates, glucagon injection location, the resident's response, and notification of physician and family.</p> <p>The three procedures and policies, however, contained the following discrepancies:</p> <ul style="list-style-type: none"> · The HP was to be implemented when BG was less than 60 mg/dl. · The HRP did not indicate a blood glucose level, but instead instructed nurses to use " good clinical judgment. " · The ISSS instructed staff to refer to the HP when fasting blood sugar was less than 60 mg/dl. · The HP directed staff to repeat interventions until BG was greater than 100 mg/dl. · The HRP directed staff to give supplemental carbohydrates if the BG remained low, however there was no value provided for " low, " or when interventions were to be discontinued. · The ISSS instructed staff to repeat interventions until BG was greater than 80 mg/dl. · The HP and ISS instructed staff to notify the 	F 281			

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F 281	<p>Continued From page 15</p> <p>physician of BGs less than 60 mg/dl, while the HRP instructed staff to call the physician and family if the resident failed to respond to interventions.</p> <p>On 10/10/14 at 11:20 AM, the DNS confirmed the resident ' s 9/20/14 Hospital Discharge Orders did not include insulin and Glimepiride. The DNS stated the facility wrote a clarification order for Glimepiride on 9/20/14, however the insulin was not included. When asked why nursing staff wrote an order for the insulin, the DNS stated, "When a resident received insulin at the facility and was discharged to the hospital and returned to the facility, the facility's protocol was to re-write the previously used sliding scale." The DNS confirmed that writing medication orders was not within a nurse ' s scope of practice. When asked why nursing then wrote orders for Glimepiride, Metformin, Tramadol, Gabapentin at bedtime, Metolazone, and Premarin, the DNS did not answer. When asked whether the Physician compared the discharge medication orders with the admission orders before he/she signed, either on a routine basis or with Resident #11 when she was re-admitted to the facility, the DNS stated she could not answer.</p> <p>NOTE: The resident's physician/facility medical director was out of the state at the time of survey and despite attempts by facility staff to contact her, she could not be reached.</p> <p>On 10/10/14 at 7:55 AM, the DNS was asked why nursing staff did not follow the facility's hypoglycemic protocol and document, signs/symptoms of hypoglycemia, blood glucose values, resident assessment, interventions administered, the resident's response, and</p>	F 281			

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F 281	<p>Continued From page 16</p> <p>notification of physician and family. The DNS stated she could not answer, but stated the staff must have given the resident something for her low blood glucose levels because the resident was able to go to breakfast and participate with therapy on the mornings her blood sugars were low.</p> <p>On 10/10/14 at 11:20 AM, the Executive Director (ED), DNS and Regional Nurse Consultant (RNC) were asked why the resident received sliding scale insulin at HS on nights that she did not eat or refused dinner, PM and/or HS snack. The DNS said she was not sure and could not answer because she was not there. The DNS said the LN providing cares at the time may not have been informed by the CNA that the resident did not eat. When asked why there were discrepancies on the Meal Monitor flow sheets and the MAR for the identified dates related to the HS snack, the ED, DNS, and RNC did not answer. The DNS was then asked how the facility identified that a cookie was an appropriate HS snack for a diabetic resident. The DNS said she was not sure who chose the cookie and it was probably not an appropriate HS snack because the resident's blood sugar would drop during the night. The DNS was asked at what point should nursing staff have discussed the HS insulin dose with the physician related to low AM blood sugars. The DNS stated, "Nursing failed to think critically and look at the big picture."</p> <p>Additional information received from the facility on 10/14/14, 10/15/14, and 10/16/14 did not resolve the identified concerns.</p> <p>The facility failed to follow its own diabetic management policy, failed to ensure a resident</p>	F 281			

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F 281	Continued From page 17 received meals and snacks before administering insulin, failed to notify the physician of critically low blood glucose levels, and nursing staff - without prior consultation with the resident's physician - wrote Admission Orders for medications, including insulin, Glimepiride, Metformin, Tramadol, Gabapentin, Metolazone, and Premarin, that were not included on Hospital Discharge Orders.	F 281			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on review of resident records, Incident/Accident reports and staff interviews, it was determined the facility failed to ensure a resident received adequate supervision to prevent a fall with injury and to ensure siderails were assessed to be safe prior to use. This was true for 2 of 7 (#s 8 & 16) sampled residents. Resident #16 was harmed when she fell, sustained a femur fracture, and required surgical intervention. 1. Resident #16 was admitted to the facility on 9/2/14 and re-admitted on 9/16/14 with diagnoses of pelvic fracture, femur fracture, generalized pain, and nocturnal enuresis.	F 323	F 323 SPECIFIC RESIDENTS Resident #16 is provide fall prevention interventions to reduce the potential for falls. The resident has not any additional falls as of this date. Resident # 8 has been reassessed for the use of ½ side rails and has been deemed to be safe. OTHER RESIDENTS Residents who have sustained a fall since January 2014 fall care plans have been reviewed and up dated to include supervision as indicated. All residents utilizing side rails were reassessed for their use and actions taken as necessary.	11/14/14	

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F 323	Continued From page 18 Review of the hospital History and Physical, documented, the 8/28/14 hospital admission was related to an acute fracture of the left superior and inferior pubic rami. The physician documented the resident had significant injuries over the past year and a half, with right hip fracture in June 2013 requiring open reduction and internal fixation, and a non-surgical pelvic fracture on 6/19/14. The current Admission MDS, dated 9/9/14, coded the resident required extensive assist of two people for transfers and toileting. The resident's balance for seated to standing and moving on/off the toilet was coded as not steady and only able to stabilize with human assistance. The facility's Falling Leaf program, updated on 9/3/14, documented, a resident with a falling leaf on his/her doorway and/or wheelchair was at high risk for falls. "Please be aware of these residents and check on them frequently to assure that they are not ambulating or transferring independently. Remember, if you pass a doorway marked with an orange leaf, you must check on them each time you pass by. Be proactive, offer toileting, food/drinks, and assure needed items are within reach, including call light." The care plan, dated 9/8/14 and 9/16/14 (current care plan), identified Resident #16 was at risk for falls with injury related to a fall risk score of 14, a recent fall(s), history of fall(s) with injury, and non-compliance with safety instruction. Additionally, the 9/16/14 care plan identified the resident was legally blind in the left eye. Care plan interventions dated 9/8/14 and 9/16/14, documented assistance of one person for	F 323	SYSTEMIC CHANGES Root cause analysis revealed: 1. Residents at risk did not have fall interventions implemented timely. 2. Nurses can miss checking the box that states "This device has been assessed to be appropriate and safe for use by this resident" when completing the restraint assessments. 3. IDT was not consistently involved with "fall Huddle" to prevent reoccurrence. Corrective Actions 1. Residents are assessed for fall risk on admit and fall prevention measures implemented from day 1. 2. The facility developed a more user friendly fall care plan for admission which promotes more extensive preventive measures to prevent falls. 3. LN received training on completing the restraint form to include checking all boxes as appropriate.		

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F 323	<p>Continued From page 19</p> <p>transfers/ toileting and glasses on [the resident] prior to getting [him/her] out of bed. Additionally, the 9/16/14 interventions included, education to resident/family on call light use. Interventions added on 9/30/14 documented, "Provide frequent checks for safety, cue [resident] to wait [and] call for help, and resident placed on the Falling Leaf program."</p> <p>The Fall Risk Evaluation, dated 9/8/14, 9/14/14, and 9/16/14 documented the resident's fall risk score was 10 or more and directed staff to promptly put interventions in place. The interventions included, "9/8 cue to wait for assistance, 9/14 non-compliant would not use call light, re-educated on call light use, send to ER for evaluation for increased pain. Call sinage [sic] placed in room, 9/16 re-educated to call light use. Encouraged to call when doing any transfers."</p> <p>The Occupational Therapy daily treatment notes on 9/6/14 documented, "Upon therapist arrival, patient attempting to clean self following incont[inent] of bowel episode. 'I couldn't get to toilet in time.' Patient admits she did not wait for assistance due to urgency. Educated patient on requesting assistance for safety."</p> <p>The Incident/Accident report and Nurse Progress note dated 9/14/14 documented, "Was summoned to [room number] observed resident sitting on buttocks. Left leg in L shape and right leg extended, ask [sic] what happened resident stated that she tried to grab to [sic] bars by the toilet, and lost her grip and fell backward. Resident refused to get out of bed and go to the bathroom last night, bed abd[omen] cloths [sic] were saturated with urine, CNA put the resident on toilet and asked her to use the call light when</p>	F 323	<p>4. All falls are reviewed by IDT during Grand Rounds, falls are again reviewed for appropriate interventions at the weekly fall meeting</p> <p>MONITOR</p> <p>The Executive Director (ED), DON and/or their designee will monitor through review of the incidents reports daily and participation in the weekly fall prevent meetings.</p> <p><u>Unit Managers and/or designee will monitor side rail assessment through review of the orders for side rails.</u></p> <p>Results of the reviews will be taken to the monthly QAPI for analysis and actions taken as indicated.</p>	

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F 323	<p>Continued From page 20</p> <p>she was done." The CNA left the room to assist another resident and when she returned to Resident #16's bathroom the resident was on the floor.</p> <p>On 9/14/14, Resident #16 was transported to a local hospital where the Operative report documented the resident had a comminuted left intertrochanteric/sub-trochanteric hip fracture (left femur) which required surgical intervention with open reduction internal fixation.</p> <p>The Physical Therapy daily treatment notes on 9/17/14 documented, "Co[current] [treatment] with OT secondary to low activity tolerance due to pain and present need for 2 person assist with mobility and ADLs;" 9/21/14 - "[Resident] unable to perform L LE [left lower extremity] exercises today due to increase [sic] hip pain;" 10/5/14 - the PT transferred the resident from the wheelchair to the toilet and asked the resident to use the call light when she was ready. "I heard pt transfer. I asked pt why she didn't use call light. The [resident] said she knows she needs to use it and self transferring has caused her falls."</p> <p>The Occupational Therapy daily treatment notes documented, 9/18/14 - "Seen for OT/PT co[current] treatment due to moderate LLE pain and poor activity tolerance following a new L[eft] hip ORIF;" 9/30/14 - "Pt stated 'they are changing my room to put me closer to the nurses station, I don't know what all the fuss is about.' Pt education for using call light secondary to safety secondary to TTWB on left LE. Pt reluctantly agreed to use the call light."</p> <p>A Final X-ray Report dated 10/7/14, read, "S/P (status post) internal fixation of left</p>	F 323			

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

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F 323	<p>Continued From page 21</p> <p>intertrochanteric femoral fracture with mild displacement and a lesser trochanteric fragment, without significant healing."</p> <p>On 10/10/14 at 8:55 AM, RCM #5 confirmed she was aware the resident had a history of falls with injury at the time of her admission. The RCM stated the Fall care plan, dated 9/8/14, did not include interventions and should have included frequent checks and/or the Falling Leaf program. The RCM was asked why the Fall care plan dated 9/16/14 did not include "provide frequent checks for safety and Falling Leaf program," which were not implemented until 9/30/14, or 14 days after the resident re-admitted with the femur fracture. The RCM stated the interventions should have been care planned when the resident re-admitted on 9/16/14.</p> <p>On 10/13/14 at 9:20 AM, the ED and DNS were notified of the above concern. When asked why a resident who was at increased risk for falls and poor safety awareness was left unattended on the toilet, the DNS said the resident didn't need to have staff wait with her because she is alert, oriented, and knows how to use the call light. The DNS said the resident had received increased supervision based on the location of her room on the 300 hall. "This hall is the rehabilitation hall and staff are in and out of residents' rooms all time and therefore all residents on this hall receive increased supervision." The DNS was asked why the Admission MDS and the care plan did not document the same information related to the resident's transfer and toileting needs. The DNS said she did not know, but confirmed the MDS documented the resident was a two person extensive assist for transfers and toileting and the Care Plan documented the resident was a one</p>	F 323		

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F 323	Continued From page 22 person extensive assist. No further information was provided to resolve this concern. 2. Resident #8 was admitted to the facility on 7/27/12 with multiple diagnoses which included Above the Knee Amputation and End Stage Renal Disease. The resident's care plan for the focus of potential for falls, dated 7/20/14, documented an intervention "1/2 Side Assist Rail X [times] 2 to promote bed mobility." The record contained Initial and Quarterly Restraint Assessments dated 2/25/14, 5/9/14, 6/9/14 and 10/9/14, signed by LN #3. Although there was a place on each assessment to document [check] that the "device [siderails] had been assessed to be appropriate and safe for use by this resident," the box was not checked. There was no other evidence that the siderails were assessed to be appropriate and safe. The resident was observed in bed with 1/2 siderails X 2 on: 10/6/14 at 2:00 PM, 10/7/14 at 2:30 PM and 3:32 PM. On 10/9/14 at 12:15 PM, LN #3 was asked for a siderail safety assessment on Resident #8. None was provided. On 10/14/14 at 9:50 AM, the Administrator and DON were informed of the observation. No further documentation was received from the facility regarding this issue.	F 323			
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	F 353	F 353 SPECIFIC RESIDENTS	11/14/14	

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F 353	<p>Continued From page 23</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on the resident group interview, review of the facility's Concern and Comment reports, and resident and staff interviews, it was determined the facility failed to ensure there was adequate staffing to meet the needs and ensure the well-being of each resident. This affected 3 of 20 sampled residents (#s 14, 15, & 19) and 1 of 6 random residents (#29), 8 residents with comment and concern reports, and 12 of 17 residents who attended the group interview. This failure created the potential for psychosocial and physical harm for all residents in the facility. Findings included:</p>	F 353	<p>Residents #14, #15, #19, and #29, concerns related to cares and services are handled on an individual basis. They have been interviewed to ensure satisfaction with services.</p> <p>OTHER RESIDENTS</p> <p>All residents can be affected by this practice. All residents who express concern about care or services are handled on an individual basis.</p> <p>SYSTEMIC CHANGES</p> <p>Root cause analysis revealed:</p> <ol style="list-style-type: none"> Morning ADL's to get up and evening ADL's getting ready to go to bed is the most difficult time to respond to call lights timely as all residents want service at the same time. New Staff do not know how to prioritize their duties. Staff turnover and call-offs affect the timeliness of cares Staff have been observed to walk past a call light that is on. 	

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F 353	<p>Continued From page 24</p> <p>1. On 10/8/14 at 11:00 AM, two surveyors conducted a group interview with 17 residents. Twelve of the 17 residents voiced concerns that their call lights were not being answered timely. The residents related this to a shortage of staff. The group voiced that the staffing problems were worse around meal times and at night. One resident stated, "There aren't enough staff." Another resident said there was a problem with timely response to the call lights.</p> <p>2. The facility provided a report for Wednesday 10/8/14, which documented a resident census of 110. There were 45 residents on the 100 hallway; 14 of them required 2 staff assistance with ADLs. There were 45 residents on the 200 hallway; 10 of them required 2 staff assistance with ADLs. There were 19 residents on the 300 hallway. The 200 hallway had 6 residents who required 2 person assist for check and change and 9 residents who required 1 person assist for check and change. The 100 and 200 hallways each had 1 nurse and 2 CNAs and the 300 hallway had 1 CNA and 1 nurse who worked the night shift on Wednesday 10/8/14.</p> <p>3. On 10/8/14 at 11:25 AM, Resident #15 was interviewed regarding call light response time. The resident stated, "It can take 20 minutes sometimes to get help. Sometimes that is too long, if you are needing to use the bathroom."</p> <p>4. On 10/8/14 at 2:10 PM, Resident #19 in response to staffing and call light response time stated, "One night about a week ago, there was 1 CNA to 22 residents. The CNAs were told not to tell us [the residents] how many CNAs were working. On occasions, it takes over 20 minutes to have a call light answered because there is not</p>	F 353	<p>Corrective Actions:</p> <ol style="list-style-type: none"> 1. Additional medication nurse was hired for the 200 hall due to the high acuity in that area. 2. Hire on bonus, referral bonus and wage increase has been implemented in order to maintain staffing 3. The brakes and lunch schedules have been reviewed to ensure adequate staff during brakes and high request for assist times. 4. Staff have been inserviced on time management and prioritizing their duties which include never walking by a call light. <p>MONITOR ED and DON will monitor through review of the daily/weekly staffing patterns for appropriate levels weekly. The resident council meeting minutes will be reviewed on a monthly basis to identify concerns regarding call lights and care needs.</p> <p>ED and Department Heads will conduct call light response audits 3 times a week for four weeks then twice a week for four weeks then weekly for four weeks. Results of the resident council meetings and call light audits will be taken to the monthly QAPI meeting for analysis and action taken as indicated.</p>		

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F 353	<p>Continued From page 25 enough staff."</p> <p>5. On 10/8/14 at 2:25 PM, Resident #14 stated, "Not enough people to do everything that needs to be done." The resident said he has had to wait 45 minutes to an hour for his call light to be answered and left in the bathroom for a very long time. He reported that he has had a longer wait time in the wee hours of the morning and especially around dinner time.</p> <p>6. On 10/8/14 at 5:00 PM, Resident #29 reported that a few days prior, she had dropped her call light. There were 2 CNAs in the room helping the resident's roommate, so she had asked them to please come and help her. The resident knew they heard her, but they turned the light off and walked out of the room without any assistance provided. Resident #29 stated, "I have to wait up to 30 minutes sometimes for them to answer my call light, when I'm on the toilet."</p> <p>7. There were 8 Concern & Comment Forms completed from 5/1/14 through 8/10/14. These residents had concerns regarding their call lights not being answered promptly and the resident's safety, dignity, and/or psychosocial well-being had been compromised.</p> <p>8. On 10/9/14 at 5:10 AM, the surveyors conducted interviews with 4 staff. Their comments were:</p> <p>a) CNA #9 stated, "I like my job a lot and work part time on this hallway. We have a good team and work together." The CNA said, there is 1 shower aide who comes in at 5:00 AM and starts bathing residents. The CNAs help her with residents who are 2 person assist and the bath</p>	F 353			

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F 353	<p>Continued From page 26</p> <p>aide will help answer call lights, if there is time. The nurse usually can't help us, she's busy with passing medications and charting. The nurse may also need to float to other halls to help. CNA #9 said the 200 hallway is a lot busier and the residents require more care.</p> <p>b) An unidentified staff member said she spoke to management regarding her concerns with staffing. The staff member stated, "I have told them I'm getting burned out and that I'm tired of feeling like I'm not providing good patient care."</p> <p>c) CNA #11 stated, "From 10 PM to 1:30 AM, constant lights, on an average we have to lay down 2 to 3 people at 10 PM, when we get here and then from 3:45 AM to 6 AM constant call lights."</p> <p>d) LN #12 stated, "75% of the time, we are staffed okay."</p> <p>9. On 10/9/14 at 8:00 AM, CNA #15 was interviewed regarding the staffing for the restorative program. The CNA said the 3 restorative aides work alternating schedules, 7 days a week and currently have 21 residents with 30 minute programs and 4 residents in the restorative dining room. When asked how often they are assigned to work the halls or other duties, the CNA stated, "As needed, we are the only therapy that can be pulled to work the halls. We also have to go with residents to outside appointments if additional assistance is needed."</p> <p>On 10/8/14 at 6:25 AM, the Administrator and DON were informed of the call light and staffing concerns. No additional information has been provided.</p>	F 353			

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F 364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on input from the Resident Group Interview, test tray evaluation, staff interview and facility grievances, it was determined the facility did not ensure food was served at a palatable texture and level of doneness. This was true for 17 of 17 residents in resident group. The deficient practice had the potential to cause more than minimal harm if residents experienced a negative impact on their nutritional status or psychosocial well-being from unpalatable food. Findings included:</p> <p>On 10/8/14 at 11:00 AM, the resident group had the following concerns with the food served in the facility: Tough chicken, pork and roast beef; and, Hot foods were not hot.</p> <p>On 10/9/14 at 12:40 PM, the surveyors, along with the Dietary Manager (DM), sampled a test tray. The tray included roasted pork loin with gravy, oven roasted potatoes, mixed vegetables, and rocky road pudding. The surveyors and the DM witnessed the temperatures and had the following comments: *The temperature of the roasted pork loin was 111 degrees Fahrenheit (F), was dry and lacked flavor.</p>	F 364	<p>F 364 SPECIFIC RESIDENTS</p> <p>Those unidentified residents who have food concerns will be addressed on an individual basis.</p> <p>OTHER RESIDENTS</p> <p>Any residents who eats in the facility have the potential to be affected by this practice. Their concerns are addressed on an individual basis.</p> <p>SYSTEMIC CHANGES</p> <p>Root cause analysis revealed:</p> <ol style="list-style-type: none"> 1. The plate warmer motor was broken. 2. Too many residents eat in their rooms 3. Staff need training on food temperatures and tray line temperatures. 4. Hall trays take too long to deliver. <p>Corrective Actions:</p> <ol style="list-style-type: none"> 1. The plate warmer motor was replaced and a backup motor has been ordered. 2. Residents are encourage to eat in the main dining room. 	11/14/14	

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F 364	<p>Continued From page 28</p> <p>*The temperature of the oven roasted potatoes was 103 F, were over cooked, not well seasoned and were extremely dry.</p> <p>*The temperature of the mixed vegetables was 101 F and lacked flavor. The carrots were tender but the squash and green beans were mushy.</p> <p>After the surveyors and DM sampled the test tray, the DM was asked what she thought about the temperature, flavor, appearance and texture of the meal. The DM stated, "I would like to see the temperatures closer to 150 F, the warmer is broke and the motor arrived today. The pork is dry, the potatoes are extremely dry, the carrots are good but the other vegetables are mushy."</p> <p>Review of the facility grievance forms for six months, April - September 2014, included the following comments:</p> <p>*"Chicken Fry Rice, no chicken, raw rice.</p> <p>*The meal was not cooked, the rice hadn't been boiled, it was uneatable. The meat was very bad. I thought it was a joke.</p> <p>*The rice was undercooked, no chicken was present and the pineapple was scarce. It was not eatable.</p> <p>*Carrots were so hard couldn't bite in to. Chicken was hard as rock, couldn't even cut it. Both carrots and chicken struggled with to cut. I request bread and butter and never get it.</p> <p>*Meat is overcooked making it tough and dry.</p> <p>*The potatoes were uncooked and very hard to eat.</p> <p>*I am very upset because my food is not being cooked. This is not the first time. I'm almost scared to eat my food.</p> <p>*I was at dinner 6:15 PM when was finally served cold fish, cold fries. Had soup but drinks didn't arrive before dinner, till after meal was</p>	F 364	<p>3. Dietary have been inserviced on maintaining food temps.</p> <p>4. Staff have been inserviced on delivery of hall trays.</p> <p>5. Dietary manager meets weekly with the residents to discuss any food concerns including palatability, temperature, and timeliness of delivery.</p> <p>MONITOR</p> <p>ED and/or designee will monitor through interviews of residents for food palatability three times weekly for four weeks, then weekly for four weeks, Residents Council meeting minutes will be reviewed monthly to determine concerns regarding food palatability.</p> <p>Results of interviews and resident council minutes will be taken to the monthly QAPI meeting for analysis and action taken as indicated.</p>		

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F 364	Continued From page 29 served...had to ask for it twice. Didn't finish the cold meal. *Food is always cold when I receive on hall. *Cold dinner, very disappointing. *Lately most of my meals come without being what I ordered...they show up without a hot plate so the food is cold long before I finish." The facility investigation findings and action taken for the above mentioned comments included: **New cook - working with cook to improve meals. *More supervision. Review menu with [name of staff]. *Keep food hot and give help to pass trays fast. *Spent 15 minutes discussing issue with res[ident] - he has multiple complaints, some are more valid and mostly r/t [related to] lack of kitchen staff. Encouraged res[ident] to ask for alternatives if served cold food. *Education with cooks. *...Educated cooks about cooking meat to [sic] long. *Working with [name of staff] to gain more skill." On 10/14/14 at 9:50 AM, the Administrator and DON were made aware of the concerns regarding inadequate temperatures and palatability. The facility offered no further information.	F 364			
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.	F 368	F 368 SPECIFIC RESIDENTS Resident # 11 no longer resides at this facility.	11/14/14	

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F 368	<p>Continued From page 30</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, resident group interview and staff interview, it was determined the facility failed to ensure residents were offered a snack at bedtime for 1 of 13 sampled residents (#11) and 17 of 17 residents, including 5 residents who were diabetic, who attended Resident Group Council with the surveyors. Lack of a bedtime snack created the potential may result in the altered nutritional status of residents. Findings included:</p> <p>1. On 10/8/14 at 11:00 AM, at the resident group interview, when asked if they were being offered a bedtime snack, the residents stated, "No, just since you showed up."</p> <p>On 10/8/14 at 4:45 PM, CNA #6 was asked when she offered snacks and stated, "On the 200 Hall there are a few [residents], I offer snacks to before bed around 8:30 PM." When asked if she offered everyone a snack, CNA #6 stated, "Me personally, no, I do not offer snacks unless asked." When asked if she had received training</p>	F 368	<p>The 17 unidentified residents perceived they did not get a snack because they didn't receive one or they forgot they had one.</p> <p>OTHER RESIDENTS</p> <p>All residents have the potential to be affected by this practice. Snacks are offered every night.</p> <p>SYSTEMIC CHANGES</p> <p>Root cause analysis revealed:</p> <ol style="list-style-type: none"> 1. All residents did not receive snacks because they were not offered consistently. 2. Diabetic snacks were offered but not documented 3. Kitchen did not provide HS snacks to all residents 4. Staff needed education on ensuring snacks are offered. <p>Corrective Actions</p> <ol style="list-style-type: none"> 1. Floor staff and dietary staff were inserviced on offering a nightly snack. 2. LN will document HS snacks for the diabetic residents. 3. The kitchen sends a variety of snacks in adequate amounts to offer a snack to all residents 		

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F 368	Continued From page 31 from the facility to offer snacks, CNA #6 stated, "I've never been trained when to offer snacks. This is my third week to work here." On 10/8/14 at 4:50 PM, CNA #7 was asked when she offered snacks and stated, "At 3:00 PM and in the evening when I put them down for the evening, I ask, 'Can I offer you anything.' If I know the resident, say they don't eat well, I encourage snacks. I am not specific about asking them if they want something to eat. I didn't realize I had to be specific about offering them something to eat before bedtime. I mainly ask, 'Can I get you anything.' I was shocked when one of my residents told me she didn't know she could have an evening snack." 2. Resident #11 was readmitted to the facility on 9/20/14 with multiple diagnoses which included care involving a rehabilitation procedure, diabetes mellitus type II, and aftercare for healing of a traumatic hip fracture. Record review of Seven Day Look Back for Diet form documented the resident was not offered a snack on 9/9, 9/11, 9/12, or 9/30/14. On 10/14/14 at 9:50 AM, the Administrator and DON were made aware of the concern regarding bedtime snacks. No further information was provided by the facility.	F 368	4. Snacks are offered every night. MONITOR: ED and/or designee will monitor through resident interviews. These interviews will be done weekly for a month, every other week for two months and monthly for 3 months. The results of the interviews will be taken to the monthly QAPI meeting for analysis and action taken as indicated.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431	F 431 SPECIFIC RESIDENTS & OTHER RESIDENTS	11/14/14

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F 431	<p>Continued From page 32</p> <p>controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug-distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure outdated medications were removed from the medication room. This failure created the potential for more than minimal harm if the outdated medications had a diminished efficacy and/or contamination.</p>	F 431	<p>The E-Kits were replaced.</p> <p>Residents are administered medication that are not expired.</p> <p>SYSTEMIC CHANGES</p> <p>Nursing staff have been inserviced on ensuring expired medication are not administered to the residents. This included medication removed from the E-Kit.</p> <p>The pharmacy has been contacted and they have replaced the E-Kits. They will also be checking them monthly to ensure no expired medications are in them.</p> <p>MONITOR</p> <p>The Staff development Coordinator and/or designee will perform audits of the E-Kits These audits will be done weekly for a month, every other week for two months and monthly for 3 months.</p> <p>The results of the audits will be taken to the monthly QAPI meeting for analysis and action taken as indicated.</p>		

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F 431	<p>Continued From page 33</p> <p>This had the potential to affect any resident who could receive expired medications. This was true for 2 of 3 medication storage rooms.</p> <p>1. On 10/9/14 at 9:35 AM, during inspection of the 100 Hall medication storage room with LN #3 in attendance, 2 medications in the E (emergency) Kit were found to be expired; Naloxone 0.4 MG (milligram) expired on 8/24/14, 1 vial, and Digoxin expired on 8/21/14, 2 tablets.</p> <p>When asked if the expired medication could be given to a resident, LN #3 stated, "If someone is not paying attention. I will have the pharmacy send new ones."</p> <p>2. On 10/9/14 at 10:00 AM, during inspection of the 300 Hall medication storage room with LN #5 in attendance 7 medications in the E (emergency) Kit were found to be expired: Augmentin 87 MG expired on 8/14/14; Coreg. 3.125 MG expired on 8/14/14; Lanoxin 0.125 MG expired on 8/14/14; Aldactone 25 MG expired on 8/14/14; Trazadone 50 MG expired on 8/14/14; Narcan 0.4 MG expired on 8/14/14; and, Glucophage 500 MG expired on 8/14/14.</p> <p>When asked about the expired medication LN #5 agreed that the medications were expired.</p> <p>On 10/14/14 at 9:50 AM, the Administrator and DON were informed of the expired medications. No further information or documentation was provided.</p>	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		11/14/14

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F 441	<p>Continued From page 34</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F 441 SPECIFIC RESIDENTS</p> <p>The towel that was left on the floor in resident #25's shower was removed.</p> <p>OTHER RESIDENTS</p> <p>Residents environment is maintained safe, and sanitary, and in a manner to prevent the transmission of disease and infection.</p> <p>SYSTEMIC CHANGES</p> <p>Root cause analysis revealed:</p> <ol style="list-style-type: none"> 1. Staff needed educations on how to handle linen. 2. Staff were not aware linen was on the floor 3. Shower was not inspected following a shower 4. No laundry hamper was available in the residents' room <p>Corrective Actions:</p> <ol style="list-style-type: none"> 1. Staff were inserviced on bagging and removing soiled linen from residents' rooms. 2. Staff are to observe for linens left on the floor by residents and remove it ASAP. 	

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F 441	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 1 random resident (#25). Failure to follow standard infection control measures placed the resident at risk for infections. Findings included: On 10/6/14 at 9:50 AM, during the initial tour of the 300 Hall, the shower floor in Resident #25's room was observed to contain several pieces of dirty clothing. On 10/6/14 at 9:55 AM, LN #8 was interviewed regarding the dirty clothing observed on the floor and stated, "Bad girls, those should not be on the shower floor, my girls are usually pretty good." LN #8 then placed the dirty clothing in a plastic bag to deliver to laundry. On 10/8/14 at 6:25 PM, the Administrator and DON were made aware of the concern with infection control. No further information was provided by the facility.	F 441	3. Staff are inserviced on hire and PRN on infection control measures and on handling soiled linen appropriately. MONITOR: ED, DON, and Unit Managers and/or designee will perform direct observations during their rounds for maintenance of infection control practices. These will be done weekly for a month, every other week for two months and monthly for three months. The results of the direct observations will be taken to the monthly QAPI meeting for analysis and action taken as indicated.	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514	F-514 SPECIFIC RESIDENTS Information was added to the medical records of resident #'s 1, 3, 7, 8, 10, 12, 13, 15, 17, and 18 as indicated. Some documentation could not legally be added.	11/14/14

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F 514	<p>Continued From page 36</p> <p>resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to accurately document information in residents' medical records. This was true for 11 of 20 residents sampled (#s 1-3, 7, 8, 10, 12, 13, 15, 17 & 18) for clinical records. This created the potential for harm if medical decisions were based on inaccurate information. Findings included:</p> <p>1. Resident #10 was admitted to the facility on 5/29/14 with multiple diagnoses which included hemiplegia affecting non-dominant side (late effects of cerebrovascular disease).</p> <p>a. Review of the resident's Physician Orders for October 2014 (recapitulation), documented an order for "Depakote ER 500 mg tablet, extended release 1 tablet PO [per oral] 2X/day [twice daily]," with a start date of 6/26/14. The indication for use documented, "Other and unspecified hyperlipidemia."</p> <p>b. The resident's medical record contained three Behavior/Intervention Monthly Flow Records which were not dated.</p> <p>c. The resident's Urinary Catheter Care Plan, dated 5/29/14, documented an approach to "change catheter per policy...MD prefers catheter [sic] change weekly...refer to MD order."</p>	F 514	<p>OTHER RESIDENTS</p> <p>Residents' medical records are maintained in accordance with accepted professional standards and practices. This includes behavior monitor sheets, care plans, and diagnosis for medications and dating of documents.</p> <p>SYSTEMIC CHANGES</p> <p>Root cause analysis revealed:</p> <ol style="list-style-type: none"> 1. Staff fail to document all the necessary information on forms in the medical record. 2. Staff need educations on the importance of completing the required information in the medical record. 3. The facility fails to hold the staff accountable when documentation is lacking. <p>Corrective Actions:</p> <ol style="list-style-type: none"> 1. Staff were inserviced on ensuring complete information is documented in the medical record. 2. Staff will receive disciplinary action as indicated for missing documentation. 	

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F 514	<p>Continued From page 37</p> <p>On 10/9/14 at 2:50 PM, RCM #14 and the DON were interviewed and shown the three Behavior/Intervention Monthly Flow Records and the DON stated, "They should be dated, definitely."</p> <p>On 10/9/14 at 5:25 PM, RCM #14 was shown the order for Depakote and asked about the hyperlipidemia diagnosis, which was listed as the indication for use. RCM #14 stated, "It really is for convulsions, not hyperlipidemia." RCM #14 was shown the Urinary Catheter Care Plan and stated, "That isn't right, our order isn't to change weekly. The order is to change monthly."</p> <p>2. Resident #17 was readmitted to the facility on 3/17/13 with multiple diagnoses which included depression.</p> <p>Review of the resident's Physician Orders for October 2014, documented an order for "Sertraline 100 mg PO Q [every] Day 2 tabs (200 mg)," with a start date of 6/20/14; however, the order did not contain a diagnosis or indication for use.</p> <p>On 10/9/14 at 4:15 PM, RCM #3 was shown the resident's order for Sertraline. She stated, "It doesn't say depression?" RCM #13 then looked at the resident's MAR (Medication Administration Record). When asked if the diagnosis was on the MAR, RCM #3 stated, "No, it isn't." She then pulled up the electronic physician order on the computer, dated 6/20/14, which did not contain the diagnosis or indication for use and stated, "It isn't on the electronic order."</p> <p>3. Resident #18 was admitted to the facility on</p>	F 514	<p>3. Medical records will check for dates, names, and room numbers on overflow records before filing them.</p> <p>MONITOR:</p> <p>Unit Managers, Medical Records and /or designee will perform MAR, TAR and new admission chart audits weekly for a month, every other week for a month and monthly for 3 months.</p> <p>The results of the audits will be taken to the monthly QAPI meeting for analysis and action taken as indicated.</p>	

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F 514	<p>Continued From page 38</p> <p>8/13/14 with multiple diagnoses which included unspecified type schizophrenia.</p> <p>Review of the resident's Physician Orders for October 2014, documented an order for "Fluoxetine 10 mg tablet give 2 and 1/2 tab (25 mg) PO daily," with a start date of 8/13/14; however, the order did not contain a diagnosis or indication for use.</p> <p>On 10/9/14 at 3:50 PM, RCM #3 was shown the resident's order for Fluoxetine (Prozac). She stated, "Prozac does not have a diagnosis." When asked if the diagnosis was on the MAR, RCM #3 stated, "No, it isn't, I will do a clarification so it will get into the recapitulation orders."</p> <p>4. Similar findings were found for the following residents: Resident #2 - Diagnosis for Norco was listed as Dementia on the MAR and recapitulation orders; Resident #3 - Behavior Monitor sheets, Pain Flow sheets and Sliding Scale Insulin sheets were not dated; Resident #7 - Two hand written medication sheets were not dated; Resident #8 - Urinary Incontinent Assessment and Behavior Monitor sheets were not dated; Resident #12 - Behavior Monitor sheets were not dated. The orders for Vitamin D3 and Cranberry capsules did not include a diagnosis or indication for use on the MAR and recapitulation orders. Resident #13 - Behavior Monitor sheets and Sliding Scale Insulin sheets were not dated; Resident #15 - Behavior Monitor sheets were not dated and a Sliding Scale Insulin sheet was not dated.</p>	F 514		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	Continued From page 39 On 10/14/14 at 9:50 AM, the Administrator and DON were made aware of the concern regarding dates and accuracy of records. No further information was provided by the facility.	F 514			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001415	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/14/2014
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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during an Annual Recertification, State Licensure, and Complaint survey of your facility. This report reflects changes resulting from the December 18, 2014 Informal Dispute Resolution (IDR) process. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Becky Thomas, RN Linda Hukill Neil, RN Judy Atkinson, RN	C 000		
C 111	02.100,02,f Provide for Sufficient/Qualified Staff f. The administrator shall be responsible for providing sufficient and qualified staff to carry out all of the basic services offered by the facility, i.e., food services, housekeeping, maintenance, nursing, laundry, etc. This REQUIREMENT is not met as evidenced by: Refer to F353 as it relates to sufficient staff to address to residents' needs.	C 111	C 111 Please refer to F 353	11/14/14
C 123	02.100,03,c,vii Free from Abuse or Restraints vii. Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient/resident from injury to	C 123	C 123 Please refer to F 221	11/14/14

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JAN 27 2015
FACILITY STANDARDS

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Robin Leary ADMINISTRATOR
TITLE
11-14-14
(X6) DATE
11/06/14

Bureau of Facility Standards

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C 123	Continued From page 1 himself or to others; This Rule is not met as evidenced by: Please refer to F221 as related to physical restraints.	C 123		
C 124	02.100,03,c,viii Confidentiality of Records viii. Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of his transfer to another health care facility, or as required by law or third-party payment contract; This Rule is not met as evidenced by: Please refer to F164 as related to privacy of records.	C 124	C 124 Please refer to F 164	11/14/14
C 159	02.100,09 Record of Ptnl/Rsdnt Personal Valuables 09. Record of Patient's/Resident's Personal Valuables. An inventory and proper accounting shall be kept for all valuables entrusted to the facility for safekeeping. The status of the inventory shall be available to the patient/resident, his conservator, guardian, or representative for review upon request. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an accounting of personal belongings was completed upon admittance and discharge for 1 of 3 resident's closed records (#23). Findings included:	C 159	C 159 SPECIFIC RESIDENT Resident # 23 was a closed record. OTHER RESIDENTS Residents inventory sheets have been reviewed to ensure their personal items are logged on the inventory sheets. SYSTEMIC CHANGES C.N.A.'s were inserviced on ensuring the residents personal items are log on the inventory sheet on admission. LN were inserviced to ensure that family/POA sign for belonging on discharge.	11/14/14

Bureau of Facility Standards

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C 159	Continued From page 2 Resident #23 was admitted to the facility on 9/5/14 with multiple diagnoses, including congestive heart failure, pulmonary emboli, and pneumonia. The resident expired on 9/7/14 at the facility. On 10/9/14 at 12:25 PM, the Health Information Manager (HIM) Assistant was interviewed regarding the account and disposition of the resident's personal belongings. The HIM Assistant stated, "The CNA and/or family fill it out when the resident comes in to the facility and the other side of the form is for when they discharge. The belongings list is not in there and should be." On 10/14/14 at 9:50 AM, the Administrator and DON were informed of the issue. No additional information was provided.	C 159	MONITOR Medical records will audit new admission inventory sheets during the new admit audits to ensure the inventory sheets are completed. Medical records will audit for signature for disposition of personal items on discharge charts. Results of audits will be taken to the monthly QAPI meeting for analysis and action taken as necessary.	
C 297	02.107,05,a Bedtime Snacks a. Bedtime snacks of nourishing quality shall be offered, and between-meal snacks should be offered. This Rule is not met as evidenced by: Please refer to F368 as it relates to evening snacks.	C 297	C 297 Please refer to F 368	11/14/14
C 311	02.107,07 Food Preparation and Service 07. Food Preparation and Service. Foods shall be prepared by methods that conserve nutritive value, flavor and appearance, and shall be attractively served at proper temperatures. This Rule is not met as evidenced by:	C 311	C 311 Please refer to F 364	11/14/14

Bureau of Facility Standards

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C 311	Continued From page 3 Please refer to F364 as it relates to palatability and inadequate temperatures.	C 311		
C 393	02.120,04,b Staff Call System at Each Bed/Room b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Please refer to F246 as it relates to call light accessibility.	C 393	C 393 Please refer to F 246	11/14/14
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview, review of Infection Control Committee (ICC) meeting minutes and attendance logs, and policy review, it was determined the facility failed to ensure a pharmacist, a representative from housekeeping, and a representative from maintenance attended	C 664	C 664 SPECIFIC & OTHER RESIDENTS No residents identified SYSTEMIC CHANGES The Pharmacist, Housekeeping and Maintenance Department Heads have been educated about attending the infection control meeting a minimum of quarterly.	11/14/14

Bureau of Facility Standards

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C 664	<p>Continued From page 4</p> <p>ICC meetings every quarter. This failure created the potential for a negative effect for all residents including 13 of 13 sample residents (#s 1-13), staff, and visitors to the facility. Findings included:</p> <p>The Infection Control Protocol was reviewed on 10/9/14 at 1:35 PM with the SDC (Staff Development Coordinator) and Infection Control Manager. The Infection Control Manager provided the sign in sheet for the monthly Infection Control Committee Meetings. Upon review of the sign-in sheets, it was determined the following ICC members did not attend/participate in the ICC meetings at least quarterly:</p> <ul style="list-style-type: none"> *Pharmacy - did not attend/participate for the 1st Quarter; *Pharmacy and Housekeeping did not attend/participate for the 2nd Quarter; and, *Housekeeping and Maintenance - did not attend/participate for the 3rd Quarter. <p>On 10/9/14 at 2:15 PM, the Infection Control Manager stated, "I will make sure someone from Pharmacy, Housekeeping and Maintenance sign the sign-in sheet from now on and will make sure there is a representative from each department on a quarterly basis."</p> <p>On 10/14/14 at 9:50 AM, the Administrator and the DON were made aware of the above mentioned concern. No further information was provided by the facility which resolved the issue.</p>	C 664	<p>MONITOR</p> <p>ED will monitor by heading the infection control meetings.</p>	
C 671	<p>02.150,03,b Handling Dressings, Linens, Food</p> <p>b. Proper handling of dressings, linens and food, etc., by staff: This Rule is not met as evidenced by:</p>	C 671	<p>C 671 Please refer to F 441</p>	11/14/14

Bureau of Facility Standards

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C 671	Continued From page 5 Please refer to F441 as it relates to infection control.	C 671		
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F280 as it relates to care plans.	C 782	C 782 Please refer to F 280	11/14/14
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F323 as it relates to falls.	C 790	C 790 Please refer to F 323	11/14/14
C 797	02.200,03,c Documentation of Nursing Assessments c. Nursing staff shall document on the patient/resident medical record, any assessments of the patient/resident, any interventions taken, effect of interventions, significant changes and observations and the administration of medications, treatments and any other services provided. Entries shall be made at the time the action occurs and shall be signed by the person making the entry and shall provide the time and date of the occurrence. At a minimum, a monthly summary of the patient's/resident's condition and reactions to care shall be written by	C 797	C797 Please refer to F281	11/14/14

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C 797	Continued From page 6 a licensed nursing staff person. This Rule is not met as evidenced by: Please refer to F281 as it relates to Professional Standards.	C 797		
C 881	02.203,02 Individual Medical Record 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Please refer to F514 as it relates to complete, systematically organized and accurate documentation.	C 881	C 881 Please refer to F514	11/14/14
C 882	02.203,02,a Resident Identification Requirements a. Patient's/resident's name and date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service (if applicable); name, address and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and disposition, signed by the attending physician, shall be part of the medical record.	C 882	C 882 SPECIFIC RESIDENT Resident # 23 cause of death is documented in his closed file. OTHER RESIDENTS Residents that discharge or expire will have the final diagnosis, cause of death (when applicable), condition on discharge and disposition signed by the attending physician, and shall be part of the medical record.	11/14/14

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C 882	<p>Continued From page 7</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to document the final diagnosis or cause of death and obtain the signature of the Physician and date. This was true for 1 of 3 (#23) closed records reviewed. Findings included:</p> <p>Resident #23 was admitted to the facility on 9/5/14, with multiple diagnoses including congestive heart failure, pulmonary emboli, and pneumonia. The resident expired on 9/7/14 at the facility.</p> <p>Review of the resident's closed record did not provide evidence the physician had documented the cause of death.</p> <p>On 10/9/14 at 12:25 PM, the Health Information Manager (HIM) Assistant was interviewed about the lack of documentation in the chart, for the cause of death, the physician's signature and date. The HMI provided a faxed second copy of the discharge summary, which contained the cause of death, physician's signature and date. The HIM assistant stated, "We faxed the discharge summary yesterday and I received this off the fax machine this morning. The doctor has signed it." The HIM Assistant said that some of the physicians are slow in signing their documents and that they may not get the original back for months.</p> <p>On 10/14/14 at 9:50 AM, the Administrator and DON were informed of the issue. There was no additional information provided by the facility.</p>	C 882	<p>MONITOR</p> <p>Medical records and/or designee will audit closed records to ensure completions of the physician discharge summary.</p> <p>ED will monitor through review of the audits.</p> <p>Results of audits will be taken to the monthly QAPI meeting for analysis and action taken as necessary.</p>	



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

November 25, 2014

FILE COPY

Robin Leary, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Ms. Leary:

On **October 14, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Post Falls. Linda Hukill-Neil, RN, Judy Atkinson, RN, Amy Barkley, RN, Becky Thomas, RN conducted the complaint investigation.

This complaint was investigated in conjunction with the facility's annual recertification survey.

The following documents were reviewed:

The records of 23 residents including that of the identified resident,
Staffing records,
Hall census and a list of residents who required one person, two person, and mechanical lift assistance,
Facility grievances (Concern and Comment Reports),
Incident and accident reports; and
Resident Council meeting minutes.

The following interviews were conducted:

Resident group,
Individual residents and their families,
Licensed Nurses (LNs) and Certified Nurse Aides (CNAs), and
Dietary Manager.

The complaint allegations, findings and conclusions are as follows:

Robin Leary, Administrator
November 25, 2014
Page 2 of 3

Complaint #ID00006479

ALLEGATION #1:

The complainant stated the facility was insufficiently staffed. On May 6, 2014, forty residents were supervised by one Registered Nurse (RN) and two Certified Nurse Aides (CNAs) on the 200 hallway. The call lights of four residents' were activated for an extended period of time.

FINDINGS #1:

Based on interviews with residents and staff and review of staffing records, it was determined the facility had ongoing residents' grievances about lack of timely response to requests for residents' needs. These grievances continued without an adequate resolution.

The complaint was substantiated and the facility was cited at F353 for having insufficient staff to meet the residents' needs.

CONCLUSIONS:

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

ALLEGATION #2:

The complainant stated the dinner meal consisted of dry meat and a dry entree. The meals served to residents in their room appeared to be different than meals served in the dining room.

FINDINGS #2:

Based on resident and staff interviews and the surveyors' sampled tray, it was determined the facility did not serve food that was palatable and the temperature of the hot foods was not adequate. Food was not observed to be different on the hall trays than the dining room.

The complaint was substantiated and the facility was cited at F364 for inadequate temperatures and palatability.

CONCLUSIONS:

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

Robin Leary, Administrator
November 25, 2014
Page 3 of 3

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, LSW, QIDP or David Scott, RN, Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

LORENE KAYSER, LSW, QIDP, Supervisor
Long Term Care

LK/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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November 25, 2014

FILE COPY

Robin Leary, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Ms. Leary:

On **October 14, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Post Falls. Linda Hukill-Neil, RN, Judy Atkinson, RN, Amy Barkley, RN, and Becky Thomas, RN conducted the complaint investigation.

The following complaint was taken by the Assisted Living Team and when the team went to investigate the complaint on June 17, 2014, they called the complainant and learned the resident was at a different facility.

It was determined the resident had not resided at the facility since September 2013, at which time he was discharged home with Veterans Affairs services for home health nursing and physical/occupational services.

The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006483

ALLEGATIONS:

1. The identified resident's bedding was not changed for weeks.
2. Medications were not given at noon per orders.
3. The call lights were not answered in a timely manner.

Robin Leary, Administrator
November 25, 2014
Page 2 of 2

4. The facility was not staffed "properly." The caregivers would bring people to the table and then leave to provide cares to other residents. There were no servers to serve the meals, therefore the caregivers had to serve meals.
5. The facility staff did not practice good infection control.
6. The quality of the food was "horrible."
7. The Administrator did not respond to complaints in a timely manner. The complainant said she turned in a formal complaint, but never received any response and the staff was changing all the time.

FINDINGS:

The survey team attempted to contact the complainant on October 1, 2014 and was unsuccessful.

On October 1, 2014 the survey team spoke with the area Ombudsman, who confirmed the resident was discharged from the facility in September 2013, and stated the resident had verbalized some complaints and concerns to her, however he did not want her to investigate them.

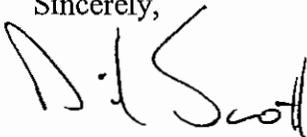
The survey team was unable to investigate the above complaint.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



DAVID SCOTT, RN, , Supervisor
Long Term Care

DS/lj