



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

December 2, 2014

Bernardo "Ben" Carotenuto, Administrator  
Clearwater Health & Rehabilitation  
1204 Shriver Road  
Orofino, ID 83544-9033

FILE COPY

Provider #: 135048

**RE:** Corrected Copy of the October 23, 2014, Recertification, Complaint  
Investigation and State Licensure Survey Cover Letter dated November 5, 2014

Dear Mr. Carotenuto:

On **November 5, 2014**, your facility was sent a certified letter (7007 3020 0001 4038 9680) from our office notifying you of the results of the October 23, 2014, Recertification, Complaint Investigation and State Licensure survey. It was discovered that this certified letter contained wrong dates on pages 2 and 3. Please replace the previously sent letter of November 5, 2014, with this corrected copy.

On **October 23, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Clearwater Health & Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be

Bernardo "Ben" Carotenuto, Administrator  
December 2, 2014  
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completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both 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 18, 2014**. Failure to submit an acceptable PoC by **November 18, 2014**, may result in the imposition of civil monetary penalties by **December 8, 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*.

Bernardo "Ben" Carotenuto, Administrator  
December 2, 2014  
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Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **November 27, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **November 27, 2014**. A change in the seriousness of the deficiencies on **November 27, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 27, 2014** includes the following:

Denial of payment for new admissions effective **January 23, 2015**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 23, 2015**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **October 23, 2014** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through

Bernardo "Ben" Carotenuto, Administrator  
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an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10.

Informational Letter #2001-10 can also be found on the Internet at:

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

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

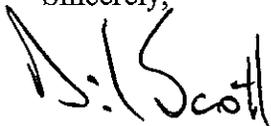
- BFS Letters (06/30/11)

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

This request must be received by **November 18, 2014**. If your request for informal dispute resolution is received after **November 18, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We apologize for any inconvenience this may have caused. Should you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, (208) 334-6626, fax (208) 364-1888.

Sincerely,



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

DS/dmj  
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>135048</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: <b>10/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER HEALTH &amp; REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1204 SHRIVER ROAD OROFINO, ID</b>		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>F 204</b>	<p><b>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG</b></p> <p>A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to account for the belongings of a deceased resident. This was true for 1 of 1 resident whose closed records were reviewed (#10). Findings included:</p> <p>Resident #10 was admitted to the facility on 7/16/14 with multiple diagnoses including pneumonia and gastrointestinal hemorrhage. The resident expired at the facility on 8/25/14.</p> <p>Review of the resident's Inventory of Personal Effects form and the last Progress Notes documented for 8/25/14 did not provide evidence the resident's belongings were accounted for.</p> <p>On 10/23/14 at 4:15 PM, the Administrator and DON were informed of the personal belongings issue. No further information or documentation was provided.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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

PRINTED: 11/05/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/23/2014
NAME OF PROVIDER OR SUPPLIER  CLEARWATER HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544	
(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	INITIAL COMMENTS  The following deficiencies were cited during the annual recertification and complaint survey of your facility. The team entered the facility October 20, 2014 and exited at October 23, 2014 at 4:15 p.m.  The survey team included:  Nina Sanderson, BSW LSW - Team Coordinator Sherri Case, LSW Judy Atkinson, RN  Definitions: ADLs - Activities of Daily Living BIMS - Brief Interview for Mental Status BSM - Behavior System Monitoring CAA - Care Area Assessment CDM - Certified Dietary Manager CNA - Certified Nursing Assistant DON/DNS - Director of Nursing FRCI - Fall Root Cause Investigation Hx - History of IPN - Interdisciplinary Progress Note LN - Licensed Nurse MAR - Medication Administration Record MDS - Minimum Data Set MG - Milligram MS - Multiple Sclerosis NN - Nurse's Note PO - Oral PT - Physical Therapy RD - Registered Dietician SSPN - Social Services Progress Note TBI - Traumatic Brain Injury UTI - Urinary Tract Infection	F 000	Preparation and execution of this Plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions sets forth in this statement of deficiencies. This plan of correction is prepared solely for the purpose of meeting Federal and State regulations.	
F 151 SS=E	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL	F 151	Continued on Page 2	

RECEIVED  
NOV 13 2014  
FACILITY STANDARDS

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



TITLE

Administrator

(X6) DATE

11/17/14

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 151	Continued From page 1  The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.  The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.  This REQUIREMENT is not met as evidenced by: Based on the resident group and staff interview, it was determined the facility failed to ensure residents were able to exercise their rights as citizens and residents of the United States by notifying the residents of an approaching state election. This affected 3 of 14 residents in the group interview and any other resident wishing to vote. Findings include:  On 10/21/14 at 3:00 PM, a group interview was conducted with residents. When the group was asked about resident rights 3 of 14 residents attending the group interview stated they were unaware that an election was approaching and didn't know if they were registered to vote or how to get registered.  On 10/23/14 at 10:06 AM, the DON she was informed of the residents' concern related to voting and registering to vote. The DON stated, "I talked to the Activity Coordinator on Monday (10/20/14) to get that coordinated. I know it is important."  On 10/23/14 at 10:55 AM, the Activity Coordinator presented a handwritten list of 3 residents who have absentee ballots and said, "I called the assessor's office for direction. I will make sure it	F 151	Continued from Page 1  F 151  1. Resident's # 4, 6, 7, and 13 were provided an absentee ballot to exercise their right to vote in the upcoming election.  2. Current residents were notified of the approaching election date and provided an opportunity to exercise their right vote utilizing an absentee ballot or visiting the polling station. Residents who chose to vote elected to use an absentee ballot. The ballots were submitted on November 6, 2014.  3. The Executive Director (ED) in-serviced the Activity and Social Service directors on the resident's right to vote. Residents will be informed of approaching election dates through Resident Council and the monthly activity calendar.  4. The Executive Director (ED) in-serviced the Activity and Social Service directors on the resident's right to vote. Residents will be informed of approaching election dates through Resident Council and the monthly activity calendar.		11/13/14

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F 151	Continued From page 2 gets done."	F 151	Continued from Page 2		
F 154 SS=D	On 10/23/14 at 4:15 PM, the Administrator and the DON were informed of the issue and no further information was provided. 483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS  The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.  The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure resident representatives were informed of the FDA Black Box warning for the use of antipsychotic medications for residents with dementia. This was true for 3 of 4 residents (#s 5, 6, and 8) sampled for antipsychotic use. The deficient practice had the potential to cause harm when resident representatives were not provided with the opportunity to make informed decisions about the risks and benefits of using these medications. Findings included:  The Lippencott Nursing 2014 Drug Handbook, page 1216, documented for Risperidone: "Black Box Warning. Fatal CV (Cardio vascular) or infectious adverse events may occur in elderly	F 154	F 154  1. Representatives for resident's # 5, 6, and 8 were informed of the FDA Black Box warning for the use of antipsychotic medications.  2. Current records of residents prescribed antipsychotic medications were audited to ensure the resident or representative were informed of the FDA Black Box warnings. 3. The IDT was in-service by the Director of Clinical Services (DSC) on obtaining informed consent from the resident or representative for the use of antipsychotic medications to include FDA Black Box warnings.	11/13/14	

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F 154	<p>Continued From page 3</p> <p>patients with dementia. Drug isn't safe or effective in these patients."</p> <p>1. Resident #5 was admitted to the facility in November 2011 with multiple diagnoses which included dementia with delusions.</p> <p>Resident #5's recapitulation orders for September 2014 documented the resident received Risperidone 0.75 mg daily for delusional disorder, beginning 1/15/13.</p> <p>Resident #5's record documented a "Medication Information" printout which listed the potential side effects of Risperidone, but did not identify the FDA Black Box warning or any special considerations when using this medication in an elderly person with dementia. The form documented the resident's responsible party was informed of the use of the medication and the information on the printout on 6/15/12.</p> <p>On 10/22/14 at 4:00 PM, the DNS stated she was unaware the facility was required to have documentation the facility had informed the resident's responsible party of the Black Box warning. The DNS was unable to explain how the determination had been made that the responsible party had made an informed decision regarding the potential risks and benefits of the use of Risperidone if not presented with this information.</p> <p>On 10/23/14 at 4:15 PM, the Administrator and DNS were informed of these findings. The facility offered no further information,</p> <p>2. Resident #6 was admitted to the facility on 7/25/12, and readmitted on 12/15/13, with multiple diagnoses that included dementia with</p>	F 154	<p>Continued from Page 3</p> <p>4. The DCS / designee will review consents for prescribed antipsychotic medications to ensure the resident or representative have been informed of the FDA Black Box warning during the weekly behavior management meeting. The ED / designee will audit consents forms for prescribed antipsychotic medication times three months to ensure residents or representatives have been provided the FDA Black Box warning information. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance.</p>		

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F 154	Continued From page 4 behavior disorder.  The resident's current physician recapitulation orders, dated 9/1/14, documented: *Risperidone 1 MG (milligram) tablet- generic for Risperdal 1 MG tablet: Give 1 tablet orally 2 times a day (Psychosis W[with]/depression).  On 10/22/14 at 10:38 AM, the DON was asked if the resident or her representative had been informed of the risk and benefits in the Black Box Warning for Risperidone. She stated, "I didn't know that we needed to put that (risks and benefits) in the chart. Shouldn't the pharmacy have picked up on that."  On 10/22/14 at 6:30 PM the Administrator and the DON were informed of the findings. No additional information was provided.  3. Resident #8 was admitted to the facility on 10/6/14 with diagnoses which included vascular	F 154	Continued from Page 4  This page was intentionally left blank.		

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F 154	Continued From page 5 dementia, obsessive compulsive disorder, edema and hemiplegia.  The resident's 9/1/14 Physician's Orders included an order for Seroquel (antipsychotic) 25 mg at bedtime for obsessive compulsive disorder, with a start date of 8/26/13.  The resident's medical record did not include documentation the resident or a family member had been informed elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death.	F 154	Continued from Page 5  This page was left blank intentionally.		
F 157 SS=D	On 10/22/14 at 2:45 p.m., the DON stated the resident had not been informed of the increased risk of death. On 10/23/14 at 4:15 p.m., the DON and Administrator were informed of the above concern. The facility provided no further information.  483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of	F 157			

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F 157	Continued From page 6 treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  <del>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</del>  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to promptly notify the resident's physician or family member when Resident #3 fell and sustained abrasions and skin tears. This was true for 1 of 6 sampled residents (#3). This failure had the potential for harm when the resident's physician was not able to make decisions and initiate treatments based on the resident's needs. Findings included:  Resident #3 was admitted to the facility on 8/25/2014. The resident had diagnoses which included after care for hip fracture, atrial fibrillation and generalized pain.  A Fall Root Cause Investigation Report documented on 10/2/14 (time not documented) Resident #3 fell when bending over in his wheel chair.	F 157	Continued from Page 6  F 157  1. The licensed nurses responsible to notify resident # 3's physician of a fall with skin tear and abrasions have been re-educated on prompt notification.  2. An audit was conduct of incident / accident (I/A) documentation for the past three months to ensure timely notification of the resident's physician and family member. No delay in notification was identified.  3. The DCS in-serviced licensed nurses on prompt notification to the physician and family member following an IA.	11/13/14	

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F 157	Continued From page 7	F 157	Continued from Page 7		
	<p>A Nurses Note (NN) on 10/2/14 at 2:00 p.m. documented that at 9:40 a.m. the resident was in his wheelchair bending over and fell. The NN documented, "Noted several facial wounds, upper forehead abrasion 3.5 cm x 1.5 cm. Mid forehead abrasion 2 cm x 0.5 cm. Temporal forehead 1 cm x 1 cm Bridge of nose 3 mm x 3 mm steri strips placed. Right lower nose 2 mm wound. Steri strips placed on skin tear on left wrist measuring 1 cm x 1.5 cm...."</p> <p>A second NN on 10/2/14 at 2:45 p.m., documented the physician and a family member were contacted regarding the fall.</p> <p>On 10/22/14 at 2:50 p.m., the DON stated the facility would call the physician right away if there was an accident during normal business hours. The DON stated the physician should have been called prior to 2:45 p.m. regarding the resident's fall.</p> <p>On 10/23/14 at 4:15 p.m. the DON and Administrator were informed of the above concern. The facility provided no further information.</p>		<p>4. The DCS / designee will review I/A documentation during clinical meetings five times a week to ensure prompt notification of the physician and family member. The ED / designee will conduct random audits of IA documentation to ensure prompt physician and family member notification weekly times four weeks, then monthly times two months. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance.</p>		
F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this</p>	F 164			

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F 164	Continued From page 8 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 the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.  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 Random Resident (#13). This failure created the potential for a negative effect on the resident's psychosocial well-being related to the need for privacy and confidentiality. Findings included:  On 10/22/14 at 4:55 PM, LN #1 was observed to leave Random Resident #13's MAR on top of the medication cart in the B-Hall in full view when she walked away and into the Activity Room. When LN #1 was asked about leaving the MAR with resident's health information exposed, she stated, "Sometimes I like to mark them, it's easier to	F 164	Continued from Page 8 F 164  1. Licensed nurse #1 was immediately re-educated on the resident's right to personal privacy and confidentiality as it relates to the medication administration record (MAR).  2. The DCS conducted an observation audit of nurses passing medication to ensure MARs were appropriately secured to protect the resident's personal privacy and confidentiality.  3. The licensed nurses were in-serviced on maintaining resident privacy and confidentiality of their personal health information including the MAR during medication administration.  4. The DCS / designee will conduct random weekly observation audits times four weeks, then monthly for two months to ensure resident health information is maintained in a private and confidential manner. The results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance.	11/13/14	

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F 164	Continued From page 9 see."	F 164	Continued from Page 9		
F 242 SS=D	<p>On 10/23/14 at 4:15 PM, the Administrator and DON were informed of the observation. No further information was provided regarding this issue.</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to allow a resident to choose a daily schedule per her preference. This was true for 1 of 9 sampled residents (#4). The deficient practice had the potential for harm if the resident suffered contractures, pressure ulcers, or boredom when required to remain either in her bed or her wheelchair for 2 hour increments. Findings included:</p> <p>Resident #4 was admitted to the facility in June 2010 with multiple diagnoses which included multiple sclerosis.</p> <p>Resident #4's most recent Quarterly MDS assessment, dated 9/30/14, coded moderately impaired cognitive skills, no behavioral</p>	F 242	<p>F 242</p> <ol style="list-style-type: none"> <li>Resident #4's behavior care plan was reviewed and updated by the IDT on 10/23/14.</li> <li>Current resident care plans have been reviewed by the IDT to ensure approaches for behaviors allow for resident choice and preferences.</li> <li>The IDT Team members will be assigned to complete an education module for managing difficult behaviors.</li> <li>The ED / designee will conduct random audits of behavior care plans to ensure they reflect resident choice and preference, weekly times four weeks then monthly times two months. The results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance.</li> </ol>	11/13/14	

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F 242	Continued From page 10 symptoms, depended on 2 persons for transfers, dependent on 1 person for bed mobility, incontinent of bowel and bladder, and impaired range of motion on all extremities.  On 4/2/14, Resident #4's care plan identified she had the potential for inappropriate behaviors which were identified as yelling, cursing, belittling staff, repeatedly calling her physician or her husband to complain about trivial things, throwing small objects, and ordering others to move out of her way. An intervention of, "Remind [Resident #4] of contract between [facility] and her if her demands are unreasonable or [contrary] to the contract agreement." An undated, unsigned document included with her care plan documented, "Every 2 hours she may be toileted, layed [sic] down, etc. She has been notified staff will respond to her needs only after it has been 2 hours, and that she needs to make sure that all of her requests will be made at that time, as you will not be able to come back for 2 hours...unforeseen emergencies...must of course respond to those issues right away..."  On 10/21/14 at 10:05 AM, Resident #4 was lying in her bed. Her call light was on. A maintenance person entered the room, and returned to the hallway and told the Administrator and LN #6 the resident wanted to lay down. LN #6 informed the Administrator the resident had a, "two hour thing. Up for two hours or down for two hours once she goes down. I'm sure it hasn't been two hours yet." The Administrator directed the resident was to get up if she was requesting to do so. At 10:25 AM, the resident was taken to the "Sit and Fit" activity.  On 10/21/14 at 2:50 PM, a CNA was observed exiting Resident #4's room, and tell CNA #7 the	F 242	Continued from Page 10  This page was intentionally left blank.		

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F 242	Continued From page 11 resident wanted to get up. CNA #7 stated the resident could not do so. When the surveyor asked CNA #7 why the resident could not get up, CNA #7 told the surveyor the resident was on a "strict" two hour schedule, and had not yet been in bed 2 hours.  On 10/22/14 at 3:45 PM, the DNS stated that before mid-September 2014, the resident's behaviors "had been a real issue. We sat down and talked with her and her husband. We all agreed the two hour schedule would be the best thing for her. Even she agreed to do it. But it should have been deleted from the care plan in September. She doesn't need it anymore." The DNS was unable to describe how the agreement empowered the resident to make choices about her daily routine, if the resident failed to recall the agreement or chose to no longer participate in it. The DNS was could not explain why 2 staff members had been observed trying to enforce the agreement.  On 10/23/14 at 4:00 PM, the DNS provided an updated copy of the resident's care plan. The intervention of reminding the resident about her "contract" with the facility had been documented as discontinued.	F 242	Continued from Page 11  This page was intentionally left blank.		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and	F 246			

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F 246	Continued From page 12 preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews, it was determined the facility did not ensure call lights were accessible for 1 of 9 sampled residents (#2). 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:  Resident #2 was admitted to the facility on 9/29/14 with diagnoses which included pubic rami fracture, chronic kidney disease and end stage liver disease.  On 10/21/14 at 2:10 p.m., Resident #2 was observed in his bed. The cord of the resident's call light was observed to be under his pillow with the call button at the top of his pillow. The resident stated he did not know where his call light was. When told where the call light was he attempted to reach it but was unable to do so. LN #2 was present and moved the call light where Resident #2 could reach it.	F 246	Continued from Page 12  F 246  1. The call light for Resident # 2 was immediately moved within reach of resident when staff learned it was not accessible.  2. An audit has been completed to ensure call lights are accessible to all residents.  3. The facility staff were in serviced on call light placement to ensure accessibility to the residents.  4. The facility management team will conduct call light accessibility during mock survey rounds each day. The ED or designee will complete a random audit of call light accessibility weekly times four, then monthly times three. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance.	11/13/14	
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	F 252			

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F 252	Continued From page 13	F 252	Continued from Page 13		
	<p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to provide a homelike environment in good repair. This was true for 8 sampled residents (#s 1, 3, 4, 5, 6, 8, 11, and 14); as well as any resident using the back dining room or independent shower room. The deficient practice had the potential to cause harm when residents were exposed to worn, stained, uneven flooring, and bathing facilities in disrepair. Findings included:</p> <p>1. On 10/21/14 at 11:35 AM, the floor in the back dining room, extending into the therapy gym, was observed with worn areas throughout the linoleum and black scuff marks covering a 3-foot by 3-foot area just inside the doorway. The entire floor had yellowed stripes, 2 to 4 inches wide, running the length of the floor, 2 to 3 feet apart. The surface of the floor was uneven. On 10/23/14 at 10:30 AM, when the Maintenance Director was asked about the flooring, he stated the room would require the sub floor to be replaced to even out the surface, and the flooring would have to be replaced in order to get rid of the yellowed stripes.</p> <p>2. On 10/23/14 at 10:10 AM, during the environmental tour with the facility Maintenance Director, several areas of disrepair in the independent shower room were noted. The floor</p>		<p>F 252</p> <p>1. Bids have been obtained and approved to replace the flooring in the back dining room and therapy gym as well as independent shower room flooring. Facility Maintenance Director to replace damaged tiles in independent shower room. Fixture in independent shower room will be repaired on 11/18/14 by facility Maintenance.</p> <p>2. The ED and Maintenance Director completed environmental rounds on 11/13/14 to ensure a safe, clean, homelike environment. No other areas of concern were identified during these rounds.</p> <p>3. The IDT has been in-serviced on utilizing the Mock Survey tool to identify areas of concern and report at the daily morning meeting five times per week. The Maintenance Director has been in-serviced to include floor inspection on the preventative maintenance checklist.</p>	11/13/14	

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F 252	Continued From page 14 was warped and uneven. An area of the floor, approximately 2 feet long by 3 feet wide, had flooring which did not match the rest of the floor. The seam on the floor where two pieces of linoleum joined had bubbled and curled. The baseboards in the room were scuffed along all walls. The divider wall between the bathtub and toilet was missing a tile at the base, and had several other damaged tiles. There was a chip in the bottom of the shower fixture. The Maintenance Director stated the sub floor had warped, causing parts of the flooring to need replacement, but the facility had been unable to find the same tile to make the repair. As a result, the floor was completed in mismatched tile. The Maintenance Director stated until the sub floor could be repaired, the floor would remain uneven with a curled seam and showed the surveyor the facility's assisted shower room, which had recently been renovated and repaired. The Maintenance Director stated as soon as the facility budgeted the funds, the independent shower room would be remodeled in the same fashion, however the damage was so extensive the repairs could not be made individually and would require a complete renovation of the room.	F 252	Continued from Page 14  4. The ED / designee will conduct random weekly environmental rounds with one other IDT member weekly times four weeks then monthly thereafter to ensure a homelike environment that is safe, clean, and comfortable. The results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		

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F 309	Continued From page 15 and plan of care.	F 309	Continued from Page 15		
	<p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review it was determined the facility failed to ensure a resident's appointment for oral surgery was re-scheduled in a timely manner after it had been canceled, and medications were given as ordered. This was true for 2 of 9 (#s 4 and 11) sampled residents. The deficient practice had the potential for harm if residents experienced pain, infection, or functional decline when these procedures and treatments were not provided timely. Findings included:</p> <p>1. Resident #11 was admitted to the facility in June 2011 with multiple diagnoses which included alcohol abuse and a traumatic brain injury (TBI) with multiple facial surgeries.</p> <p>Resident #11's most recent Annual MDS assessment, dated 9/23/14, coded the resident had obvious/likely cavities and/or broken natural teeth. The CAA for that date documented the resident was not having pain, had no infection, and did not want to see a dentist.</p> <p>On 1/15/14 at 1:40 PM, Resident #11's Social Services Progress Notes (SSPN) documented she had agreed to a dental appointment and had been seen by a dentist. The SSPNs documented: *1/21/14. The treatment plan for the resident included extractions. The facility initiated the approval process through Medicaid. *3/3/14. Medicaid authorization was received. The</p>		<p>F 309</p> <p>1. Resident # 11's was seen by the dentist on 6/12/14. An order was obtained from resident #4's attending physician to hold Copaxone until prior authorization is obtained.</p> <p>2. The resident appointment calendar was reviewed for the past 3 months to ensure appointments have been completed. Current resident records have been audited to ensure prior authorizations have been addressed. The DCS / designee will track prior authorizations to ensure a 48 hour turnaround time from the time the facsimile notification is received.</p>	11/13/14	

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F 309	<p>Continued From page 16</p> <p>nearest oral surgeon willing to accept Medicaid was in a community 3 hours away. A pre-operative examination was scheduled for 3/13/14.</p> <p>*3/6/14. The appointment was re-scheduled for 3/24/14, as the Board of Guardians needed to review the resident's information before consenting.</p> <p>*3/25/14. The oral surgeon determined the resident would require intravenous anesthetic for the procedure, which required additional Medicaid authorization. A request for Medicaid coverage was initiated.</p> <p>*4/10/14. Authorization was received, and a surgical appointment was scheduled for 4/23/14. A CNA would be required to accompany the resident. [NOTE: Given the amount of time to travel to and from the community where the procedure was going to take place, and the time necessary for the procedure, it would require a full 8 hour shift for a CNA to accompany the resident.]</p> <p>*4/21/14. The surgical appointment was canceled as the CNA scheduled to accompany the resident was no longer available. Per the documentation, the cancellation was at the direction of the Administrator in Training, who was the facility's Administrator at the time the survey was conducted.</p> <p>*5/8/14, documented as a late entry for 4/5/14. "...SS [Social Services] had to explain to [guardian] that [Resident #11's appointment] was canceled due to lack of staff to go with her...haven't been given okay to reschedule..." [NOTE: If accepted as a late entry for 4/5/14, the resident's appointment had not yet been scheduled, as Medicaid authorization had not yet been received. See F 514 for details.]</p>	F 309	<p>Continued from Page 16</p> <p>3. The Social Service Director has been in-serviced on the importance of tracking the completion of resident appointments. Any barriers to completing an appointment will be addressed promptly. The resident appointment calendar will be reviewed at the daily morning meeting five times per week. Licensed nurses have been in-serviced on the procedure for processing prior authorizations in a timely manner. The DCS is responsible to ensure prior authorizations are addressed within forty-eight hours of receiving the facsimile notification to prevent delay in treatment.</p>	

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F 309	<p>Continued From page 17</p> <p>No further entries were made in the SSPN regarding the oral surgery appointment.</p> <p>On 5/14/14 at an unknown time, Resident #11's Nurse's Notes documented the oral surgeon's office was contacted, and an appointment made for the procedure on 6/12/14.</p> <p>On 6/12/14, a physician's operative report in Resident #11's record documented the procedure was completed.</p> <p>On 10/23/14 at 11:15 AM, the DNS stated she made the 5/14/14 entry in the resident's record regarding the June appointment. The DNS stated that on that date the resident's guardian had come to the facility to find out the date for which the appointment had been re-scheduled from the cancellation on 4/10/14. The DNS stated when she contacted the oral surgeon's office, it was discovered the appointment had not been made, so the next available appointment was given to the resident.</p> <p>On 10/23/14 at 1:45 PM, the Administrator stated she recalled an interaction with SS regarding the April appointment for this resident. The Administrator stated Resident #11 had a tendency towards verbal outbursts related to her TBI, which became worse when the resident was overwhelmed or upset. The facility was concerned this would happen due to the nature of the procedure, and there was a safety concern that an outburst would occur when the resident was alone in the facility's van with just the van driver on such a long outing. The Administrator stated the CNA selected to accompany the resident for that appointment had been specifically selected due to her relationship with</p>	F 309	Continued from Page 17		
			4. The ED / designee will conduct random weekly audits to ensure prior authorizations have been addressed promptly, weekly times four weeks then monthly times two months. The results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance. Social Services and or designee will audit appointment calendar weekly times 4, and monthly thereafter times three months, to ensure all appointments were attended by residents and or rescheduled.		

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F 309	Continued From page 18 the resident, which seemed to calm the resident down. When the facility realized that CNA was not available to accompany the resident, the decision was made to re-schedule the appointment for another time. The Administrator stated SS was instructed to re-schedule for the next available appointment, not just cancel outright. The Administrator stated the SS person left employment with the facility a few days after this conversation, and the facility presumed the appointment had been re-scheduled. It was not until the guardian approached the DNS on 5/14/14 that the facility realized the appointment had not been re-scheduled. The Administrator stated the facility corrected the problem as soon as it was recognized, but acknowledged this error caused a delay in treatment for this resident.  On 10/23/14 at 4:15 PM, the Administrator and DNS were informed of these findings. The facility offered no further information.  2. Resident #4 was admitted to the facility in June 2012 with multiple diagnoses which included Multiple Sclerosis (MS).  Resident #4's physician's orders documented she was to receive a Copaxone 20 mg injection daily for a diagnosis of MS, beginning 6/7/10.  Resident #4's MAR documented she received her injection on 10/1/14, but the injection was not provided from 10/2/14 through 10/21/14.  Resident #4's Nurse's Notes documented only 2 entries regarding the missing Copaxone doses. On 10/3/14, the day after the first dose was missed, an entry documented, "Phone call follow up to pharmacy [related to] no delivery. Awaiting	F 309	Continued from page 18  This page was left blank intentionally.		

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F 309	Continued From page 19 prior [authorization]. Requested refax [physician]...[Physician] notified...states has not received [preauthroization request]...[No] adverse effect [related] missing doses..." Seven days later, on 10/10/14, an entry documented, "[Physician] reminded of resident [not] receiving Copaxone [for more than] a week. States he will call [pharmacy name] [and] get preauthorization form." There were no further entries in the nurse's notes as of 10/21/14, eleven days later. The physician had not provided an order to hold the medication.  On 10/22/14 at 3:45 PM, the DNS stated the resident's supply of the medication was depleted, and the physician had not completed the necessary forms for the resident's insurance company to authorize more medication. The DNS stated the physician was aware the resident had not received the medication, but provided no documentation to that effect, nor provided an order to hold the medication until a supply could be obtained. The DNS was unaware the issue was not yet resolved, and that the resident was still not receiving the medication. The DNS could not explain why there was a delay of 7 days between the time the physician was first notified and the facility's follow-up, nor why another 11 days passed with no further documented contact with the physician.  On 10/23/14, the facility provided a physician's order to hold the resident's Copaxone until a supply could be obtained from the pharmacy.  On 10/23/14 at 4:15 PM, the Administrator and DNS were informed of these findings. The facility offered no further information.	F 309	Continued from Page 19  This page was left blank intentionally.		

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F 323 F 323 SS=D	Continued From page 20 483.25(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 observation, review of resident records, incident/Accident reports and staff interviews, it was determined the facility failed to ensure fall prevention interventions were implemented and to ensure siderails were assessed to be safe prior to use. This was true for 1 of 6 (#3) sampled residents. These failures had the potential for harm if the resident sustained a fracture from falling or if entrapped in a siderail for injury or possibly death. Findings included:  Resident #3 was admitted to the facility on 8/25/2014 with diagnoses which included after care for hip fracture, atrial fibrillation and generalized pain.  A Nurses Note (NN) on 10/2/14 at 2:00 p.m. documented at 9:40 a.m. the resident was in his wheelchair bending over and fell. The NN documented, "Noted several facial wounds, upper forehead abrasion 3.5 cm x 1.5 cm. Mid forehead abrasion 2 cm x 0.5 cm. Temporal forehead 1 cm x 1 cm Bridge of nose 3 mm x 3 mm steri strips placed. Right lower nose 2 mm wound. Steri	F 323 F.323	Continued from Page 20 F323  1. The nursing staff responsible for resident #3's care were re-educated directly following the incident on the importance of ensuring fall interventions are in place; alarm placement and function, as well as wheelchair positioning. Resident #3's mobility status was reassessed and the cane rail was removed on 10/23/14. 2. An audit of current residents at risk for falls was completed to ensure fall prevention interventions are in place per plan of care including alarm placement and function. The IDT audited the transfer mobility status for current residents to ensure a safe hazard free environment. 3. The nursing staff has been in-serviced on application of fall prevention interventions to include alarm placement and function and wheelchair positioning. The IDT is responsible to ensure the resident's transfer mobility status is assessed on admission, quarterly, and with significant change to provide a safe hazard free environment as is possible.	11/13/14	

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F 323	<p>Continued From page 21 strips placed on skin tear on left wrist measuring 1 cm x 1.5 cm...."</p> <p>A Fall Root Cause Investigation Report (FRCI) documented on 10/2/14 (time not documented) Resident #3 fell when bending over in his wheel chair.</p> <p>The FRCI documented an alarm was in use (type of alarm not specified) but was not turned on and an incontinence pad was over his gel pad.</p> <p>A 10/3/14 Interdisciplinary Progress Note (IPN) documented the resident had leaned forward and fell from his wheelchair. The IPN documented the resident had poor safety awareness, and the resident's pressure alarm was not turned on but probably would not have prevented the fall. Additionally the IPN documented the resident had an incontinent pad on top of his gel cushion, which may have contributed to the fall.</p> <p>On 10/21/14 at 3:30 p.m. and 4:00 p.m., and on 10/22/14 at 4:05 p.m., the resident was observed in bed with the cane rails in the raised position.</p> <p>The resident's medical record did not include documentation the resident had been assessed to be safe for use of the side rails.</p> <p>On 10/22/14 at 2:50 p.m., the DON stated a safety assessment had not been completed for Resident #3 for the use of the side rails. On 10/23/14 the DON stated the facility had removed the siderails from the bed.</p> <p>On 10/23/14 at 4:15 p.m., the DON and Administrator were informed of the above concern. The facility provided no further</p>	F 323	Continued from Page 21  4. The IDT will conduct daily rounds utilizing the Mock Survey tool to ensure the resident environment remains as free of accident hazards as is possible. The DCS / designee will conduct random audits of fall prevention interventions to include alarm placement and function weekly times four weeks then monthly for three months. Results of these audits will be reported the monthly QAPI committee to ensure substantial compliance.		

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F 323	Continued From page 22 information.	F 323	Continued from Page 22		
F 329 SS=E	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	F 329  1. Residents # 5, 6, 7, and 8's Behavior Medication Symptom Monitoring (BSM) records were reviewed and updated to reflect target behaviors, non-pharmacological and pharmacological interventions. Psychoactive medications requiring a gradual dose reduction (GDR) were reviewed by the physician, pharmacist, and IDT to determine appropriate therapeutic dose.  2. Current records of residents receiving psychoactive medications were audited to ensure the BSM flow record accurately reflects targeted behaviors and interventions. During the weekly behavior management meeting IDT will monitor documentation accuracy. The BSM flow record will be utilized by the attending physician when considering GDRs.	11/13/14	
	Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents were free from unnecessary medications. The facility failed to monitor behaviors for which 3 of 8 sample residents (#s 5, 6, 7) received psychopharmacological				

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F 329	<p>Continued From page 23</p> <p>medication, and did not have documentation to justify the continued use of an antipsychotic medication for a resident (#5) who was experiencing adverse effects to that medication. Additionally, for a resident with a diagnoses of dementia (#8), the facility failed to ensure clinical indication for the use of an antipsychotic or provide clinical justification for not attempting a reduction. This practice placed the residents at risk for unanticipated declines or newly emerging or worsening symptoms. Findings included:</p> <p>1. Resident #8 was admitted to the facility on 10/6/14 with diagnoses which included vascular dementia, obsessive compulsive disorder, edema and hemiplegia.</p> <p>The resident's 9/1/14 Physician's Orders included an order for Seroquel (antipsychotic) 25 mg at bedtime for obsessive compulsive disorder, with a start date of 8/26/13.</p> <p>The resident's 2/9/14 Behavior Management Care Plan identified behaviors of hoarding and irritability.</p> <p>Interventions for hoarding included to allow 20 adult briefs daily on the resident's bedside table and 2 boxes of tissue daily. The intervention for irritability was to redirect when the resident was in the dining room.</p> <p>The Behavior Symptom Monitoring (BSM) for 8/14 through 10/21/14 documented 0 incidents of hoarding. On 9/9/14 a behavior in the dining room was documented.</p> <p>A Psychoactive Medication Physician Progress</p>	F 329	<p>Continued from Page 23</p> <p>3. The IDT will be re-educated on the Behavior Management Tool Kit. The DCS will in-service licensed nursing staff regarding documentation on the BSM flow record to track targeted behaviors. The facility Medical Director will be educated by the pharmacist on documentation requirements related to GDR for residents receiving psychoactive medications.</p> <p>4. The DCS / designee will conduct random audits weekly times four weeks, and monthly times three months to ensure documentation on BSM flow records accurately reflect resident behaviors. The pharmacist will conduct a quarterly review of residents receiving psychoactive medications to ensure documentation by the physician meets the requirement for GDR including rationale if contraindicated. Results of these audits will be reported to the monthly QAPI committee to ensure substantial compliance.</p>	

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F 329	Continued From page 24 Note, dated 9/28/14, documented the physician had evaluated the use of the Seroquel and determined a reduction was not clinically indicated "due to recent increase in behavioral issues."  On 10/23/14 at 10:30 a.m. the DON stated the incident documented on 9/9/14 on the BSM was Resident #8 grabbed another resident's hand, causing a skin tear, when the resident attempted to take his coffee. The DON stated Resident #8 had reacted to the resident's attempt to take his coffee but did not initiate the behavior. The DON stated although the physician had stated a reduction of the medication was not indicated due to increased behaviors, data did not document an increase of behaviors. When asked if the behaviors were harmful to the resident or others which required pharmacological intervention the DON stated, "No."  2. Resident #5 was admitted to the facility in November 2011 with multiple diagnoses which included dementia with delusions.  Resident #5's recapitulation orders for September 2014 documented the resident received Risperidone 0.75 mg daily beginning 1/15/13 for delusional disorder, and Benztropine 1 mg twice per day for extra-pyramidal reaction/tardive dyskinesia.  Resident #5's most recent Annual MDS assessment, dated 10/1/14, coded the resident had long and short term memory deficits and moderately impaired decision making skills.  Both the 10/1/14 MDS, and the most recently completed Quarterly MDS dated 7/4/14, coded	F 329	Continued from Page 24  This page was left blank intentionally.		

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F 329	Continued From page 25 the resident had delusions, but no physical or verbal aggression towards others, and no behaviors placing the resident, others, or the social environment at risk of illness, injury, or disruption.  Resident #5's 10/1/14 care plan documented problem areas of risk for side effects of psychoactive medications, periods of severe confusion and delusions, and the potential for inappropriate behaviors related to paranoia, delusional thoughts, and false accusations towards staff. Interventions included monitoring tremors and reporting to the physician, offering reassurance, and offering rest periods after meals. There was no documentation on the resident's care plan as to how the paranoia and delusions presented. There was no documentation that the resident was not only at risk of side effects of the antipsychotic, but was actually experiencing side effects and required medication to treat those effects.  Resident #5's Physician's progress notes documented: *5/20/14, "...She has had long standing issues with paranoia which has required that she be given antipsychotic medications for control. She has had extrapyramidal effects to medications since prior to entering the facility. She has ongoing tremor and uncontrolled facial movements...This has been controlled with Benztropine which her payor is now refusing to pay for claiming it is an unsafe medication..." *7/23/14, "...recently been treated for a UTI....has had increased paranoia which is common when she has infection...she converses pleasantly then moved on to mildly paranoid comments about unknown parties..."	F 329	Continued from Page 25  This page was left blank intentionally.		

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F 329	Continued From page 26 *9/26/14, "...She is asleep on my arrival but on awakening is at her usual state of confusion - does not recognize me speech includes references to events not currently seen by others..."  On 5/20/14 and 9/23/14, Psychoactive Medication Physician Progress Note forms in Resident #5's record documented a dosage reduction was not clinically indicated due to previous deterioration. However, there was no documentation of how the resident's behavior was harmful to herself or others when these deteriorations occurred, nor when the last attempt at reducing the resident's antipsychotic medication had been made and determined to be unsuccessful.  Resident #5's Behavior Symptom Monitoring Flow record documented the facility was tracking paranoid delusions and false accusations towards staff. The monitors were blank unless an identified behavior had occurred. From July 2014 through September 2014, only 2 behaviors were documented to have occurred. On 7/26/14, the resident was documented as, "grabbing staff," with the cause documented as confusion, although the resident was on an antibiotic for a UTI on that date. On 8/11/14, the resident was documented as, "B-others," and the cause was documented as a UTI. No data was provided for October 2014.  Resident #5's nurse's notes between 7/25/14 and 10/21/14 documented the resident was pleasantly confused with the exception of 7/26/14, where she was documented to have grabbed at staff.  On 10/22/14 at 4:00 PM, the DNS stated the resident's behavior was harmful when first	F 329	Continued from Page 26  This page was left blank intentionally.		

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F 329	Continued From page 27 admitted in 2011. The DNS stated the resident, "Was thinking men were getting into her bed or throwing her on the floor." The DNS could not tell, from the documentation on the behavior flow sheet, what the behavior documented on 8/11/14 was. The DNS stated that the historically identified behavior had not been observed recently, but based on that history the physician refused to reduce the dosage of the resident's Risperidone as there was concern perhaps her behaviors would return without the medication. The DNS did not know if or how the physician had determined the benefit of the antipsychotic outweighed the risk of its use, given that the resident was now being medicated for side effects from the Risperidone. The DNS stated she did not know why the facility's behavior monitors did not document the behaviors for which the resident had originally been started on the medication, or how the data gathered from the behaviors being monitored was determined to be an effective indication of whether or not the medication was benefiting this resident.  On 10/22/14, a Physician's telephone order documented Resident #5's Risperidone was to be decreased to 0.5 mg daily, with a decrease to 0.25 mg daily in 30 days.  On 10/23/14 at 4:15 PM, the Administrator and DNS were informed of these findings. The facility offered no further information.  3. Resident #6 was admitted to the facility 7/25/14 and readmitted on 12/15/14, with multiple	F 329	Continued from Page 27  This page was left blank intentionally.		

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F 329	Continued From page 28 diagnoses including dementia with behavior disorder.  The facility's Behavior Symptom Monitoring Flow Record for the months of August and September 2014 documented that the resident was being monitored for behaviors of "negative statements towards staff, refusal of ADL's, hallucinations and increased confusion." The only behavioral documentation for this resident was on 8/24/14 of increased confusion. There was no further behavior documentation for either August or September.	F 329	Continued from Page 28  This page was left blank intentionally.		
	4. Resident #7 was admitted to the facility 11/16/11 with multiple diagnoses including dementia with behaviors disturbance, delusional disorder, mood disorder and Alzheimer's.  The facility's Behavior Symptom Monitoring Flow Record for the months of September and October, 2014 stated that the resident was being monitored for behaviors of, "Hx [history] of physical aggression and paranoia." There was no documentation that the facility had monitored Resident #7 for these behaviors during the months of September or October.  On 10/22/14 at 2:05 PM, during an interview with the DON about staff not charting the residents behaviors on a daily basis, she stated, "If they have a behavior it is documented on the Behavior Flow sheet, if they don't [have a behavior], they [staff] don't document anything. We chart by exception."  On 10/22/14 at 6:30 the Administrator and DON were notified of these findings. No further information was provided.				

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NAME OF PROVIDER OR SUPPLIER  CLEARWATER HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
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F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333	Continued from Page 29		
	<p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a resident was free from significant medication errors. This was true for 1 of 9 residents (#1). This deficient practice had the potential for more than minimal harm if the resident experienced increased nausea due to missing the 6:00 PM and midnight dose of Zofran.</p> <p>Resident #1 was admitted to the facility 9/16/14, with multiple diagnoses including nausea.</p> <p>The resident's 9/22/14 Physician's order included an order for, "Change Zofran to 4 MG (milligrams) ODT (orally disintegrating tablet) every 6 hours scheduled." There was an additional Physician's order dated 9/25/14, "Hold 2400 (midnight) Zofran if resident is sleeping."</p> <p>Resident #1's October, 2014 MAR documented the resident received Zofran 4 MG at 6:00 AM, noon, and the midnight dose was held on 10/6/14, 10/7/14, 10/8/14, 10/12/14, 10/15/14 and 10/22/14. The 6:00 PM dose was documented as only given once on 10/1/14.</p> <p>On 10/22/14 at 2:05 PM, during an interview with the DON regarding the physician's order for Resident #1's Zofran, she stated, "They are missing the third dose. [They can miss the</p>	F 333	<p>Continued from Page 29</p> <p>F 333</p> <ol style="list-style-type: none"> <li>1. Resident #1's order for Zofran was corrected and transcribed per physician order.</li> <li>2. An audit of current resident medication orders was completed to ensure medication orders were transcribed accurately. No discrepancies were noted. Accurate transcription of medication orders will be verified by the nurse manager during the clinical meeting five times a week.</li> <li>3. Licensed nurses were in-serviced on medication administration to include accurate transcription of orders onto the MAR.</li> <li>4. DCS / designee will conduct medication pass audits to include order transcription weekly times four weeks, then randomly for two months to ensure residents are free of significant medication errors. The results of the audit will be reported the monthly QAPI committee to ensure substantial compliance.</li> </ol>	11/13/14	

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F 333	Continued From page 30 midnight dose.] That is a problem.[missing the 6:00 PM dose]."	F 333	Continued from Page 30		
F 366 SS=E	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE  Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.  This REQUIREMENT is not met as evidenced by: Based on observation, resident group interview, menu review, and staff interview, it was determined the facility failed to offer a nutritionally comparable alternate to meals being served. This was true for 8 of 14 residents in the resident group, Random Resident # 14, and had the potential to impact any resident not wishing to eat the main meal offered. The deficient practice had the potential for harm if residents experienced hunger from not having a complete meal served. Findings included:  On 10/20/14 at 3:50 PM, the surveyors were provided with the facility's menus and spreadsheets for the week of survey. No alternate meal was listed on either document. The CDM stated the facility had an "always available" menu, which was posted outside the dining room, but the RD had not yet approved that menu. The	F 366	F 366 1. The always available items menu and extensions has been approved by the Registered Dietician (RD) and posted at both dining room areas.  2. The always available items menu will be reviewed at the next Resident Council meeting. Menus are printed in large bold font and posted at wheelchair eye level for viewing in both dining room areas.  3. Facility staff in-serviced on always available items menu, offering alternate meals of similar nutritive value, and the procedure for ordering meal substitutions.	11/13/14	

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F 366	<p>Continued From page 31</p> <p>CDM stated residents could always have a peanut butter and jelly sandwich, or leftovers from the previous meal if they were available.</p> <p>On 10/21/14 at 12:00 noon, Random Resident #14 was sitting in the back dining room. She was served vegetable lasagne, carrot coins, and a roll for the noon meal, with a cup of pineapple tidbits for dessert. The resident stated she did not want the lasagne. The DNS asked the resident if she would like a peanut butter and jelly sandwich. No other alternatives were offered. The resident stated, "No, just peanut butter." The DNS removed the plate with the lasagne, carrots, and roll. At 12:05 PM, an unknown dietary person brought the resident a small plate with a peanut butter and jelly sandwich, not just peanut butter as the resident had requested. There were no other items on the plate. The resident's lunch now consisted of a peanut butter and jelly sandwich and a cup of pineapple tidbits. The resident stated she did not want pineapple. The item was removed with no alternative offered.</p> <p>On 10/21/14 at 12:05 PM, the surveyor observed the "always available" menu posted outside the back dining room. The menu was on a letter-size paper (8.5 by 11 inches), in what appeared to be a 12 or 14 point font, regular print (not bold). The menu documented peanut butter and jelly sandwiches were always available, with other sandwiches available if the supplies were on hand; several soups always available; and a cottage cheese and fruit plate. The menu was posted on the wall above another bulletin board, at eye level for the 5'10" surveyor in 2" heels. [NOTE: Only one of the residents in the back dining room was ambulatory. The remaining residents were in wheelchairs as they entered the</p>	F 366	<p>Continued from Page 31</p> <p>4. ED / designee will conduct random weekly meal audits times four weeks, the monthly times two months to ensure residents who refuse meals are offered substitutes of similar nutritive value. The results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance.</p>		

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F 366	Continued From page 32 area. It was not possible to visualize the menu, or read it, from a seated position.]  On 10/21/14 at 3:00 PM, during the resident group interview, the residents unanimously reported they were regularly offered a peanut butter and jelly sandwich as an alternate if they did not like the meal being served. Eight of the 14 residents present stated they would like more variety in the alternate meal. Two of the residents were ambulatory, and stated they knew about the "always available" menu posted. The remaining residents stated they were not aware of the choices presented on that document.	F 366	Continued from Page 32  This page was left blank intentionally.		
	On 10/22/14, the RD stated the facility started using the "always available" menu the previous week, but she did not officially approve the menu until that day because she wanted to be sure a nutritionally complete meal was offered when a sandwich was used as an alternative. The RD stated it would be the expectation that if a sandwich was provided as a substitute meal item, it would replace only the entree. The side dishes and dessert should still be provided. The RD stated the peanut butter and jelly sandwiches were probably offered first because so many of the residents had historically requested them. The RD stated there had been an in-service with the kitchen staff the previous week to ensure awareness of the items on the "always available" menu. However, the RD stated she did not think the nursing staff who are responsible to take the residents' orders and offer alternatives as needed were in-serviced on the menu. The RD agreed that posting the menu approximately 5-and-a-half feet above the floor impeded access for wheelchair-bound residents.				

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F 366	Continued From page 33	F 366	Continued from Page 33		
F 514 SS=E	<p>On 10/23/14 at 4:15 PM, the Administrator and DNS were informed of these findings. The facility offered no further information.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the 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 staff interview and record review, it was determined the facility failed to ensure medical records were complete and accurate. This was true for 9 of 14 sample residents (#s 1, 2, 4, 5, 6, 8, 9, 11, and 12). The deficient practice had the potential for harm when a resident experienced a delay in her appointment with an oral surgeon, and when it could not be determined whether the facility had been providing oral care for residents requiring assistance. Findings included:</p> <p>1. According to the American Health Information Management Association (<a href="http://www.ahima.org">www.ahima.org</a>), "When using late entries, document as soon as</p>	F 514	<p>F 514</p> <ol style="list-style-type: none"> <li>1. Activity of daily living (ADL) flow records for residents #1, 2, 4, 5, 6, 8, 9, 11, and 12 have been updated to include oral care.</li> <li>2. Current dependent resident ADL flow records have been updated to include oral care documentation.</li> <li>3. Nursing staff were in-serviced on providing and documenting oral care. Facility staff authorized to document in the medical record were in-serviced on timely "late entry" notations to ensure reliability of documentation.</li> <li>4. DCS / designee will conduct random weekly audits of ADL flow records times four weeks, then monthly times two months to ensure oral care is documented for dependent residents. The results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance.</li> </ol>	11/13/14	

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F 514	Continued From page 34 possible. There is no time limit to writing a late entry; however, the more time that passes, the less reliable the entry becomes."  Resident #11 was admitted to the facility in 2010 following a traumatic brain injury.  On 9/24/13, Resident #11's annual MDS assessment documented the presence of likely cavities and/or broken teeth.  On 4/10/14 at 10:00 AM, Resident #11's Social Service Progress Notes (SSPN) documented, "...called [oral surgeon's name's] office on Medicaid approval and was informed they just [received approval]..." On that same date at 1:00 PM, the SSPNs documented an appointment for the procedure had been scheduled for 4/23/14.  On 5/8/14 at 8:00 AM, Resident #11's SSPNs documented, "Late entry...After [Resident #11's guardian] came in to see [Resident #11] on Monday, April 5th she [the guardian] asked me why [Resident #11] still had her teeth. [Social Services] had to explain that [Resident #11's] appointment was canceled..." [Note: It was not until 4/10/14, 5 days after the conversation in the 5/8/14 entry, that authorization was received and the procedure scheduled. The person who made the entries was no longer employed at the facility at the time of survey.]  On 10/23/14 at 1:45 PM, the Administrator stated she had been unaware of the contents of the SSPN, but the person who made the entry left employment at the facility either on the date it was made or shortly thereafter. The Administrator stated the appointment for the procedure was made as soon as authorization was received, and	F 514	Continued from Page 34  This page was left blank intentionally.	

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F 514	Continued From page 35 could not explain why the late entry documented the appointment had been canceled before authorization had been received. The Administrator stated she felt a late entry made 33 days after a conversation took place would not be reliable.  On 10/23/14 at 4:15 PM, the Administrator and DNS were informed of these findings. The facility offered no further information.  2. The MDS's for the identified residents documented the residents required assistance for hygiene as follows:	F 514	Continued from Page 35  This page was left blank intentionally.	
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	*Resident #1, Admission assessment 9/23/14, extensive assistance of 1; *Resident #2, Admission assessment 10/6/14, extensive assistance of 1; *Resident #4, Quarterly assessment 9/30/14, extensive assistance of 1; *Resident # 5, Annual assessment 10/1/14, dependent on 1; *Resident #6, Quarterly assessment 9/9/14, extensive assistance of 1; *Resident #8, 5 day assessment 10/13/14, extensive assistance of 1; *Resident #9, Quarterly assessment 9/22/14, extensive assistance of 1; *Resident #11, Annual assessment 8/25/14, dependent on 1; and *Resident #12, Annual assessment 9/8/14, limited assistance of 1.  On 10/22/14 at 8:40 AM, the DNS was asked for documentation of oral care being provided for the above residents. The DNS stated the facility documented on the resident care plans that assistance with ADLs was required, but did not document whether or not oral care had actually			
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F 514	Continued From page 36 been provided. The DNS stated, "It would be nice if we did. We document other ADLs, but not oral care. We should be taking credit for all the hard work we do."  On 10/23/14 at 4:15 PM, the Administrator and DNS were informed of these findings. The facility offered no further information.	F 514	Continued from Page 36  This page was left blank intentionally.		

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C 000	16.03.02 INITIAL COMMENTS  The following deficiencies were cited during the annual recertification and complaint survey of your facility. The team entered the facility October 20, 2014 and exited at October 23, 2014 at 4:15 p.m.  The survey team included:  Nina Sanderson, BSW LSW - Team Coordinator Sherri Case, LSW Judy Atkinson, RN  Definitions:	C 000	Preparation and execution of this Plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions sets forth in this statement of deficiencies. This plan of correction is prepared solely for the purpose of meeting Federal and State regulations.	
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	ADLs - Activities of Daily Living BIMS - Brief Interview for Mental Status BSM - Behavior System Monitoring CAA - Care Area Assessment CDM - Certified Dietary Manager CNA - Certified Nursing Assistant DON/DNS - Director of Nursing FRCI - Fall Root Cause Investigation Hx - History of IPN - Interdisciplinary Progress Note LN - Licensed Nurse MAR - Medication Administration Record MDS - Minimum Data Set MG - Milligram MS - Multiple Sclerosis NN - Nurse's Note PO - Oral PT - Physical Therapy RD - Registered Dietician SSPN - Social Services Progress Note TBI - Traumatic Brain Injury UTI - Urinary Tract Infection			
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C 117	02.100.03,c,i Fully Informed of Rights  i. Is fully informed, as evidenced	C 117	Please refer to F 151  Continued on Page 2	
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Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*[Signature]*

TITLE  
*Administrator*

(X6) DATE  
11/17/14

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C 117	Continued From page 1  by the patient's/resident's written acknowledgement, prior to or at the time of admission and during his stay, of these rights and of all rules, regulations and minimum standards governing patient/resident conduct and responsibilities. Should the patient/resident be medically or legally unable to understand these rights, the patient's/resident's guardian or responsible person (not an employee of the facility) has been informed on the patient's/resident's behalf;	C 117	Continued from Page 1	
C 119	This Rule is not met as evidenced by: Please refer to F151 as related to voting rights.  02.100,03,c,iii Informed of Medical Condition by Physician  iii. Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research; This Rule is not met as evidenced by: Please see F 154 as it pertains to informed consent for antipsychotic medications.	C 119	Please refer to F 154	
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	C 124	Please refer to F164	

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C 124	Continued From page 2  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 medical record privacy.	C 124	Continued from Page 2	
C 147	02.100,05,g Prohibited Uses of Chemical Restraints  g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Please refer to F329 as it is related to behavior monitoring.	C 147	Please refer to F 329	
C 155	02.100,08 NOTIFICATION OF CHGE PTNT/RSDNT STATUS  08. Notification of Change in Patient/Resident Status. There shall be written policies and procedures relating to notification of next of kin, or sponsor, in the event of a significant change in a patient's/resident's status. This Rule is not met as evidenced by: Please see F157 as it pertains to family notification of change in the resident's condition..	C 155	Please refer to F 157	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001140	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/23/2014
NAME OF PROVIDER OR SUPPLIER  CLEARWATER HEALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 173	Continued From page 3	C 173	Continued from Page 3	
C 173	02.100,12,d Immediate Notification of Physician of Injury  d. The physician shall be immediately notified regarding any patient/resident injury or accident when there are significant changes requiring intervention or assessment. This Rule is not met as evidenced by: Please see F 157 as it pertains to physician notification.	C.173	Please refer to F 157  added per TC w/ DON 12/5/14 at 9:45 AM AS/ashy Dr	
C 317	02.107,07,d Appropriate Food Substitutes Available  d. If a patient/resident refuses the food served, appropriate substitutes shall be offered. This Rule is not met as evidenced by: Please see F 366 as it pertains to food substitutions.	C 317	Please refer to F 366	
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT  07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Please see F 252 as it pertains to maintenance of the physical environment.	C 361	Please refer to F 252	
C 393	02.120,04,b Staff Calling System at Each Bed/Room	C 393	Please refer to F 246	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001140	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/23/2014
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NAME OF PROVIDER OR SUPPLIER  CLEARWATER HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 393	Continued From page 4  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	Continued from Page 4	
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 the Dietary Supervisor, a representative from from housekeeping, and a representative from maintenance attended the ICC meetings every quarter. This failure created the potential for a negative effect for all residents including 9 of 9 sample residents (#1-9), staff, and visitors to the facility when the facility management staff were	C 664	C 664  1. Resident's # 1-9 have had no negative outcome related to infection control practices by the dietary, housekeeping, or maintenance departments  2. The Dietary Supervisor, Housekeeping/Laundry Supervisor, and Maintenance Director attended the Quality Assurance Performance Improvement (QAPI) committee meeting on 10/29/14. The facility infection control practices are reviewed and discussed at this monthly meeting.	11/13/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001140	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 10/23/2014	
NAME OF PROVIDER OR SUPPLIER  CLEARWATER HEALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 664	Continued From page 5  not involved in the implementation of safe infection control practices. Findings included:  The Infection Control Protocol, which was reviewed on 10/22/14 at 2:40 PM with the Infection Control Manager, provided the sign-in sheet for the monthly Infection Control Meetings. Upon review of the sign-in sheets from April 2014 through September 2014, it was determined the following ICC members did not attend/participate in the ICC meetings: *Dietary Supervisor; *Housekeeping representative; *Maintenance representative.  On 10/23/14 at 10:06 AM, during an interview with the DON she stated, in regards to required staff attending the ICC meeting, "I will make sure they attend in the future."  On 10/23/14 at 4:15 PM, the Administrator and DON were made aware of the concern. No further information was provided.	C 664	Continued from Page 5  3. The Interdisciplinary Team (IDT) has been in-serviced on the required attendance at the monthly QAPI committee meeting to ensure the facility management staff is involved in the implementation of safe infection control practices.  4. The Regional Director of Clinical Services / designee will review the monthly QAPI attendance record to ensure the Dietary Supervisor, Housekeeping/Laundry Supervisor, and Maintenance Director attend the committee meeting. This audit will be conducted for 3 months to ensure substantial compliance.	
C 784	02.200,03,b Resident Needs Identified  b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please see F 309 as it pertains to delay in treatment and medications.	C 784	Please refer to F 309	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001140	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/23/2014
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NAME OF PROVIDER OR SUPPLIER  CLEARWATER HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 790	Continued From page 6	C 790	Continued from Page 6	
C 790	02.200,03,b,vi Protection from Injury/Accidents  vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as it related to safety assessments for bed siderails and fall prevention.	C 790	Please refer to F 323	
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders  04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following:  a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Please refer to F 333 as related to medication administration written order.	C 798	Please refer to F 333	
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 see F 514 as it pertains to accurate and complete medical records.	C 881	Please refer to F514	



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 26, 2014

Bernardo Carotenuto, Administrator  
Clearwater Health & Rehabilitation  
1204 Shriver Road  
Orofino, ID 83544-9033

Provider #: 135048

FILE COPY

Dear Mr. Carotenuto:

On **October 23, 2014**, a Complaint Investigation survey was conducted at Clearwater Health & Rehabilitation. Judy Atkinson, RN, Nina Sanderson, LSW, and Sherri Case, LSW, QMRP, and conducted the complaint investigation.

The following items were reviewed as part of this complaint investigation as a whole:

- The records of 14 sample residents, including the identified residents;
- Dental records and oral surgery reports were reviewed for identified residents;
- Resident, staff, and resident family interviews were conducted;
- Observations were made for a four-day period in the facility;
- Resident care plans were reviewed.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006484**

**ALLEGATION #1:**

The complainant reported an identified resident's oral surgery was cancelled due to lack of staff availability to accompany the resident.

**FINDINGS:**

The identified resident had oral surgery scheduled for April 23, 2014. On April 21, 2014, the

Bernardo Carotenuto, Administrator  
November 26, 2014  
Page 2 of 5

facility cancelled the appointment. The surgeon's office was not contacted to re-schedule the appointment until May 14, 2014. This portion of the complaint was substantiated and cited at F 309.

#### CONCLUSIONS:

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

#### ALLEGATION #2:

The complainant stated an identified resident was taken to a surgical appointment in a community three hours away from the facility. The complainant stated the surgeon had directed the facility send a Certified Nursing Assistant with the resident, due to the length of the journey. The complainant stated there was no attendant sent with the resident, and the resident returned to the facility with blood on his face and shirt.

#### FINDINGS:

The survey team reviewed the pre-operative instructions from the surgeon, reviewed the resident's nurses notes from before and after the procedure, and interviewed the resident, van driver, and nursing staff.

The resident was transported to his surgical appointment, which was in a community approximately three hours from the facility, in the facility's van. The only person with the resident was the facility's van driver.

The pre-operative instructions from the oral surgeon did not stipulate the resident would require an attendant after the procedure, other than someone to drive him home.

The resident's nurse's progress notes upon his return to the facility did not document the resident had blood on his face or his clothing. The resident was documented to be stable upon his return.

The resident was interviewed, and recalled the trip from the surgeon's office to the facility. The resident stated he did not see a reason there should have been a Certified Nursing Assistant with him. The resident did not recall that he had blood on his face or his shirt when he returned to the facility. The resident stated he felt safe during the trip home.

The facility van driver stated he had been an Emergency Medical Technician for sixteen years prior to coming to work at the facility. The driver did not recall any difficulty with the resident on the trip to or from the appointment on the day in question. The driver stated he did not recall the resident having blood on his face or shirt, other than a small amount when the resident exited the

Bernardo Carotenuto, Administrator

November 26, 2014

Page 3 of 5

appointment. The driver stated it had been snowing the day of the resident's appointment, and as such the van had to pull over several times along the way to clear ice and snow from the windshield wipers. The driver stated every time he did this, he checked on the resident, and there were no problems noted or reported.

This portion of the complaint was not substantiated.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #3:

The complainant reported an identified resident with functional and communication deficits, had a difficult time getting staff assistance to get to the bathroom and often had to wait for extended periods of time without using or being offered the toilet.

#### FINDINGS #3:

The survey interviewed the identified resident. Though the resident had delayed and limited verbal responses, she was able to interact with the survey team enough to make herself understood on this issue.

The resident reported when she used her call light, staff would respond timely, and if she was sitting in her wheelchair in the doorway to her room, they would usually stop to offer assistance. The resident did indicate she did not like to ask for help to use the bathroom, but preferred it when staff anticipated when she might need assistance and ask her discreetly. The resident stated at times, when she needed to use the bathroom when coming in from smoking, she was embarrassed asking for assistance as she passed the nurse's station on the way to her room, and felt it could take too long for staff to help her at those times. The resident stated it had been getting better within the last couple of weeks.

When interviewed, the Director of Nursing said the facility was aware the resident could become embarrassed when having to ask to use the bathroom, and had been working with the resident for some time to resolve the issue. The Director of Nursing stated the facility had started by offering the resident assistance with the bathroom on a regular schedule-- before and after meals, upon arising and before bed, which was successful for quite some time. The Director of Nursing stated approximately a month earlier, the resident began to accept offers to use the toilet per that schedule less and less frequently, but was clearly unhappy about asking to use the toilet at other times. The facility talked to the resident about this, and the resident told them there were certain activities she looked forward to, so sometimes declined an offer to use the toilet if it was going to interfere with

Bernardo Carotenuto, Administrator  
November 26, 2014  
Page 4 of 5

her ability to participate in an activity. The Director of Nursing stated the resident and facility agreed to monitor the resident's patterns of toilet use, and revise the resident's care plan to reflect those patterns and preferences. The facility had identified specific times the resident wanted to use the toilet throughout the day, and revised the resident's care plan to reflect those specific times.

Throughout the week of survey, the survey team observed the resident being offered the toilet per the schedule in the revised care plan.

The facility had identified the resident was unhappy with her bathroom routine, worked with the resident to develop an individualized toileting plan, implemented that plan, and was monitoring for the effectiveness of the plan. The allegation is found to be true, but the facility was attempting to resolve the issue with the resident per regulatory requirement.

#### CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

#### ALLEGATION #4:

The complainant reported an identified resident was required to stay out of bed for at least two hours once she was out of bed, and stay in bed for at least two hours once she got into bed.

#### FINDINGS:

The care plan for the identified resident did document a schedule for the resident to remain in bed for at least two hours once she was in bed, or to stay out of bed for at least two hours once she was out of bed.

The survey team observed the facility's staff to enforce this schedule on at least one occasion during the survey, and attempt to enforce this schedule on at least one other occasion.

This portion of the complaint was substantiated and cited at F 242.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #5:

The complainant reported residents, in general, did not receive necessary assistance with oral care.  
ALLEGATIONS:

Bernardo Carotenuto, Administrator  
November 26, 2014  
Page 5 of 5

The survey team interviewed both individual residents, and residents as a group, as well as made observations in the facility for four days.

The resident interviews revealed the residents felt they had assistance with oral care two to three times daily. Observations of the residents revealed residents with clean teeth and mouths, wearing dentures when indicated.

However, when reviewing resident care plans, assistance with oral care was not present. Additionally, the facility could not provide documentation oral care had been offered and provided to residents on a regular basis.

This portion of the complaint was substantiated and cited at F 514.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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,



DAVID SCOTT, RN, Supervisor  
Long Term Care

DS/lj



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

DEBRA RANSOM, R.N., R.H.I.T., Chief  
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Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

November 25, 2014

Bernardo Carotenuto, Administrator  
Clearwater Health & Rehabilitation  
1204 Shriver Road  
Orofino, ID 83544-9033

Provider #: 135048

Dear Mr. Carotenuto:

On **October 23, 2014**, a Complaint Investigation survey was conducted at Clearwater Health & Rehabilitation. Judy Atkinson, RN, Nina Sanderson, LSW, and Sherri Case, LSW, QIDP conducted the complaint investigation.

The following items were reviewed as part of this complaint investigation as a whole:

- The records of 14 sample residents, including the identified residents;
- Dental records and oral surgery reports were reviewed for identified residents;
- Resident, staff, and resident family interviews were conducted;
- Observations were made for a four-day period in the facility;
- Resident care plans were reviewed.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006541**

**ALLEGATION #1:**

The complainant reported an identified resident with functional and communication deficits had a difficult time getting staff assistance to get to the bathroom and often had to wait for extended periods of time without using or being offered the toilet. The complainant also reported the resident leaned in her wheelchair.

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## FINDINGS:

The surveyors interviewed the identified resident. Though the resident had delayed and limited verbal responses, she was able to interact with the survey team enough to make herself understood on this issue.

The resident reported when she used her call light, staff would respond timely, and if she was sitting in her wheelchair in the doorway to her room, they would usually stop to offer assistance. The resident did indicate she did not like to ask for help to use the bathroom, but preferred it when staff anticipated when she might need assistance and ask her discreetly. The resident stated at times, when she needed to use the bathroom when coming in from smoking, she was embarrassed asking for assistance as she passed the nurse's station on the way to her room, and felt it could take too long for staff to help her at those times. The resident stated it had been getting better within the last couple of weeks.

When interviewed, the Director of Nursing said the facility was aware the resident could become embarrassed when having to ask to use the bathroom, and had been working with the resident for some time to resolve the issue. The Director of Nursing stated the facility had started by offering the resident assistance with the bathroom on a regular schedule - before and after meals, upon arising and before bed, which was successful for quite some time. The Director of Nursing stated approximately a month earlier, the resident began to accept offers to use the toilet per that schedule less and less frequently, but was clearly unhappy about asking to use the toilet at other times. The facility talked to the resident about this, and the resident told them there were certain activities she looked forward to, so sometimes declined an offer to use the toilet if it was going to interfere with her ability to participate in an activity. The Director of Nursing stated the resident and facility agreed to monitor the resident's patterns of toilet use, and revise the resident's care plan to reflect those patterns and preferences. The facility had identified specific times the resident wanted to use the toilet throughout the day, and revised the resident's care plan to reflect those specific times.

Throughout the week of survey, the survey team observed the resident being offered the toilet per the schedule in the revised care plan.

The resident was observed in a wheelchair with a specialized seating system. Review of the resident's record revealed she had occupational therapy services beginning several months before the survey, and continuing intermittently, including developing a seating system for her. The resident was well-positioned in her wheelchair throughout the survey.

The facility had identified the resident was unhappy with her bathroom routine, worked with the resident to develop an individualized toileting plan, implemented that plan, and was monitoring for the effectiveness of the plan. The facility had also identified the resident needed assistance with her positioning in her wheelchair, and had involved occupational therapy to correct the issue.

The allegation is found to be true, but the facility was attempting to resolve the issues with the resident per regulatory requirement. There were no deficiencies cited.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant reported an identified resident was required to stay out of bed for at least two hours once she was out of bed, and stay in bed for at least two hours once she got into bed.

FINDINGS:

The care plan for the identified resident did document a schedule for the resident to remain in bed for at least two hours once she was in bed, or to stay out of bed for at least two hours once she was out of bed.

The survey team observed the facility's staff to enforce this schedule on at least one occasion during the survey, and attempt to enforce this schedule on at least one other occasion.

This portion of the complaint was substantiated, and cited at F 242.

ALLEGATION #3:

The complainant reported an identified resident's oral surgery was cancelled due to lack of staff availability to accompany the resident. The complainant stated in general, the facility did not provide oral care for the residents.

FINDINGS:

The identified resident had oral surgery scheduled for April 23, 2014. On April 21, 2014, the facility cancelled the appointment. The surgeon's office was not contacted to re-schedule the appointment until May 14, 2014.

The survey team interviewed both individual residents, and residents as a group, as well as made observations in the facility for four days.

The resident interviews revealed the residents felt they had assistance with oral care twice to three times daily. Observations of the residents revealed residents with clean teeth and mouths, wearing dentures when indicated.

However, when reviewing resident care plans, assistance with oral care was not present. Additionally, the facility could not provide documentation oral care had been offered and provided to residents on a regular basis.

This portion of the complaint was substantiated and cited at F 309 and F 514.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #4:

The complainant stated an identified resident was taken to a surgical appointment in a community three hours away from the facility. The complainant stated the surgeon had directed the facility send a Certified Nursing Assistant with the resident, due to the length of the journey. The complainant stated there was no attendant sent with the resident, and the resident returned to the facility with blood on his face and shirt.

The complainant also reported the resident had to have his teeth pulled due to lack of oral care in the facility.

#### FINDINGS:

The survey team reviewed the pre-operative instructions from the surgeon, reviewed the resident's nurses notes from before and after the procedure, and interviewed the resident, van driver, and nursing staff.

The resident was transported to his surgical appointment, which was in a community approximately three hours from the facility, in the facility's van. The only person with the resident was the facility's van driver.

The pre-operative instructions from the oral surgeon did not stipulate the resident would require an attendant after the procedure, other than someone to drive him home.

The resident's nurse's progress notes upon his return to the facility did not document the resident had blood on his face or his clothing. The resident was documented to be stable upon his return.

The resident was interviewed, and recalled the trip from the surgeon's office to the facility. The resident stated he did not see a reason there should have been a Certified Nursing Assistant with him. The resident did not recall that he had blood on his face or his shirt when he returned to the facility.

Bernardo Carotenuto, Administrator  
November 25, 2014  
Page 5 of 5

The resident stated he felt safe during the trip home.

The facility van driver stated he had been an Emergency Medical Technician for sixteen years prior to coming to work at the facility. The driver did not recall any difficulty with the resident on the trip to or from the appointment on the day in question. The driver stated he did not recall the resident having blood on his face or shirt, other than a small amount when the resident exited the appointment. The driver stated it had been snowing the day of the resident's appointment, and as such the van had to pull over several times along the way to clear ice and snow from the windshield wipers. The driver stated every time he did this, he checked on the resident, and there were no problems noted or reported.

The resident's record documented he had poor dentition for an extended period of time, but did not want to have his teeth pulled. The resident consented to having his teeth pulled only at the insistence of his physician, when he started to develop infection.

The resident was interviewed about the oral care he had received in the facility prior to his extractions. The resident stated he had received oral care regularly in the facility, but had poor dentition for years even prior to his admission. The resident stated he did not see the need to have his teeth pulled, but because his physician was so insistent he agreed. The resident did admit he had less trouble with infections since the procedure.

This portion of the complaint was not substantiated.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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,



LORENE KAYSER, LSW, QIDP, Supervisor  
Long Term Care

LK/lj