



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
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CERTIFIED MAIL: 7012 1010 0002 0836 2083

November 6, 2013

Michael E. Borup, Administrator
Quinn Meadows Rehabilitation & Care Center
1033 West Quinn Road
Pocatello, ID 83202-2425

Provider #: 135136

Dear Mr. Borup:

On **October 24, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Quinn Meadows Rehabilitation & Care Center by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag in column X5 Complete Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 19, 2013**. Failure to submit an acceptable PoC by **November 19, 2013**, may result in the imposition of civil monetary penalties by **December 9, 2013**.

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

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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

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- 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*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 24, 2014**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. 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)

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

This request must be received by **November 19, 2013**. If your request for informal dispute resolution is received after **November 19, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

A handwritten signature in cursive script that reads "Loretta Todd".

LORETTA TODD, R.N., Supervisor
Long Term Care

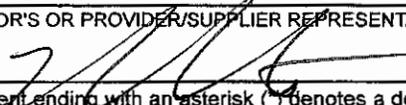
LT/dmj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/24/2013
NAME OF PROVIDER OR SUPPLIER QUINN MEADOWS REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1033 WEST QUINN ROAD POCATELLO, ID 83202		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification and complaint survey conducted at Quinn Meadows Rehabilitation and Care Center. The survey team entered the facility on October 21, 2013 and exited on October 24, 2013.</p> <p>The survey team conducting the survey were: Arnold Rosling, RN, BSN, QMRP Amy Jensen, RN, BSN</p> <p>Survey Definitions:</p> <p>ADL = Activities of Daily Living BID = Twice Daily CAA = Care Area Assessment CAD = Coronary Artery Disease CNA = Certified Nurse Aide DON = Director of Nursing ESRD = End Stage Renal Disease LN = Licensed Nurse MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set assessment Pt = Patient PVD = Peripheral Vascular Disease RES = Resident LSW = Licensed Social Worker LCSW = Licensed Clinical Social Worker</p>	F 000	<p><i>Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority. Accordingly, the facility has drafted this Plan of Correction in accordance with Federal and State Laws which mandate the submission of a Plan of Correction as a condition for participation in the Medicare and Medicaid program. This Plan of Correction shall constitute this facility's credible allegation compliance with this section.</i></p>		
F 271 SS=D	<p>483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE</p> <p>At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 271	<p>F- 271 SS=D §483.20(a) - Admission Physician Orders for Immediate Care</p> <p>The facility does ensure that a resident has an admission order signed by a physician from the discharging hospital (not a physician extender), prior to admission to the facility.</p>	<p>RECEIVED NOV 18 2013 FACILITY STANDARDS</p> <p>12/09/13</p>	

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

TITLE

(X6) DATE

 Administrator 11/15/13

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

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F 271	<p>Continued From page 1</p> <p>by: Based on record review and staff interview, it was determined the facility failed to ensure that one resident had an admission order signed by the physician prior to admission to the facility. This was true for 1 of 10 (# 7) sampled residents. There was a potential for harm because without an order to outline the care the resident was to receive by the facility the resident may not improve to a level they could return home. Findings include:</p> <p>Resident #7 was admitted to the facility 10/10/13 with diagnoses of aftercare following joint repair (right total knee), diabetes mellitus type II, and depressive disorder.</p> <p>The admission orders for the resident's care were not signed by a physician. They were signed by a physician extender. The DON was interviewed on 10/23/13 at 4:00 p.m. When asked about the orders she indicated that the physician should have signed the orders. No further information was provided.</p>	F 271	<p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #7 is no longer a Resident of the facility.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.</p> <p>However, to address other residents who may have the potential to be affected by this deficiency, the facility Administrator on 11/25/2013, sent PMC Hospital Director of discharge planning a correspondence via e-mail regarding F 271 on the importance of having a physician (not a physician extender) sign the admission orders being sent to the facility prior to admission.</p> <p>F 271 continued on next page</p>	
F 272 SS=E	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information;</p>	F 272		

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F 272	Continued From page 2 Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to complete a comprehensive assessment of the residents that resided in the facility. The facility had completed an MDS on the residents, but areas that triggered or required further assessment were not assessed, or the assessments were vague and did not evaluate all areas that could have created the identified problem. This was true for 8 of 9 (#s 1-6, 8 & 9) sampled residents. There was a	F 272	Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure that the deficient practice does not recur, on 11/25/2013 the IDT (Interdisciplinary Team) were in-serviced by the facility Administrator related to F-271 with emphasis on ensuring that a physician (not a physician extender) has signed the admission orders being sent to the facility prior to admission. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through: The Director of Nurses or designee will review all "Admission Referral Transfer orders," to ensure that the admission orders coming from PMC hospital are signed by a Physician (not a Physician Extender) prior to admitting a Resident to the facility. Monitoring will start on 12/09/2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. F 271 continued on next page	
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F 272	<p>Continued From page 3</p> <p>potential for harm when the facility failed to assess areas that could create further medical problems and the facility did not have a plan to intervene and prevent further complications. Findings include:</p> <p>The instructions for further assessing the resident were outlined in the October 2012 RAI manual on page 4-5. These were:</p> <p>"In addition to identifying causes and risk factors that contribute to the resident's care area issues or conditions, the CAA process may help the IDT:</p> <ul style="list-style-type: none"> -Identify and address associated causes and effects; -Determine whether and how multiple triggered conditions are related; -Identify a need to obtain additional medical, functional, psychosocial, financial, or other information about a resident's condition that may be obtained from sources such as the resident, the resident's family or other responsible party, the attending physician, direct care staff, rehabilitative staff, or that requires laboratory and diagnostic tests; -Identify whether and how a triggered condition actually affects the resident's function and quality of life, or whether the resident is at particular risk of developing the conditions; -Review the resident's situation with a health care practitioner (e.g., attending physician, medical director, or nurse practitioner), to try to identify links among causes and between causes and consequences, and to identify pertinent tests, consultations, and interventions; -Determine whether a resident could potentially benefit from rehabilitative interventions; -Begin to develop an individualized care plan with measurable objectives and timetables to meet a resident's medical, functional, mental and 	F 272	<p>The facility Director of Nursing or designee will submit to the Administrator or his/her designee and to the QA&A Committee her findings and/or corrective actions taken during the quarterly QA&A Committee Meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p> <p>F- 272 SS=E \$483.20(b) (1) - Comprehensive Assessments</p> <p>The facility does ensure that areas triggered on the MDS that could create further medical problems are assessed and have a plan to intervene and prevent further complications.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident # 1 is no longer a Resident in the facility.</p>	12/09/13
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F 272	<p>Continued From page 4 psychosocial needs as identified through the comprehensive assessment."</p> <p>The October 2012 RAI manual on page 4-6 and page 4-7 documents what the CAA should document. These were: "CAA documentation. CAA documentation helps to explain the basis for the care plan by showing how the IDT determined that the underlying causes, contributing factors, and risk factors were related to the care area condition for a specific resident; for example, the documentation should indicate the basis for these decisions, why the finding(s) require(s) an intervention, and the rationale(s) for selecting specific interventions. Based on the review of the comprehensive assessment, the IDT and the resident and/or the resident's representative determine the areas that require care plan intervention(s) and develop, revise, or continue the individualized care plan. -Relevant documentation for each triggered CAA describes: causes and contributing factors; -The nature of the issue or condition (may include presence or lack of objective data and subjective complaints). In other words, what exactly is the issue/problem for this resident and why is it a problem; -Complications affecting or caused by the care area for this resident; -Risk factors related to the presence of the condition that affects the staff's decision to proceed to care planning; -Factors that must be considered in developing individualized care plan interventions, including the decision to care plan or not to care plan various findings for the individual resident; -The need for additional evaluation by the attending physician and other health professionals, as appropriate;</p>	F 272	<p>In regards to Resident # 3, on the triggered areas of the MDS dated 06/07/2013 Relating to the ADL function, urinary incontinence, psychosocial well being, activities, fall, nutritional status, and pressure ulcers;</p> <ul style="list-style-type: none"> By 12/06/2013, MDS Care Area Assessment (CAA) Documentation Notes will be completed by the MDS Coordinator or designee, to include what triggered them, what co-morbidities were associated with them, if the resident and family were involved in further assessment, and if a care plan was developed to address the problems/needs. <p>Resident # 6 is no longer a Resident of the facility.</p> <p>Resident # 8, a new comprehensive annual assessment with ARD of 10/25/2013 was done by the MDS Coordinator, the triggered areas in relation to ADL function, Urinary Incontinence, Falls, Nutritional Status, and Pressure Ulcers. By 12/06/2013, Care Area Assessment (CAA) Documentation Notes will be done by the MDS Coordinator, to include what</p>	
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F 272	<p>Continued From page 5</p> <p>-The resource(s), or assessment tool(s) used for decision-making, and conclusions that arose from performing the CAA; -Completion of Section V (CAA Summary; see Chapter 3 for coding instructions) of the MDS."</p> <p>1. Resident #1 was admitted to the facility on 9/26/13 with diagnoses of aftercare fractured hip, kidney disease stage III, dementia unspecified without behaviors and blind in the left eye.</p> <p>The admission MDS assessment dated 10/3/13, documented the resident: * was cognitively intact with a BIMS of 15, * required extensive assistance with bed mobility, transfers, dressing, personal hygiene and bathing. * was occasionally incontinent of bowel and bladder.</p> <p>The MDS triggered the need for further assessments in the areas of ADL function, Urinary Incontinence, Psychosocial Well Being, Activities, Falls, Nutritional Status and Pressure Ulcers. In the MDS Care Area Assessment Documentation Notes, dated 10/3/13, seven care areas were identified but there was no documentation about what triggered them, what co-morbidities were associated with them, if the resident and family were involved in further assessment and if the facility was going to develop a care plan to address the problems/needs.</p> <p>2. Resident #3 was admitted to the facility 5/31/13 with diagnoses of care involving use of rehabilitation (fracture left hip), other cerebral degenerations, Lupus.</p>	F 272	<p>triggered them, what co-morbidities were associated with them, if the resident and family were involved in further assessment, and if a care plan was developed to address the problems/needs.</p> <p>Resident # 2, #4, #5, and #9 comprehensive MDS assessment Care Area Assessment (CAA) Documentation Notes, will be reviewed by 12/06/2013, by the MDS Coordinator to ensure that areas triggered include in their Care Area Assessment (CAA) Documentation Notes what triggered them, what co-morbidities were associated with them, if the resident and family were involved in further assessment, and if a care plan was developed to address the problems/needs.</p> <p>The MDS Coordinator had formal MDS training; what the Director of Nursing mentioned during the survey process on the MDS training she and the other 2 License Nurses had recently attended, was a continuous endeavor by the facility to have multiple License Nurses be able to avail of the facility financially sponsored education in order to give Nurses opportunity to enhance their education e.g. the MDS training and its requirements.</p>	
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F 272	<p>Continued From page 6</p> <p>The admission MDS assessment, dated 6/7/13, documented the resident:</p> <ul style="list-style-type: none"> - was cognitively intact with a BIMS of 15, - required extensive assistance for bed mobility, transfers, locomotion, dressing, personal hygiene and bathing. <p>The MDS triggered the need for further assessments in the areas of ADL function, Urinary Incontinence, Psychosocial Well Being, Activities, Falls, Nutritional Status and Pressure Ulcers. In the MDS Care Area Assessment Documentation Notes, dated 6/7/13, seven care areas were identified but there was no documentation about what triggered them, what co-morbidities were associated with them, if the resident and family were involved in further assessment and if the facility was going to develop a care plan to address the problems/needs. In addition, the narrative information provided only addressed ADL function, Urinary incontinence, Falls and Pressure ulcers. There was no information about Nutrition, Activities and Psychosocial Well Being.</p> <p>3. Resident #6 was admitted to the facility on 10/19/13 with diagnoses of sepsis, pyelonephritis, altered mental state, and gastrointestinal hemorrhage unspecified.</p> <p>The admission MDS assessment, dated 9/3/13, documented the resident:</p> <ul style="list-style-type: none"> - was cognitively intact with a BIMS of 15, - required extensive assistance for bed mobility, transfers, dressing, toilet use, and limited assistance with personal hygiene. - was frequently incontinent of urine. <p>The MDS triggered the need for further</p>	F 272	<p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>To address other residents that may have the potential to be affected by this deficiency, all current Residents triggered areas in the comprehensive MDS will be reviewed by 12/06/2013, by the MDS Coordinator or designee and DNS or designee to ensure that triggered areas includes what triggered them, what co-morbidities were associated with them, if the resident and family were involved in further assessment, and if a care plan was developed to address the problems/needs in their Care Areas Assessment Documentation notes.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur, a "Checklist," will be developed by the DNS or designee and Administrator or designee by</p>	
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F 272	<p>Continued From page 7</p> <p>assessments in the areas of ADL function, Urinary Incontinence, Falls, Nutritional Status, Dehydration, Pressure Ulcers and psychotropic drug Use. In the MDS Care Area Assessment Documentation Notes, dated 9/3/13, six care areas were identified but there was minimal to no documentation about what triggered them, what co-morbidities were associated with them, if the resident and family were involved in further assessment and if the facility was going to develop a care plan to address the problems/needs.</p> <p>4. Resident #8 was admitted to the facility 11/5/10 with diagnoses of morbid obesity, general symptoms of malaise and fatigue, muscle weakness and cellulitis and abscess of leg.</p> <p>The annual MDS, dated 10/17/12, documented the resident:</p> <ul style="list-style-type: none"> - was cognitively intact with a BIMS of 15, - required limited to extensive assistance with bed mobility, transfers, dressing, toileting, personal hygiene, - was occasionally incontinent of bowel and bladder. <p>The MDS triggered the need for further assessments in the areas of ADL function, Urinary Incontinence, Falls, Nutritional Status, and Pressure Ulcers. In the MDS Care Area Assessment Documentation Notes, dated 10/17/12, five care areas were identified but there was minimal to no documentation about what triggered them, what co-morbidities were associated with them, if the resident and family were involved in further assessment and if the facility was going to develop a care plan to address the problems/needs. There was no</p>	F 272	<p>12/03/2013, for the IDT to utilize in reviewing all scheduled completed Comprehensive MDS Care Areas Assessment (CAA) Documentation notes to ensure that areas triggered contain the following: what triggered them, what co-morbidities were associated with them, if the resident and family were involved in further assessment, and if a care plan was developed to address the problems/needs.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Administrator or designee and the DNS or designee will review at least five (5) completed Comprehensive MDS Care Areas Assessment Documentation notes to ensure that areas triggered contain the following: what triggered them, what co-morbidities were associated with them, if the resident and family were involved in further assessment, and if a care plan was developed to address the problems/needs.</p> <p>Monitoring will start on 12/09/2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p>		

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F 272	Continued From page 8 assessment of the resident's nutritional status, the resident had diagnoses of morbid obesity and was on a limited calorie diet. 5. The same findings were found for Residents #s 2, 4, 5 and 9. The DON and MDS person were interviewed 10/23/13 at 4:00 p.m. about completion of the CAAs. The DON indicated that she was the person responsible for overseeing the completion of the CAAs. She had just completed training on the MDS 3.0 and the requirements. The person completing the MDS's was an LPN and had not attended any formal MDS training.	F 272	The Administrator or designee and the DNS or designee will present to the quarterly QA&A Committee meeting their findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	
F 280 SS=E	The Administrator and DON were informed on 10/23/13 at 6:30 p.m. of the assessment issues. No further information was provided. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280	F- 280 SS=E §483.20(d) (3), 483.10 (k) (2) - Right to Participate Planning Care-Revise CP The facility does ensure that care plans are revised if necessary to meet the needs of the resident and that residents or the residents' responsible party or power of attorney are invited to care conferences.	12/09/13

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F 280	Continued From page 9 each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident and resident group interview and record review, the facility failed to: - revise resident care plans to meet the needs of the resident. - invite residents or the residents' powers of attorney to care conferences. This failed practice could potentially affect all residents in the facility but specifically 9 of 9 (#s 1- 9) sampled residents. There was a potential for harm when residents do not attend care plan meetings. A potential for declines in the resident's psychosocial and physical well being may occur and residents may also refuse interventions put in place if they were not involved in creating them. Findings include: 1. During the Resident Group interview held on 10/22/13 at 2:00 p.m. when asked if the residents attended or were involved in their care planning meetings, everyone in the group stated they were not aware of when the meetings occurred. Interviews with two resident family members (Resident #1 on 10/22/13 at 10:15 a.m. and #5 on 10/24/13 at 9:10 a.m.) it was found they were not aware of when care conferences were and also indicated they would attend if they knew when they occurred. On 10/24/13 at 10:00 a.m. the social worker and MDS nurse were interviewed about notifying the resident and families. Their response was they called families on the phone to invite them but not many attended the	F 280	<i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i> Residents who attended the group interview with the surveyor, will be scheduled for a care conference and be invited via mail correspondence, by the facility LSW or designee by 12/05/2013. Regarding the two Residents Family Members of Resident #1 and Resident #5, who mentioned during the interview to the surveyor that they were not aware on when care conference were: <ul style="list-style-type: none"> Resident #1 is no longer a Resident of the facility. Resident # 5 family will be invited for a care conference by the facility LSW or designee via mail, by 12/05/2013. Resident #3 care plan will be updated by the MDS Coordinator or designee by 12/06/2013, to include the following: <ul style="list-style-type: none"> ADL potential for self care deficit on the assistance needed for bed mobility, transfers, ambulation, dressing, toilet use, personal hygiene, and bathing. 	

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F 280	<p>Continued From page 10 meetings. They did not respond to the question about inviting residents to meetings. They indicated there was no documentation to show families were contacted about care plan meetings.</p> <p>2. Resident #3 was admitted to the facility 5/31/13 with diagnoses of care involving use of rehabilitation (fracture left hip), other cerebral degenerations, Lupus.</p> <p>The admission MDS assessment, dated 6/7/13, documented the resident: - was cognitively intact with a BIMS of 15, - required extensive assistance for bed mobility, transfers, locomotion, dressing, personal hygiene and bathing.</p> <p>The resident's June 2013 "Plan of Care" failed to have a plan for problems identified on the resident's most recent comprehensive MDS assessment which was dated 6/3/13. These were: - ADL function/Rehabilitation Potential was identified as a problem on the MDS. The assessment identified the resident needed assistance for Bed Mobility, Transfers, ambulation, dressing, Toilet use, Personal Hygiene and Bathing. The "Plan of Care" documented, "potential for self care deficit related to decreased mobility secondary to Left hip ORIF. [open reduction internal fixation] The interventions were: "Keep call light in reach, assist with cares as needed, 1/2 side rails x 2 to assist with positioning and mobility; Keep usually used items in reach; Encourage her to work with therapy. Encourage her to do as much as she is able; and She is a 1-2 person assistance with all care, limited to extensive assistance. *Note -</p>	F 280	<ul style="list-style-type: none"> Urinary Incontinence care plan on how to maintain or restore the resident continence, the needed assistance for toileting. The Potential for Unavoidable Spontaneous Fracture care plan related to the Osteoporosis, when on 06/30/2013 the Resident had a spontaneous fracture and fell, to include in her care plan her current limitation if any, with turning and repositioning needs, and mechanical devices used if indicated. <p>Resident #8 with regards to the following;</p> <ul style="list-style-type: none"> Hx (history) of having a negative attitude toward staff members in regards to color of their skin, The care plan will be updated by the MDS Coordinator or designee by 12/06/2013, to ensure that the interventions relate to the problem. 	
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F 280	<p>Continued From page 11</p> <p>Status may change at any time related to ability and or condition."</p> <p>- Urinary Incontinence and indwelling catheter was identified on the MDS. There was no care plan on how the facility was to maintain or restore the resident's continence. The resident needed assistance for toileting and was having occasional incontinence [assessed on the 6/3/13 annual MDS].</p> <p>- Falls were identified on the MDS and the resident had a spontaneous fracture and fell on 6/30/13 at 1:45 a.m. The resident was confined to bed for several months after the fall and fracture. The problem dated 6/21/13 documented, "Potential for unavoidable spontaneous fracture related to osteoporosis." The Interventions were: "Transfer with care, Treat as ordered by Md, Observe for signs and symptoms of fractures, and Keep MD informed of signs/symptoms of fracture." The resident's care plan was not updated after the fall and fracture with the limitations,(e.g. bed rest), turning and positioning needs, and mechanical devices used.</p> <p>The DON was interviewed about these issues and the lack of specific interventions and failing to update the care plan on 10/23/13 at 4:00 p.m. No further information was provided.</p> <p>3. Resident #8 was admitted to the facility 11/5/10 with diagnoses of morbid obesity, general symptoms of malaise and fatigue, muscle weakness and cellulitis and abscess of leg.</p> <p>The annual MDS, dated 10/17/12, documented the resident:</p> <p>- was cognitively intact with a BIMS of 15, - required limited to extensive assistance with bed mobility, transfers, dressing, toileting, personal</p>	F 280	<ul style="list-style-type: none"> A Behavior care plan will be completed by the MDS Coordinator or designee by 12/06/2013 with regards to the Services that Residents receives from a LCSW that includes goals/interventions for what the LCSW visits were to and will accomplish. <p>Resident # 2 wounds (left heel and right lateral heel) related to her peripheral vascular disease were healed 09/26/2013 prior to the survey, per wound clinic. The skin plan of care "Potential for further development of unavoidable skin integrity.....," the interventions will be reviewed and evaluated by the MDS Coordinator or designee by 12/06/2013, to ensure the effectiveness and modifications if indicated, to prevent development of new sores unless the individual's clinical condition demonstrate that they were unavoidable. (Reference to F 314).</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p>		

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F 280	<p>Continued From page 12</p> <p>hygiene, - was occasionally incontinent of bowel and bladder.</p> <p>The resident's "Plan of Care" did not include a plan for problems identified on the MDS assessment and behaviors that the resident exhibited. These were:</p> <ul style="list-style-type: none"> - The resident had a "Problem" dated 9/29/11 and last reviewed 5/14/13, that documented, "Resident has a Hx [history] of having a negative attitude toward staff members in regard to the color of their skin." Upon review of the interventions, it was difficult to determine how they related to the problem. These were, "Praise patient's efforts and accomplishments; Encourage resident to participate in all activities of interest; and When resident exhibits restlessness, encourage resident to spend time with friends and family." - The resident received services from a LCSW for a history of behavioral symptoms. There was no care plan for the "Behaviors" nor goals/interventions for what the LCSW visits were to accomplish. The resident's June 2013 - September 2013 behavior monitoring did not document any behaviors. The resident was interviewed 10/22/13 at 5:45 p.m. and stated that three weeks prior to the survey there were some problems with her behavior as it related to bathing. [Note: there was no documentation about the incident in the medical record but the ADL care plan added specifics about a bath aide on 8/17/13.] <p>The facility LSW was interviewed on 10/24/13 at 10:00 a.m. She stated the LCSW started on June 25, 2013, seeing Resident #8. There was discussion about the lack of goals and</p>	F 280	<p>All current Residents in the facility may have the potential to be affected by the non-notification of their care conference meeting. Hence, the facility LSW or designee will send all Residents in the facility and/or Residents responsible party or power of attorney correspondence via mail an invitation for their care conference. <i>by 12/05/13 MD</i></p> <p>Residents who needs care plan on ADL, Urinary, Spontaneous Fracture resulting in fall, Behavior, and Skin as identified in their most recent comprehensive MDS assessment may have the potential to be affected by this deficiency. Therefore, Residents who were identified with needs as regards to their ADL, Urinary, Spontaneous Fracture resulting in fall, Behavior, and Skin care plans will be reviewed by the MDS Coordinator or designee <i>by 12/06/2013</i>, to ensure subsequent care planning when necessary and updates of interventions if necessary.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that deficient practice does not recur;</p>	
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F 280	<p>Continued From page 13</p> <p>interventions in the resident's Plan of Care. The LSW acknowledged and stated they did talk about the resident and the LCSW does document her visits. No further information was provided.</p> <p>4. Resident #2 was admitted to the facility on 4/4/12 with multiple diagnoses to include, ESRD (End Stage Renal Disease), diabetes mellitus, anemia, CAD (Coronary Artery Disease), and PVD (Peripheral Vascular Disease).</p> <p>Resident #2's "Skin Plan of Care" dated, 10/21/12, and reviewed on 1/8/13, 4/3/13, and 7/1/13 identified the the same problem area, "Potential for further development of unavoidable skin integrity..."</p> <p>The interventions were dated 11/14/12, and documented the following:</p> <ul style="list-style-type: none"> - Heel protectors as ordered; - Licensed nurse to do weekly skin assessment; - Encourage her [the resident] to change position often; - Air mattress overlay on Standard Facility Mattress, DC'd (discontinued) on 8/14/13; - Gel Mattress dated 8/14/13; <p>A hand written Short Term Care Plan, dated 8/29/13, documented the following:</p> <ul style="list-style-type: none"> - Assessment and Identification of problem, "1 cm x 0.5 cm x unk[nown] perimeter to [right] lateral heel." - Interventions, "1. Treat per facility skin treatment protocol. 2. Pt [patient] will be evaluated for vascular changes at wound clinic. 3. Keep MD [medical doctor] informed as appropriate." <p>A hand written Short Term Care Plan, dated</p>	F 280	<ul style="list-style-type: none"> • A "Care Conference Invitation Check List Log," will be developed by facility LSW or designee by 12/05/2013, to ensure that the Resident and/or the Resident's Responsible Party or Power of Attorney is or are invited via mail correspondence on their scheduled care conference. • The Facility Administrator will in-service the IDT (Interdisciplinary Team), by 11/25/2013, regarding F-280 as it relates to the importance of ensuring that Residents who were identified with problems in regards to ADL, Urinary Incontinence, Spontaneous Fracture resulting in fall, Behavior, and Skin care plans are reviewed to check for subsequent care planning and updates of interventions if necessary. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p>	
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F 280	<p>Continued From page 14</p> <p>9/6/13, documented the following:</p> <ul style="list-style-type: none"> - Assessment and Identification of problem, "1.5 cm x 1.5 cm wound to left heel." - Interventions, "1. Treat per facility skin treatment protocol. 2. Pt [patient] will be evaluated for vascular changes at wound clinic. 3. Keep MD informed as appropriate. 4. Order for diabetic shoes." <p>NOTE: The facility identified the first pressure ulcer on the right lateral heel on 8/29/13 and the second pressure ulcer on the left lateral heel on 9/6/13. According to the resident's "Skin Plan of Care," the interventions remained the same for both pressure ulcers. The facility failed to monitor and evaluate the effectiveness of the preventative interventions and modify as necessary to prevent the development of a second pressure ulcer.</p> <p>On 10/24/13 at 10:45 a.m. the DNS and MDS nurse were interviewed related to facility's failure to review and revise the "Skin Plan of Care" after identification of the right heel pressure ulcer to prevent the left heel pressure ulcer from developing. The DNS and MDS nurse said daily skin checks were completed on the Right heel. The surveyor asked the DNS how the facility determined the effectiveness of the above intervention and how was the "Skin Plan the Care" reviewed and revised to discontinue ineffective interventions and implement new interventions. The DNS and MDS nurse said the facility implemented the same interventions for the left heel pressure ulcer identified on 8/29/13 and the right heel pressure ulcer identified on 9/6/13.</p> <p>(Please refer to F314)</p>	F 280	<ul style="list-style-type: none"> • The Administrator or designee and the DNS or designee will review the "Care Conference Invitation Checklist Log," and from the list will interview at least three (3) Residents and at least three (3) Resident's Responsible Party or Power of Attorney (if available in the facility), to ensure that they have received via mail correspondence their invitation for a care conference. • The Administrator or designee and the DNS or designee will review at least three (3) Residents who were identified with problems with regards to ADL, Urinary Incontinence, Spontaneous Fracture resulting in fall, Behavior, Skin care plans to check for subsequent and updates of interventions if necessary. <p>Monitoring will start on 12/09/2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Administrator or designee and the DNS or designee will present to the quarterly QA&A Committee meeting their findings and/or corrective actions taken.</p>	
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F 280	Continued From page 15	F 280	Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		
F 309 SS=D	<p>On 10/24/13 at 2:00 p.m. the Administrator was notified. Additional information was submitted to the Bureau of Facility Standards on 10/27/13 via fax, but did not alter these findings.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure the facility had an agreement with the Dialysis Agency to determine how medical and non-medical emergencies would be handled, development and implementation of the resident's care plan, and the exchange of information for 1 of 9 (#2) sampled residents. This failed practice had the potential for more than minimal harm if the resident had an emergency and bled/hemorrhaged from her fistula site or developed an infection. Findings include: Resident #2 was admitted to the facility on 4/4/12 with multiple diagnoses to include, ESRD (End Stage Renal Disease), diabetes mellitus, anemia, CAD (Coronary Artery Disease), and PVD (Peripheral Vascular Disease).</p>	F 309	<p>F- 309 SS=D §483.25 - Provide Care/Services for Highest Wee Being</p> <p>The facility does ensure that the facility has an agreement with the Dialysis Agency and a policy on dialysis.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident # 2, the dialysis agency was contacted by the facility Administrator via telephone on 10/25/2013, regarding F-309 to acquire a facility agreement.</p> <p>A copy of the facility dialysis policy and procedure will be placed by 11/25/2013 in the Medication Administration Binder, for the License Nurses to reference to as needed for Residents receiving dialysis.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p>	12/09/13	

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F 309	<p>Continued From page 16</p> <p>Resident #2's Dialysis Plan of Care, documented the following:</p> <ul style="list-style-type: none"> - 8/16/12, Problem area, "Has fistula for dialysis." - 8/16/12, Interventions, "1. Dialysis to monitor fistula. 2. After dialysis observe fistula for bleeding. 3. If abnormal bleeding notify MD and treat as ordered." <p>NOTE: Resident #2's Dialysis Plan Of Care did not include information related to the following:</p> <ul style="list-style-type: none"> - What to do in the event of a medical and/or non-medical emergency. - How to identify complications such as bleeding/hemorrhage, infection, and septic shock. - Which arm the resident's blood pressure should be taken on. <ul style="list-style-type: none"> - On 10/23/13, at 3:45 p.m., the Administrator was asked to provide the surveyor with the agreement the facility had with the Dialysis Agency for managing residents on dialysis. The Administrator said it was the resident's choice where the resident went for dialysis. The Administrator stated, "He had never heard that a facility had to have an agreement with the Dialysis Agencies for residents receiving dialysis." The surveyor referred the Administrator to the Federal Guidance at F309, "Resident Receiving Dialysis Services." No additional information was provided to resolve this issue. - On 10/23/13, at 4:00 p.m., the DNS was asked to provide the surveyors with the facility's policy and procedure for residents receiving dialysis. The DNS said she would look for the policy. - On 10/24/13, at 10:45 a.m., the DNS was asked to provide the surveyors with the facility's policy and procedure for residents receiving dialysis. No additional information was provided to resolve this issue. 	F 309	<p><i>This deficiency is an isolated deficiency as reflected in the Statement of Deficiencies-form CMS 2567.</i></p> <p>On 10/25/2013, the Director of Nursing and Administrator reviewed all current Residents in the facility, and there are no other Residents identified in the facility that are receiving Dialysis services from a Dialysis Clinic.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>Potential Residents will not be admitted in the facility until a Dialysis Agreement is provided by the particular Dialysis Clinic to the facility, if there is not one in place.</p> <p>In the event that a Resident in the facility requires dialysis at a particular dialysis clinic, then the facility will request an agreement if there is not one in place between that dialysis clinic and the facility.</p> <p>The License Nurses will be in-serviced by 11/25/2013, by the Director of Nursing or designee on Dialysis Policy and Procedure and to make the License Nurse aware that a copy was placed in the Medication Administration Binder, for them to reference to as needed for Residents receiving dialysis.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORMAL REVIEW
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/24/2013
NAME OF PROVIDER OR SUPPLIER QUINN MEADOWS REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1033 WEST QUINN ROAD POCATELLO, ID 83202		
(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 314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure a resident who had Peripheral Vascular Disease and Diabetes Mellitus wore heel protectors while in her wheel chair and recliner to prevent pressure sore development and to evaluate and modify improperly fitting diabetic shoes. This was true for 1 of 9, (#2) sampled residents. This deficient practice caused harm when Resident #2 developed a pressure sore to her right heel on 8/29/13 and another pressure sore on her left heel on 9/6/13. Findings include:</p> <p>Resident #2 was admitted to the facility on 4/4/12 with multiple diagnoses to include, ESRD (End Stage Renal Disease), diabetes mellitus, anemia, CAD (Coronary Artery Disease), and PVD (Peripheral Vascular Disease).</p> <p>Resident #2's most recent Quarterly MDS, dated 7/1/13, coded the following: - BIMS of, "15" or cognitively intact. - Extensive assistance of 1 person for bed mobility, transfers, dressing, and toilet use.</p>	F 314	<p>F 309 continued</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through: The Administrator or designee and Director of Nursing or designee will review all current Residents in the facility to ensure that an agreement is in place with the facility for that particular dialysis clinic.</p> <p>The Administrator or designee and Director of Nursing or designee will visually check to ensure that a copy of the dialysis policy remains in the Medication Administration Binder, for the License Nurses to reference to as needed for Residents receiving dialysis.</p> <p>Monitoring will start 12/09/2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Administrator or designee and the DNS or designee will present to the quarterly QA&A Committee meeting their findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>		

DEPARTMENT OF HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 18</p> <ul style="list-style-type: none"> - Limited assistance of 1 person for personal hygiene and bathing. - Functional limitation in range of motion to upper/lower extremity, "No impairment." - Is the resident at risk for developing pressure ulcers, "Yes." - Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher, "No." - Skin and Ulcer treatment, "pressure reducing device for bed." <p>Resident #2's Pressure Ulcer CAA (Care Area Assessment) dated 4/4/13, documented the following, "...Resident has decreased mobility and comorbidity that increase risk for skin issues. Resident has pressure relieving mattress to bed. Licensed nurse to do weekly skin assessment. Will continue the plan of care."</p> <p>NOTE: Chapter 4 of the RAI Manual, CAA Process and Care Planning, page 4-2 documented, When implemented properly, the CAA process should help staff:</p> <ul style="list-style-type: none"> - "Develop, to the extent possible, interventions to help improve, stabilize, or prevent decline in physical, functional, and psychosocial well-being, in the context of the resident's condition, choices, and preferences for interventions." <p>Resident #2's "Skin Plan of Care," dated 8/26/12, identified the following problem, "Admitted with soft heels...."</p> <p>Resident #2's "Skin Plan of Care," dated 8/26/12 and reviewed on 10/21/12, 1/8/13, 4/3/13, 7/1/13 identified the the following problem area, "Potential for further development of unavoidable skin integrity related to decreased mobility and diagnosis of renal disease, diabetes, severe PAD,</p>	F 314	<p>F- 314 SS=G \$483.25 (c) - Treatment/SVCS to Prevent/Heal Pressure Sores</p> <p>The facility does ensure that residents who enter the facility without a pressure sore, do not develop pressure sore unless the individual's clinical condition demonstrate that they were unavoidable; and a Resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p><i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>Resident # 2's wounds related to the peripheral vascular disease (left lateral heel and right lateral heel were healed on 09/26/2013 as according to the wound clinic, prior to the survey.</p> <p>Resident #2's with regards to her new diabetic shoes, the Podiatrist has assessed on 09/23/2013, the Resident to ensure that her diabetic shoes do fit properly.</p> <p>On 11/15/2013 a Physician order was received from the Primary Physician of Resident #2 to discontinue the use of heel</p>	12/09/13
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F 314	<p>Continued From page 19 peripheral neuropathy, diabetic neuropathy, PVD..."</p> <p>The interventions were dated 11/14/12, and documented the following:</p> <ul style="list-style-type: none"> - Heel protectors as ordered; - Air mattress overlay on Standard Facility Mattress with a hand written DC'd (discontinued) date of 8/14/13; - Gel Mattress (hand written), dated 8/14/13; - Licensed nurse to do weekly skin assessment; and - Encourage her [the resident] to change position often. <p>Resident #2's October 2013 Physician's Orders documented the following orders:</p> <ul style="list-style-type: none"> - "Skin checks (head to toe) every week (monday eve[ning]. - Heel protectors on while in bed or wheel chair." <ul style="list-style-type: none"> - On 10/21/13 at 3:15 p.m., Resident #2 was observed sitting outside on the patio, in her wheel chair with her diabetic shoes on. - On 10/21/13 at 4:15 p.m., Resident #2 was observed sitting her recliner, in her room, with her diabetic shoes on. - On 10/22/13 at 8:15 a.m., and 5:30 p.m. Resident #2 was observed in the dining room, in her wheel chair, with her diabetic shoes on. - On 10/22/13 at 1:45 p.m., Resident #2 was observed sitting her recliner, in her room, with her diabetic shoes on. <p>NOTE: The resident did not have heel protectors on as care planned, but was observed wearing shoes.</p> <p>Resident #2's Nurse Treatment Notes documented the following:</p>	- F 314	<p>protectors when sitting in a chair, or wheelchair, or a recliner; and as per the new physician order Resident may use the diabetic shoes or boot style fur line rubber soled slippers as per Resident's preference. The skin care plan will be reviewed by 12/06/2013, by the DNS or designee and MDS Coordinator or designee to evaluate effectiveness of interventions and to ensure updates with this new intervention.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p><i>This deficiency is an isolated deficiency as reflected in the Statement of Deficiencies-form CMS 2567.</i></p> <p>To address other Residents that may have the potential to be affected by this deficiency;</p> <ul style="list-style-type: none"> • A visual observation will be done by a License Nurse by 12/06/2013, to ensure that all current Residents with physician orders for heel protector had heel protector in placed according to that resident's particular order. • All current Residents with peripheral vascular disease will be assessed by the facility Treatment Nurse or designee and the DNS or 		

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F 314	<p>Continued From page 20</p> <p>- 8/12/13 - "No new skin issues noted trace amount BLLE (bilateral lower extremity edema)."</p> <p>- 8/19/13 - "No new skin issues noted 1+ edema BLLE..."</p> <p>- 8/26/13 - "No new skin issues..."</p> <p>- 8/29/13 - "Res[ident] c/o [complains of right] heel pain on assessment 1cm x 0.5 cm x unk[own] area to heel. N.O. [new order] obtained skin prep area BID [twice daily] float heels [with] heel protectors while in bed measure weekly and resolve when appropriate."</p> <p>A facility Incident Report, dated 8/29/13 at 11:00 a.m., documented the following:</p> <p>- "Res[ident] was [in the] bathe [sic] today cna alerted LN that pt [patient] had a dark area to [right] lateral heel."</p> <p>- Assessment by the licensed staff, "1cm x 0.5cm x unk[nown] perimeter clean/clear intact, [zero] abrasive noted to shoe... pt [patient] does state 'tenderness' to area."</p> <p>- Current interventions in place, "Skin prep area BID [twice daily] float heels while in bed."</p> <p>- Immediate interventions implemented, "Skin prep area, physician notified order received for eval[uation] [at] wound clinic for vascular changes appt. [appointment] [with podiatrist]."</p> <p>A hand written Short Term Care Plan, dated 8/29/13, documented the following:</p> <p>- Assessment and Identification of problem, "1 cm x 0.5 cm x unk[nown] perimeter to [right] lateral heel."</p> <p>- Interventions, "1. Treat per facility skin treatment protocol. 2. Pt [patient] will be evaluated for vascular changes at wound clinic. 3. Keep MD informed as appropriate."</p> <p>Resident #2's Nurse Treatment Notes</p>	F 314	<p>designee by 12/06/2013, to ensure that their shoes fit.</p> <ul style="list-style-type: none"> The Health Information Director or designee by 12/06/2013, will review all Residents who have pressure sore to ensure consistent documentation of the size, shape, location, and appearance of the area as documented in the "Ulcer Skin Condition Record." All License Nurses will be in-serviced by Director of Nursing or designee by 11/25/2013, regarding F-314 about the importance of implementing heel protectors when ordered by the physician, consistent documentation of the size, shape, location, and appearance of the area of sore as documented in the "Ulcer Skin Condition Record," and/or updating care plans on skin changes if indicated, to promote healing and/or prevent new pressure sore from developing unless the individual's clinical condition demonstrate that they were unavoidable. 	

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F 314	<p>Continued From page 21 documented the following:</p> <ul style="list-style-type: none"> - 9/2/13 - "...Skin intact over bony prominences... [Zero] other skin issues at this time." - 9/5/13 - "[Zero] change in [right] lateral foot ulcer. Area is dry intact. perimeter of wound is intact." - 9/6/13 - "New issue, [left] lateral heel area 1.5cm x 1.5cm circle skin still intact. Skin prep applied, heel boots, heels floated." <p>A second facility Incident Report, dated 9/6/13 at 2125 [9:25 p.m.], documented the following:</p> <ul style="list-style-type: none"> - Assessment by licensed staff, "While applying skin prep to [right] lateral heel diabetic ulcer pt [patient] informed me that she believed she had one on her [left] heel. Diabetic ulcer noted same location on [left] heel as on [right] heel 1.5 cm x 1.5cm w[idth]." - Current interventions in place, "Heel boots applied and heels floated while in bed." - Immediate interventions implemented, "Skin prep applied and heel boots on heels floated. Pt [patient] has appointment for evaluation of lower extremity vascular changes. Pt [patient] has order for diabetic shoes." <p>A hand written Short Term Care Plan, dated 9/6/13, documented the following:</p> <ul style="list-style-type: none"> - Assessment and Identification of problem, "1.5cm x 1.5cm wound to left heel." - Interventions, "1. Treat per facility skin treatment protocol. 2. Pt [patient] will be evaluated for vascular changes at wound clinic. 3. Keep MD informed as appropriate. 4. Order for diabetic shoes." <p>Resident #2's Nurse Treatment Notes documented the following:</p> <ul style="list-style-type: none"> - 9/7/13 - "Dry [dressing] gently removed from 	F 314	<p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur; The facility on 11/15/2013 developed a "Skin Team."</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The facility "Skin Team," will do visual observation and/or review;</p> <ul style="list-style-type: none"> • Sampling of ten (10) current Residents in the facility to ensure that their shoe fits. • Sampling of five (5) to ensure implementation of heel protector when ordered by the physician. • Residents who have pressure sores to ensure consistent documentation of the size, shape, location, and appearance of the area as documented in the "Ulcer Skin Condition Record," and/or updating care plans on skin changes if indicated, to promote healing and/or prevent new pressure sores from developing unless the individual's clinical condition demonstrate that they were unavoidable. 	
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F 314	<p>Continued From page 22</p> <p>[right] lateral heel ulcer, leaving an area 0.5 x 0.5 x 0. Area protected with Mepilex with center cut out followed with Allevyn. Pt encouraged to off load heel while in chair.</p> <p>- 9/10/13 - "[Right] heel is healing well [without] complications, perimeter of wound is sloughing/intact. [Left] heel is macerated, indented [with] protected Mepilex. Area left OTA [Open To Air] and will follow [treatment] as [right] heel will cont[inue] [treatment with] floating heels and use of heel protectors."</p> <p>- 9/10/13 - " Pt does have a gel mattress. Diabetic shoes are pending arrival."</p> <p>- 9/17/13 - "PT [Patient] cont[inues] to go to WCC (wound clinic) for diabetic foot. Bilateral feet healing well getting smaller in size."</p> <p>- 9/21/13 - "...[Right and Left] lateral ulcers healing well. Cont[inues] to use heel protectors while in recliner/ bed. Uses blue slippers and areas decreasing in size."</p> <p>- 9/29/13 - "Pt [patient] rec[eived] diabetic shoes on 9/23/13 wears them daily [without] discomfort. On 9/26 pt [patient] DC'd [discontinued] from WCC [wound clinic] state, 'pt [patient] is healed.' Will cont[inue] to monitor prophylactic tx [treatment] to prevent further complications. Will continue floating heels while in bed. Heel protectors while in recliner."</p> <p>NOTE: The facility failed to monitor and evaluate the effectiveness of the initial preventative interventions and to modify those interventions as necessary to prevent the development of a second pressure ulcer.</p> <p>A hand written time-line and measurements, provided by the facility was received by the Bureau of Facility Standards, on 10/27/13. It documented the following:</p>	F 314	<p>Monitoring will start 12/09/2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The "Skin Team," or their designee will present their findings and/or corrective actions taken to the Administrator his/her designee and to the QA&A Committee, during their quarterly QA&A meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>	
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F 314	<p>Continued From page 23</p> <ul style="list-style-type: none"> - 8/28 [Right] lateral heel 1cm x 0.5cm x unk[nown], treatment skin prep BID [twice daily] float heels. - 9/5 [Right] lateral heel 1cm x 0.5 cm x unk, treatment heel protectors. - 9/6 [Left] lateral heel 1.5cm x 1.5cm x unk, [treatment] same as right heel. - 9/10 [Left] lateral heel 2 cm x 1.7cm x unk. - 9/14 [Right] lateral heel 0.6cm x 0.5cm x [less than or equal to] 0.1cm. - 9/21 [Right] lateral heel 0.3cm x 0.5cm x [less than or equal to] 0.1cm. - 9/14 [Left] lateral heel 2cm x 1.7cm x unk. - 9/21 [Left] lateral heel 1.5cm x 1.3cm x unk. - 9/26 Wound Clinic visit, "[patient] is healed." QM [Quality Measures] will cont[inue] prophylactic [treatment] to prevent further complications - 9/27 Treatment [changed] to Mepilex border per WCC. - 9/29 [Right] lateral heel 0.6cm x 0.3cm x [less than or equal to] 0.1cm, - 9/29 [Left] lateral heel 1.5cm x 1.3cm x unk. - 10/7 Resolved heel ulcers. <p>NOTE: The above hand written time-line and measurements were not found in Resident #2's record during the survey process.</p> <p>Resident #2's, "Charge Nurse Notes" documented the following:</p> <ul style="list-style-type: none"> - 8/29/13 - "Follow up on report of 1cm x 0.5cm x unk[nown] perimeter wound to Right lateral heel. Patient states, 'It started hurting a few days ago.' [Resident's name] states that she does wear her shoes daily upon getting up in the morning. Shoes inspected and noted that fabric around back of heel, (but not in area of reported site) is starting to wrinkle down. Order received from [Physician's name] to obtain appointment at 	F 314		

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F 314	<p>Continued From page 24</p> <p>wound clinic for evaluation of vascular changes. Appt. will also be made for podiatrist to seek order for shoes."</p> <p>- 9/7/13 - "F/U [follow up] on report of 1.5cm x 1.5cm wound to left heel. Pt [patient] states, "I think I hurt my foot when I put it down."</p> <p>Resident #2's, "Nurses Notes" documented the following:</p> <p>- 9/6/13 - "...While applying skin prep to [Right] lateral heel. Resident informed me she thinks she has one on her [Left] heel. Noticed diabetic ulcer [Left] lateral heel 1.5cm x 1.5cm, MD notified. Skin prep applied, heel boots applied, heels floated, will cont[inue] to observe."</p> <p>- 9/7/13 - "Bilat[eral] heels evaluated."</p> <p>- 9/9/13 - "...[dressing] intact to [left] heel. Will assess on 9/10 a.m."</p> <p>- 9/10/13 - "Pt [right] diabetic foot ulcer is getting smaller in size and is stable. [Left] heel is macerated. Area [treatment] will be [changed] to skin prep [bid] OTA [open to air]. Float heels/heel protectors while in bed/recliner. Pt is to receive diabetic shoes...[Left] heel has [zero] signs odor/infection/drainage. Res to float heels while up in recliner."</p> <p>- 9/11/13 - "Were [wear] blue slippers while up. Pt heels floated while up in chair."</p> <p>- 9/21/13 - "...Bilat[eral] heels cont. to heal [without] complications. Ulcers getting smaller in size. Cont. to float heels [with] heel protectors while in bed/recliner. Use blue slippers daily."</p> <p>NOTE: None of the above listed interventions were on the resident's permanent "Skin Plan of Care," nor were the interventions listed on the Treatment Record. The only intervention listed on the Treatment Record [TAR] for July, August, and September 2013 was, "Heel protectors on while</p>	F 314			

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F 314	<p>Continued From page 25 in bed or in wheel chair." This intervention was identified on the TAR as information only. The boxes for the nurses' initials were blank and it could not be determined whether or not the heel protectors were being used.</p> <p>Resident #2's, "Doctor's Progress Notes" documented the following: - 9/5/13 - "[Right] lateral foot [ulcer] 2cm x 2cm area with hyperpigmentation..." - 9/9/13 - The resident was seen by the Podiatrist and he documented the following, "...She does have cracks/wounds on heels [bilateral]... Continue keeping the wounds clean, apply antibiotic ointment and bandages until healed... Keep heel protectors on feet as much as possible and avoid pressure on her heels." - 9/23/13 - "Diabetic shoes dispensed. They fit well. Break them in slowly, watch for sings [signs] of rubbing or irritation." - 9/24/13 - "Peripheral vascular disease -causing foot ulcer which with treatment are getting better so no intervention for vessels yet." - 10/17/13 - "[Bilateral] heel ulcers appear to be healing well; but will cont. to closely monitor as plan will be to re-eval vasculature via angiogram [and] potential angioplasty if heel sores are not healing well."</p> <p>Wound care and hyperbaric medicine clinic notes documented the following: - 9/12/13 - "...Attention was then directed to the heel wound, the right heel wound reveals a very small eschar over the lateral aspect of the heel. This wound is completely healed, does not require any specific treatment today. There is an intact lesion along the lateral posterior left heel. There is no open wound noted, then no specific wound care was provided today with the</p>	F 314	<p>F- 315 SS=D §483.25(d) – No Catheter, Prevent UTI, Restore Bladder</p> <p>The facility does ensure that a resident with occasional incontinence has been evaluated for toilet training program.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #8 CAA will be completed by 12/06/2013, to ensure that a bladder re-training program is offered.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.</p> <p>However, Residents who are occasionally incontinent of bladder may have the potential to be affected by this deficient practice; hence, The Director of Nursing or designee and the MDS Coordinator or designee</p>	12/09/13	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 26 exception of silver foam and cover." - 9/19/13 - "...Bilateral heels: patient had some blisters that were noted at her previous appointment..."</p> <p>NOTE: The only documentation of eschar on the resident's right heel was on 9/12/13, when the resident was seen by the wound care clinic.</p> <p>A letter from the resident's attending physician was provided to the Bureau of Facility Standards, on 10/27/13 documented the following: - 10/26/13 - "In my understanding she [Resident #2] was found to have two mirror image superficial skin openings on each lateral heel, but about 8 days apart. I believe these were probably from abrasions by her shoes that were tighter than usual due to more edema." The physician reviewed the clinical visit note from the WCC on 9/12/13 and wrote, "The report says both right and left heel wounds were healed over and only needed protection. Obviously these wounds were very superficial that they could heal so quickly, despite very poor circulation. I believe her weight and peripheral edema fluctuates so much because she cannot tolerate dialysis taking off as much fluid as would be best. [Resident's name] does not ambulate more than a couple of steps, so the shoes she wore were only meant for standing and transfers. More edema of her feet contributed to the new problem with her heels, I believe. Both lateral heel wounds were healed, according to [wound clinic physician's name] at the wound clinic, by 9/12/13, the very next visit. For both to heal that quickly the wounds must have both been superficial."</p> <p>On 10/22/13 at 1:45 p.m. the following was observed by the DNS, charge nurse, and</p>	F 314	<p>will review all Urinary Care Area Assessment (CAA) Documentation Notes, to ensure completion on</p> <p>Residents triggered in the Comprehensive MDS assessment with occasionally incontinent of bladder. This will be done by 12/06/2013.</p> <p>By 12/06/2013, all current Residents in the facility that are occasionally incontinent of bladder and when identified as good candidates, will be offered a bladder re-training program.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur, by 11/29/2013, the MDS Coordinator will be provided with 1:1 education by the Director of Nursing or designee, regarding F-315, with emphasis ensuring the completion of the Urinary Care Area Assessment (CAA) Documentation Notes on Residents triggered in the Comprehensive MDS assessment with occasionally incontinent of bladder. The importance of offering them a bladder re-training program when they are assessed as with occasional incontinence of bladder and are identified as a good candidate for re-training.</p>	
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F 314	<p>Continued From page 27 surveyor:</p> <ul style="list-style-type: none"> - Bilateral heels were pink, soft (as described by LN #1), and had superficial skin slough. - Yellow, dry, closed, scabbed areas present to the lateral aspect of bilateral heels, - Right Great Toe, tip of the toe, hyperpigmentation, hard, and calloused, - On the top of each foot, in the same place, was a blanchable red area where the tongue of the resident's shoe had been. <p>The DNS stated to the charge nurse, the resident's shoes needed to be looked at because it looked liked the resident's shoes were "too tight or not fitting right."</p> <ul style="list-style-type: none"> - On 10/24/13 at 10:45 a.m. the DNS and MDS nurse were interviewed related to facility's failure to review and revise the "Skin Plan of Care" after identification of the right heel pressure ulcer to prevent the left heel pressure ulcer from developing. The DNS and MDS nurse said daily skin checks were completed on the Right heel. The surveyor asked the DNS how the facility determined the effectiveness of the above intervention and how was the Plan the Care reviewed and revised to discontinue ineffective interventions and implement new interventions. The DNS and MDS nurse said the facility implemented the same interventions for the left heel pressure ulcer identified on 8/29/13 and the right heel pressure ulcer identified on 9/6/13. <p>Resident #2 was harmed when:</p> <ul style="list-style-type: none"> - The facility failed to ensure a resident who had Peripheral Vascular Disease and Diabetes Mellitus wore heel protectors while in her wheel chair and recliner to prevent pressure sore development. 	F 314	<p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i></p> <p>Monitoring will be done through: The Director of Nurses or designee will review at least five (5) Resident to make sure that Urinary Care Area Assessment documentation notes has been completed on Residents triggered in the Comprehensive MDS assessment with occasionally incontinent of bladder.</p> <p>The Director of Nurses or designee will review at least five (5) Residents who were assessed with occasional incontinence of bladder and are identified as a good candidate for re-training; to ensure that a bladder re-training program will be offered..</p> <p>Monitoring will start 12/09/2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Director of Nursing or designee will submit to the Administrator or designee and to the QA&A Committee her findings and/or corrective actions taken during the quarterly QA&A Committee Meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>		

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F 314	Continued From page 28 - The facility failed to evaluate and modify improperly fitting shoes, that contributed to the development of the pressure sores when she had increased edema in her feet. - The facility failed to have consistent documentation of the size, shape, location, and appearance of the areas on the bilateral heels. - The facility failed to review and revise the resident's Plan of Care after the first pressure sore was identified. On 10/24/13 at 2:00 p.m. the Administrator and DNS were notified. Additional information was submitted to the Bureau of Facility Standards on 10/27/13 via fax. However, the information did not alter the findings.	F 314	F- 363 SS=D §483.35(c) - Menus Meet Res. Needs/Prep in Advance/Followed The facility does ensure that food is served as planned on the menu for residents on renal diet, and that residents are served the correct portions as indicated on the menu of pureed foods to residents on pureed diet. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:	12/09/13	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure a resident that had occasional incontinence was evaluated for a toilet training program. This was true for 1 of 9 (# 8) sampled residents. The failure to completely	F 315	Resident # 6 is no longer a resident of the facility. The cook identified during the survey, who did not use a ladle for correct serving sizes will be provided with 1:1 education the Dietary Manager or designee by 11/25/2013, regarding F 363 on making sure that a ladle is use for correct serving sizes when indicated on the menu for pureed foods. The cook identified during the survey who did not served the food on Resident # 2 as planned on the menu for a Renal diet, will be provided a 1:1 education by the Dietary Manager or designee by 11/25/2013, regarding F363, with emphasis on the importance of serving the food as planned on the menu for residents who are on Renal Diet.		

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F 315	<p>Continued From page 29</p> <p>assess a resident's continence could potentially harm the resident by creating skin issues and poor bladder function. Findings include:</p> <p>Resident #8 was admitted to the facility 11/5/10 with diagnoses of morbid obesity, general symptoms of malaise and fatigue, muscle weakness and cellulitis and abscess of leg.</p> <p>The annual MDS, dated 10/17/12, documented the resident:</p> <ul style="list-style-type: none"> - was cognitively intact with a BIMS of 15, - required limited to extensive assistance with bed mobility, transfers, dressing, toileting, personal hygiene, - was occasionally incontinent of bowel and bladder. <p>The CAA for Urinary Incontinence was not a complete assessment of the problem. The CAA did document, on 10/19/12, "The resident prefers to toilet self and wear protective undergarments. She has some incontinence of bladder.</p> <p>The comprehensive care plan provided for the resident had multiple dates with the last being July 2012. There was no care plan about the resident's incontinence and what to do for the resident.</p> <p>The record included a "Bladder Incontinence Evaluation" form, which was first completed on 11/5/10 and was reviewed 12 times with the last being 7/27/13. All the re-evaluations had the same notation of, "No Changes." The section "Evaluation for Bladder Program Potential" documented the resident was, "Able to participate in program." There was additional documentation of, "Plan: Aware of toileting needs. Prefers to</p>	F 315	<p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.</p> <p>However, other residents who are receiving Pureed, and/or Renal diets may have the potential to be affected by this practice. Therefore, a visual observation will be done by the facility Dietary Manager or designee by 11/25/2013, to make sure that a ladle is use for correct serving sizes when indicated on the menu for pureed foods, and on serving the food as planned on the menu for residents who are on Renal Diet.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur, All Dietary Cooks will be in- serviced by the Dietary Manager or designee by 11/25/2013, with regards to F-363, with reference to making sure that a ladle is use for correct serving sizes when indicated on the menu for</p>	

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F 315	Continued From page 30 wear protective undergarments." The "Bowel and Bladder Training" form, dated 11/5/10 and reviewed 12 times with the last on 7/27/13, scored the resident as a 20. This translated to, "Good candidate for individualized training." The "Interdisciplinary Progress Report Toileting Program" form had an "X" next to number "5. Toileting Program #5 - This program is for those individuals whoa re[sic] continent of bowel and bladder. These individuals should be reassessed when a change in condition is triggered by the care plan team." The resident was not on a bladder training program. The DON and MDS LPN were interviewed on 10/23/13 at 4:00 p.m. The MDS nurse stated that she did the last review of the resident's Bladder Assessment and stated the resident was occasionally incontinent. She further said the resident wanted to wear protective undergarments and did not change the forms to reflect that the resident was occasionally incontinent and did not look into a bladder training program. When asked if the resident would benefit from a prompted toileting program the MDS nurse responded with, "I didn't think about that, I put what she wanted." The Administrator and DON were informed 10/24/13 at 2:00 p.m. of the lack of a bladder program for Resident #8. No further information was provided.	F 315	Pureed foods, and the importance of serving the food as planned on the menu for residents who are on Renal Diet. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through: The Dietary Manager or Designee will do a visual observation during food preparation at a minimum of 1 meal, to ensure that a ladle is use for correct serving sizes when indicated on the menu for Pureed foods, and food is served as planned on the menu for residents who are on Renal Diet. Monitoring will start on 12/09/2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. The facility Dietary Manager or his/her designee will submit to the Administrator or his/her designee and to the QA&A Committee her findings and/or corrective actions taken during the quarterly QA&A Committee Meeting.	
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended	F 363	Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	

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F 363	<p>Continued From page 31</p> <p>dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the menus, the facility failed to:</p> <ul style="list-style-type: none"> - serve the food as planned on the menu for a resident that was on a renal diet, - serve the correct portions as indicated on the menu of pureed foods to residents on a pureed diet. <p>This was true for 2 of 9 (#s 2 & 6) sampled residents. Failing to provide nutrition according to menus could put residents at risk for potential harm by not receiving adequate nutritional caloric intake. Findings include:</p> <p>1. On 10/23/13 at 12:20 p.m. the cook was observed picking up a bowl with pureed potatoes. Using a tablespoon, the cook scraped a portion of the pureed potatoes onto a plate. He did the same with pureed vegetables and meat. The cook did the same process for a second plate. He did not measure the food he put on either of the plates but it was observed the three items filled each of the plates. Then the two plates were covered and placed on the food cart. At 12:35 p.m. the cook was observed picking up a bowl with pureed potatoes. Using the same tablespoon, the cook scraped a portion of the pureed potatoes onto a plate. He did the same with the pureed vegetables and meat. Then the cook got three small bowls and poured the remaining pureed food into them. This serving</p>	F 363	<p>F- 371 SS=E §483.35(i) – Food Procure, Store/Prepare/Serve-Sanitary</p> <p>The facility does ensure that coffee cups used by residents were able to be sanitized.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Immediately upon identification by the surveyor during the survey process, the cups found to have gouges, and/or scratches, and/or uneven surfaces were promptly removed and disposed by the Dietary Manager from service and replaced them with cups that have surfaces that can be sanitized. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following: To address other Residents have the potential to be affected by this practice, on 10/23/2013 the facility did dispose all its food service plastic cups that are not able to be sanitized. The facility is using food service cups that can be sanitized for all food service.</p>	12/09/13

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F 363	<p>Continued From page 32</p> <p>was for Resident #6 who was in isolation. The portion size of the food served to Resident #6 appeared substantially less (filling only half of the small bowls) than the food on the other three plates served to residents.</p> <p>The menu for Fall and Winter Cycle, week three, Wednesday, indicated the residents on a pureed diet were to receive:</p> <ul style="list-style-type: none"> - Lemon Baked Fish, #16 ladle was to be used to equal 2 oz of fish or equaled 1/4 cup. - Garlic Roasted Potatoes, #12 ladle was the serving size which equals 1/3 cup. - Mixed Vegetables, #8 ladle was the serving size which equals 1/2 cup. <p>The Cook did not use a ladle for correct serving sizes.</p> <p>2. On 10/23/13 at 12:23 p.m. the cook was observed to plate up the meal for Resident #2. Resident #2 was on a renal diet and had restrictions on what food she could have. The menu indicated the resident was to have:</p> <ul style="list-style-type: none"> - Lemon Baked Fish 3 ounces, - Rice, #8 ladle serving. - Low Salt Carrots, #8 ladle serving. <p>The resident did not receive the rice or carrots. The cook served the resident noodles in place of the rice and mixed vegetables instead of the Low Salt Carrots. The cook was interviewed at 12:23 p.m. and said the resident did not like rice and did not comment on the vegetables. Review of the Nutritional Facts label for the mixed vegetables revealed the package contained green beans, sliced carrots, green zucchini and yellow squash. The sodium content was 20 mg of Sodium and had 5 grams of Carbohydrates.</p> <p>On 10/23/13 at 3:30 p.m. the surveyor talked with</p>	F 363	<p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur; All Dietary staff will be in-serviced by the Dietary Manager by 11/25/2013, regarding F-371 on the importance of using facility food service cups that can be sanitized.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done by:</p> <p>The Dietary Manager or designee will do visual observation to ensure that all facility food service cups used have surface that can be sanitized.</p> <p>Monitoring will start on 12/09/2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Dietary Manager or designee will submit to the Administrator or designee and to the QA&A Committee her findings and/or corrective actions taken during the quarterly QA&A Committee Meeting</p>		

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F 363	Continued From page 33 the dietary manager about the serving sizes and the vegetables used for a renal diet. She provided the Vegetable bag for the Nutritional information and said the cook should have used the proper ladles for serving pureed diets.	F 363	Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		
F 371 SS=E	The Administrator and DON were informed of the dietary issues on 10/24/13 at 2:00 p.m. No further information was provided. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the coffee cups used by residents were able to be sanitized. This had the potential to affect many of the residents in the facility including 9 of 9 (#s 1 - 9) sampled residents. There was a potential for food-borne illness if bacteria remained on the cups because the surfaces were not able to be sanitized. Findings include: On 10/23/13 at 12:00 noon the room cart was observed to have a rack of plastic cups on top. Checking the cups it was found that 14 had deep	F 371	F- 431 SS= \$483.60(b), (d), (e) - Drug Records, Labels/Store Drugs & Biologicals The facility does ensure that open bottle of insulin is dated and expired medication and glucose testing supplies were removed from the medication cart. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Immediately upon identification by the surveyor during the survey process, the opened bottle of insulin that was not dated, the expired medications and glucose testing supplies identified were immediately disposed and replaced. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following: All residents have the potential to be affected by this practice. A License	12/09/13	

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F 371	Continued From page 34 gouges and scratches on the inside. The Dietary manager was contacted and during the discussion about the cups the Dining room cart was checked. An additional 10 cups were found to have uncleanable, uneven surfaces. The dietary manager promptly removed them from service and replaced them with clean glass cups. The Administrator and DON were informed on 10/24/13 at 2:00 p.m. No further information was provided.	F 371	Nurse will check the Medication Carts by 11/25/2013 to ensure that open undated bottles of insulin, expired medication and glucose testing supplies were all disposed from the medication carts. Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431	To ensure that the deficient practice does not recur, all Licensed Nurses will be in-serviced by the Director of Nursing or designee by 11/25/2013 regarding F-431, with reference to the importance of dating bottles of insulin upon opening and the importance of removing expired medication and glucose testing supplies from the medication cart. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through: The Director of Nurses or designee will do a visual sampling of; <ul style="list-style-type: none">• at three (3) open bottled insulin in the medication cart to ensure that they are dated as to when they were opened.• at least two (2) glucose	

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F 431	<p>Continued From page 35</p> <p>controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure an opened bottle of insulin was dated and expired medications and glucose testing supplies were removed from the medication carts. This was true for 2 of 2 medication carts, the 100 hall medication cart and the 200/300 medication cart. This failed practice created the potential for harm if residents received expired insulin and/or medications; if blood glucose machines gave inaccurate readings; and if residents received expired glucagon for hypoglycemic emergencies. Findings include:</p> <p>On 10/22/13 at 7:45 a.m., during an inspection of the 100 hall medication cart the following was observed:</p> <ul style="list-style-type: none"> - High level and the Normal level control solutions, used with the glucometer to test blood sugar levels, had expiration dates of 6/6/13 and were still being used by nursing staff. - Opened Lantus multidose vial without an open date on it, - Loperamide HCl 2 mg caplets expired on 9/2013, - Geri-Dryl (generic benadryl) 25mg tablets expired on 7/2013. 	F 431	<p>testing supplies and at least five (5) other medications, to validate that no expired medications are in the medication carts.</p> <p>Monitoring will start on 12/09/2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Director of Nursing or his/her designee will submit to the Administrator or his/her designee and to the QA&A Committee her findings and/or corrective actions taken during the quarterly QA&A Committee Meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p> <p>F- 441 SS=F §483.65 – Infection Control, Prevent Spread, Linens</p> <p>The facility does ensure that it has an active surveillance program for infection control and that the linens are handled in a manner to prevent cross contamination.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p>	12/09/13

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

FORM NO. 100-100-010
OMB NO. 0938-0391

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F 431	<p>Continued From page 36</p> <p>On 10/23/13 at 8:50 a.m., LN #2 was asked about the expired medications found on the 100 hall medication cart. LN #2 said she noticed the High and Normal solutions were expired today and replaced both of the expired solutions with new ones. She said she did not know the Loperamide or the Geri-Dryl were expired, but would remove them from the medication cart. LN #2 said she was not sure when the Lantus was opened, but the resident had not been there for very long and it was probably opened the day it was received from the pharmacy.</p> <p>On 10/23/13 at 8:30 a.m., during an inspection of the 200/300 hall medication cart the following was observed:</p> <ul style="list-style-type: none"> - Normal level control solution for blood sugar testing expired on 8/2013 and was still being used by nursing staff. - Oyster Shell Calcium 500 mg plus Vitamin D expired on 6/2013. - One Glucagen Hypokit, for a hypoglycemic emergency, expired on 7/2013. - One Glucagen Hypokit, for a hypoglycemic emergency expired on 8/2013. <p>On 10/23/13 at 8:45 a.m., LN #1, was asked about the expired medications found on the 200/300 hall medication cart. LN #1 said she was unaware the Normal level control solution, the Oyster Calcium, and the Glucagen Hypokits (2) were expired. LN #1 said she would remove the expired items from the medication cart.</p> <p>On 10/23/13 at 10:30 a.m., the DNS was notified related to the above findings and she said the expired items should not be on the medication carts. The surveyor asked the DNS who was</p>	F 431	<p>The Laundry Staff identified during the survey who did not use the rubber gloves hanging on the wall when she was loading the washer with dirty laundry and who did not use a protective gown over her clothing when loading the washer with dirty laundry will be provided with 1:1 education on 11/25/2013 by the Administrator or designee about F-441, emphasizing the significance of using the rubber gloves and protective gown hanging on the wall in the laundry labeled as "Personal Protective Equipment," when loading the washer with dirty laundry to prevent cross contamination of clean and dirty laundry.</p> <p>The Director of Nursing will be provided with 1:1 education by the Administrator or designee on 11/25/2013, with reference to F-441 on the importance of following the facility surveillance policy and procedure with regards to collection of data, calculating the nosocomial infection rate for the facility to aid in determining if there was an increase or decrease of infections, importance of analyzing the surveillance to identify trends as the policy outlined, the interpretative guidance at F-441 on</p>	
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F 431	Continued From page 37 auditing the medication carts for expired medications and how often the auditing was being done. The DNS said there was no one assigned to conduct audits on the medication carts and the facility was waiting for the corporate office to send the facility an "audit" form. The DNS said this form would provide for accountability to ensure audits are being done.	F 431	the "standard written definition (criteria) of infections," used to determined if a resident had a facility or community acquired infection, and on the significance of using the forms as provided in the infection control surveillance manual.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following: The Administrator or designee will in-service on 11/25/2013 all Laundry Staff on the subject of F-441 emphasizing the significance of using the rubber gloves and protective gown hanging on the wall in the laundry labeled as "Personal Protective Equipment," when loading the washer with dirty laundry to prevent cross contamination of clean and dirty laundry. The Director of Nursing read and confirmed understanding as evidenced by statement of confirmation signed 11/25/2013, with regards to the Federal Regulations F-441 on the "standard written definition (criteria) of infections," used to determined if a	

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F 441	<p>Continued From page 38 hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the infection control surveillance program, the facility failed to ensure that there was an active surveillance program and the linen was handled in a manner to prevent cross contamination. This had the potential to affect all residents in the facility including 9 of 9 (#s 1 - 9) sampled residents. Failed infection control practices put residents at potential for harm by creating an environment that puts residents at risk for acquiring nosocomial infections. Findings include:</p> <p>1. On 10/24/13 at 9:45 a.m. the laundry was inspected. The laundry aide was interviewed at the same time. The laundry was small and contained a commercial washer and dryer beside each other. Next to the dryer was a table used for folding clean laundry. Across from the washer was a yellow bin for dirty laundry and across from the dryer was a basket cart for clean laundry. Hanging on the wall at the far end of the table was a full length plastic gown, protective goggles and shoulder length rubber gloves.</p> <p>The laundry aide was asked how dirty laundry was processed. She indicated the dirty laundry was put in the yellow basket, then transferred to</p>	F 441	<p>resident had a facility or community acquired infection, the importance of following the facility surveillance policy and procedure with regards to collection of data, calculating the nosocomial infection rate for the facility to aid in determining if there was an increase or decrease of infections, importance of analyzing the surveillance to identify trends as the policy outlined, and on the significance of using the forms as provided in the infection control surveillance manual.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur,</p> <ul style="list-style-type: none"> By 11/27/2013 the Administrator will do a visual observation to make sure that the laundry aides are using the rubber gloves and protective gown hanging on the wall in the laundry labeled as "Personal Protective Equipment," when loading the washer with dirty laundry to prevent cross contamination of clean and dirty laundry. 	
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F 441	<p>Continued From page 39</p> <p>the washer, then transferred to the dryer, and then transferred to the basket cart when dried. When asked about gloves she stated she put gloves on when she was loading the washer with dirty laundry. She pointed to a box of exam gloves on the shelf, not the rubber gloves hanging on the wall. She did not indicate she used any barrier over her clothing when loading the washer. [Note: The facility had 4 residents that had isolation precautions due to antibiotic resistant organisms.] When the isolation laundry came into the laundry room she indicated that she used the same process as with the regular laundry. She did not use a protective gown, potentially resulting in cross contamination of clean and dirty laundry.</p> <p>2. The DON was the infection control nurse. The infection control program was reviewed on 10/23/13 at 1:45 p.m. The surveillance program was reviewed. There was information on infections for the last 10 months to review. The surveillance policy and procedure, dated 2001 and revised March 2009, was reviewed with the DON. The Surveillance that the DON was doing did not correspond with the process the facility policy outlined. Some of the differences were:</p> <p>a. The collection of data the DON used were only lab results and antibiotic orders. The facility policy indicated the use of, "a. Laboratory reports; b. Skin care sheets; c. Infection control rounds or interviews; d. Infection surveillance sheets; e. Temperature logs; f. pharmacy records (e.g., residents on antibiotics); and g. Transfer log/summaries."</p> <p>b. Data collected on each resident. The DON did not use the forms provided in the manual. The</p>	F 441	<ul style="list-style-type: none"> Starting on 12/02/2013, the Director of Nursing or designee will integrate in the DNS Infection Control Surveillance, the data collection forms as provided in the infection control surveillance manual defined to identify evidence of infection, if resident had a facility or community acquired infection, in relevance to the interpretive guidance of F 441. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <ul style="list-style-type: none"> The Director of Nursing or designee will do a visual observation to ensure that the laundry aides are using the rubber gloves and protective gown hanging on the wall in the laundry labeled as "Personal Protective Equipment," when loading the washer with dirty laundry to prevent cross contamination of clean and dirty laundry. 	
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F 441	<p>Continued From page 40</p> <p>information the surveillance policy identified to collect was, "a. Identifying information (i.e., resident's name, age, room number, unit, and Attending Physician); b. Diagnoses; c. Admission date, date of onset of infection (may list onset of symptoms, if known, or date of positive diagnostic test); d. infection site (be as specific as possible, i.e., cutaneous infections should be listed as 'pressure ulcer, left foot,' pneumonia as 'right upper lobe,' etc); e. Pathogens; f. Invasive procedures or risk factors (i.e., surgery, indwelling tubes, Foley, etc., fractured hip, malnutrition, altered mental status, etc.); g. Pertinent remarks (additional relevant information, i.e., temperature, other symptoms of specific infection, white blood cell count, etc.) (Also, record if the resident is admitted to the hospital, or expires.); h. Preventive measures and comments (interventions, steps taken that might have decreased risk, or would do so in the future [i.e., barrier techniques, efforts to prevent immobilization, head elevated during tube feedings, resident non-compliance, etc.]).</p> <p>c. The DON did not calculate, according to the policy, the nosocomial infection rate for the facility to aid in determining if there was an increase or decrease of infections.</p> <p>d. There was no Analysis of the Surveillance Data as the policy outlined. The policy documented, "Analyze the data to identify trends. Compare the rates to previous months, and the same month in previous years, to identify seasonal trends. Consider how increases or decreases might relate to recent process changes, events, or activities in the facility (i.e., change in handwashing preparations, increased turnover in personnel or residents, etc.)</p>	F 441	<ul style="list-style-type: none"> The Director of Nursing or designee will complete her monthly infection control surveillance report using the forms provided in the infection control surveillance manual. Data collected will be presented during the monthly Infection Control Meeting to ensure compliance is met. <p>Monitoring will start 12/09/2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Director of Nursing or designee will submit to the Administrator or designee and to the QA&A Committee her findings and/or corrective actions taken during the quarterly QA&A Committee Meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p> <p>F- 514 SS=D §483.75(L) (1) – Res. Records- Complete/Accurate/Accessible</p> <p>The facility does ensure that the physicians' recapitulation diet order matched the original order.</p>	12/09/13
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F 441	Continued From page 41 In addition, the interpretive guidance at F 441 documented, "outcome surveillance is designed to identify and report evidence of an infection. The outcome surveillance process consists of collecting/documenting data on individual cases and comparing the collected data to standard written definitions (criteria) of infections." The DON failed to provide any type of "standard written definitions (criteria) of infections" used to determine if a resident had a facility or community acquired infection. The Administrator and DON were informed of the infection control issues on 10/23/13 at 6:30 p.m. No further information was provided.	F 441	Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Upon identification during the survey process, Resident #8 recapitulation diet order had been updated to match the original order.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that physician	F 514	Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following: This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, to address other residents who may have the potential to be affected by this deficiency, on 12/04/2013, the physicians' recapitulation diet order will be reviewed by the Health Information Director or designee to matched the original order. Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure that the deficient practice does not recur, by 11/25/2013 the Health Information Director will be	

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F 514	<p>Continued From page 42</p> <p>recapitulation orders matched the original order. This was true for 1 of 9 (# 8) sampled residents. There was a potential for harm because had the recapitulation order been implemented it could have put the resident at severe nutritional risk. Findings include:</p> <p>Resident #8 was admitted to the facility 11/5/10 with diagnoses of morbid obesity, general symptoms of malaise and fatigue, muscle weakness and cellulitis and abscess of leg.</p> <p>The annual MDS, dated 10/17/12, documented the resident:</p> <ul style="list-style-type: none"> - was cognitively intact with a BIMS of 15, - required minimal assistance with eating, - received a therapeutic diet. <p>The physician's recapitulation orders to start 9/1/13 documented the resident was ordered on 2/5/13 to have a "1000 calorie diet no concentrated sweets with regular texture." During interview with the DON, on 10/23/13 at 4:00 p.m. it was found the resident was to have been changed on 2/5/13 to an 1800 calorie diet. Upon further investigation it was found the resident had been receiving the 1800 calorie diet.</p> <p>The Administrator and DON were informed on 10/24/13 at 2:00 p.m. about the discrepancies in order transcriptions. No further information was provided.</p>	F 514	<p>in-service by the Director of Nursing or designee, with regards F-514 on the importance of ensuring that the physicians' recapitulation diet order matched the original order.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Director of Nurses or designee will review at least five (5) Residents physician recapitulation diet orders to validate that recapitulation matched the original diet order.</p> <p>Monitoring will start 12/09/2013. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Director of Nursing or designee will submit to the Administrator or his/her designee and to the QA&A Committee her findings and/or corrective actions taken during the quarterly QA&A Committee Meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>	
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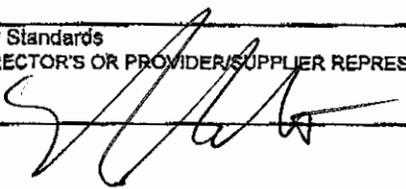
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001635	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/24/2013
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NAME OF PROVIDER OR SUPPLIER QUINN MEADOWS REHABILITATION & CARE (STREET ADDRESS, CITY, STATE, ZIP CODE 1033 WEST QUINN ROAD POCATELLO, ID 83202
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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 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiency was cited during state licensure and complaint investigation of your facility. The survey team entered the facility on October 21, 2013 and exited on October 24, 2013. The surveyors conducting the survey were: Arnold Rosling , RN, BSN, QMRP Amy Jensen, RN, BSN	C 000		
C 299	02.107,05,c Menus Prepared At Least One Week Prior c. Menus shall be prepared at least a week in advance. Menus shall be corrected to conform with food actually served. (Items not served shall be deleted and food actually served shall be written in.) The corrected copy of the menu and diet plan shall be dated and kept on file for thirty (30) days. This Rule is not met as evidenced by: Refer to F 363 as it related to menus.	C 299	Reference "Plan of Correction," CMS 2567 form – F-363 As it relates to Menus	12/09/13
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare	C 325	Reference "Plan of Correction," CMS 2567 form – F-371 As it relates to Kitchen Sanitation	12/09/13

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



TITLE
Administrator

(X6) DATE
11/15/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001635	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/24/2013
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C 325	Continued From page 1 Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F 371 as it relates to kitchen sanitation.	C 325		
C 669	02.150.03 PATIENT/RESIDENT PROTECTION 03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Refer to F 441 as it relates to infection control surveillance.	C 669	Reference "Plan of Correction," CMS 2567 form – F-441 As it relates Infection Control Surveillance	12/09/13
C 671	02.150.03,b Handling Dressings, Linens, Food b. Proper handling of dressings, linens and food, etc., by staff. This Rule is not met as evidenced by: Please refer to F441 as it relates to the proper handling of linen.	C 671	Reference "Plan of Correction," CMS 2567 form – F-441 As it relates to Proper Handling Of Linen	12/09/13
C 736	02.154.02,e Physician Plan of Care e. A physician's plan of care shall be provided to the facility upon admission of the patient/resident which reflects medication orders, treatments, diet orders, activity level approved, and any other directives to the facility for the care of the patient/resident. This Rule is not met as evidenced by: Refer to F 271 for information on physician admission orders.	C 736	Reference "Plan of Correction," CMS 2567 form – F-271 For Information on Physician Admission Orders	12/09/13

Bureau of Facility Standards

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C 781	02.200,03,a,iii Written Plan, Goals, and Actions iii. Written to include care to be given, goals to be accomplished, actions necessary to attain the goals and which service is responsible for each element of care; This Rule is not met as evidenced by: Please refer to F272 as it relates to initial care plans.	C 781	<i>Reference "Plan of Correction," CMS 2567 form – F-272 As it relates to Initial Care Plans</i>	12/09/13
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F 280 as it relates to periodically reviewing and revising care plans.	C 782	<i>Reference "Plan of Correction," CMS 2567 form – F-280 As it relates to Periodically Reviewing and Revising Care Plans</i>	12/09/13
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please refer to F314 as it relates to pressure sores.	C 789	<i>Reference "Plan of Correction," CMS 2567 form – F-314 As it relates to Pressure Sores</i>	12/09/13
C 795	02.200,03,b,xi Bowel/Bladder Evacuation/Retraining xi. Bowel and bladder evacuation and bowel and bladder retraining	C 795	<i>Reference "Plan of Correction," CMS 2567 form – F-315 As it relates to Bladder Retraining</i>	12/09/13

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C 795	Continued From page 3 programs as indicated; This Rule is not met as evidenced by: Refer to F315 as it relates to bladder retraining.	C 795		
C 821	02.201,01,b Removal of Expired Meds b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days. This Rule is not met as evidenced by: Please refer to F431 as it relates to expired medication.	C 821	<i>Reference "Plan of Correction," CMS 2567 form – F-431 As it relates to Expired Medication</i>	12/09/13
C 886	02.203,02,e Physician Orders e. Physician's order record containing the physician's authorization for required medications, tests, treatments, and diet. Each entry shall be dated and signed, or countersigned, by the physician. This Rule is not met as evidenced by: Refer to F 514 as it relates to medical records and physician orders.	C 886	<i>Reference "Plan of Correction," CMS 2567 form – F-514 As it relates to Medical Records And Physician Orders</i>	12/09/13



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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December 9, 2013

Michael E. Borup, Administrator
Quinn Meadows Rehabilitation & Care Center
1033 West Quinn Road
Pocatello, ID 83202-2425

Provider #: 135136

Dear Mr. Borup:

On **October 24, 2013**, a Complaint Investigation survey was conducted at Quinn Meadows Rehabilitation & Care Center. Amy Barkley, R.N. and Arnold Rosling, R.N., Q.M.R.P. conducted the complaint investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005955

ALLEGATION #1:

The complainant alleged that two female staff was rough when transferring a named resident causing an open area to his/her hip that bled for days.

FINDINGS:

This complaint investigation was completed in conjunction with the facility's annual Recertification and State Licensure survey. During the investigation, the following was reviewed:

- Medical records for seven residents including the identified resident were reviewed. There were no documented incidents of residents stating staff was rough while providing cares.

Michael E. Borup, Administrator
December 9, 2013
Page 2 of 2

- Grievance files and Investigation and Accident reports reviewed for the previous six months did not identify any concerns with rough handling of residents during transfers. The Investigation Summary for the identified resident documented the Administrator, Director of Nursing and the resident's physician interviewed the resident. During the interviews the resident was asked, "If she felt safe at the facility" and the resident stated, "Yes," she felt safe.
- During observations throughout the survey, CNA's were not observed to be rough towards the residents during transfers.
- A group interview was held with four residents in attendance. The residents did not express any concerns related to rough handling by CNA's during transfers.
- A family member of an interviewed resident and another resident's family member were interviewed. Neither expressed any concerns related to rough handling by CNA's.
- Two individual residents interviewed did not express any concerns related to rough handling by CNAs.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,



LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj