



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7012 1010 0002 0836 2069

November 8, 2013

Gregory A. Bolen, Interim Administrator
Life Care Center of Lewiston
325 Warner Drive
Lewiston, ID 83501-4437

Provider #: 135128

Dear Mr. Bolen:

On **October 25, 2013**, a Recertification and State Licensure survey was conducted at Life Care Center of Lewiston 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) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

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Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 21, 2013**. Failure to submit an acceptable PoC by **November 21, 2013**, may result in the imposition of civil monetary penalties by **December 11, 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.

- 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.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **November 29, 2013 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **November 29, 2013**. A change in the seriousness of the deficiencies on **November 29, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 29, 2013** includes the following:

Denial of payment for new admissions effective **January 25, 2014**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 25, 2014**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **October 25, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State

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Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

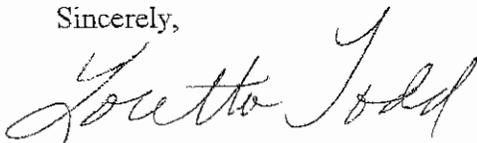
2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **November 21, 2013**. If your request for informal dispute resolution is received after **November 21, 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,



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

LT/dmj
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135128	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 10/25/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 278	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the MDS Coordinator verified resident assessments were completed after the different disciplines completed Section Z0400 of the MDS. This was true for 2 of 11 (#s 3 and 8) sampled residents for verifying overall MDS Assessment completion. Findings included:</p> <ol style="list-style-type: none"> 1. Resident #3 was admitted to the facility on 3/25/13 with multiple diagnoses including aftercare following surgery for injury and trauma, muscle weakness, abnormality of gait, and hypertension. <p>Record review of Resident #3's most recent Admission MDS, dated 4/1/13, documented in Section Z0500 B, the RN Assessment Coordinator signed the assessment was completed on 4/2/13. However, multiple sections at Z0400 were completed on 4/3/13, 4/6/13 and 4/9/13.</p> <ol style="list-style-type: none"> 2. Resident #8 was admitted to the facility on 7/8/13 with multiple diagnoses including aftercare for healing of a traumatic fracture of the right upper leg, muscle weakness, dysphagia, pain and anemia. <p>Record review of Resident #8's most recent Significant Change MDS, dated 9/22/13, documented in Section Z0500 B, the RN Assessment Coordinator signed the assessment was completed on 9/27/13. However, an assessment in Z0400 was completed on 10/3/13.</p> <p>NOTE: The RN Assessment Coordinator verified the MDS was completed prior to the different disciplines</p>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 278	<p>Continued From Page 1 completing Section Z0400 for Residents #3 and #8.</p> <p>Federal Guidance at F-278 documents "the RN Assessment Coordinator is responsible for certifying overall completion once all individual assessors have completed and signed their portion(s) of the MDS."</p> <p>On 10/24/13 at 3:55 PM, LN #11 was interviewed regarding the MDS assessment completion dates in Section Z0500 B for Residents #3 and #8. She indicated agreement Section Z0500 B was signed as completed before some of the sections in Z0400. She stated the computer should not allow you to close a section if it hasn't been filled out. She admitted a logic error came up indicating a certain section had not been finalized. LN #11 stated she thought the computer had a glitch.</p> <p>On 10/28/13, the facility faxed to the Bureau of Facility Standards a letter from the facility's Resource Utilization Specialist which documented their awareness of the MDS computer software issue and would be working to correct this system error as fast as possible.</p>		

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID 83501
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual Federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Karen Marshall, MS, RD, LD Team Coordinator Bradley Perry, LSW, BSW Lauren Hoard, RN, BSN Rebecca Thomas, RN</p> <p>The survey team entered the facility on Monday, 10/21/13, and exited the facility on Friday, 10/25/13.</p> <p>Survey Definitions:</p> <p>ADL = Activities of Daily Living CAA = Care Area Assessment CNA = Certified Nurse Aide DM = Dietary Manager DON/DNS = Director of Nursing/Director of Nursing Services FSI = Fall Scene Investigation FYI = For Your Information LN = Licensed Nurse MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set assessment MG = Milligrams ML = Milliliters PRN = As Needed RD = Registered Dietitian RN = Registered Nurse UTI = Urinary Tract Infection</p>	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE	F 176		

RECEIVED
NOV 21 2013
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Tullang Na</i>	TITLE Executive Director	(X6) DATE 11/20/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 176	<p>Continued From page 1</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure residents were determined to be safe to self-administer medications. This affected 1 of 8 residents (#2) during the medication pass observation when Resident #2 was left unattended during a nebulizer breathing treatment. This failed practice created the potential for the resident to receive less than the prescribed amount of the nebulizer medication. Findings included:</p> <p>Resident #2's October 2013 recapitulation of Physician Orders included an order for DuoNeb (a combination of Albuterol and Ipratropium), Inhale 3 ml by nebulizer every 6 hours.</p> <p>On 10/23/13 at 11:20 a.m., LN #1 was observed as she set up Resident #2's DuoNeb breathing treatment, placed a face mask on the resident, turned on the nebulizer machine, told the resident she would be back in a few minutes to check on it, then left the room. LN #1 was asked if Resident #2 had been assessed as safe to self-administer the nebulizer breathing treatment at which she replied, "Yes, he has."</p> <p>On 10/23/13 at 3:15 p.m., LN #4 was asked if Resident #2 had been assessed as safe to self-administer the DuoNeb breathing treatment.</p>	F 176	<p>Corrective Action for Specific Residents Resident #2 was assessed to be safe to self-administer the duo nebulizer treatment and the facility received an MD order to self-administer the nebulizer treatment on 10/23/13. ✓</p> <p>Other Residents Affected Other resident who receive duoneb treatments have the potential to be affected by this practice. Audit of current residents with duoneb orders have been completed to ensure that licensed staff is administering the duoneb treatments or that the residents have a self-administration of medications assessment completed and have been assessed to be safe with self-administration. ✓</p> <p>What measures will be put into place/systemic changes to prevent recurrence.</p> <p>Licensed staff and Unit Managers have been in-serviced that duonebs cannot be applied to a resident and then left unattended during treatment unless a self-administration of medications assessment has been completed and the resident is deemed safe to self-administer the nebulizer breathing treatments.</p>	

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F 176	Continued From page 2 The LN replied, "We got one today." LN #4 was asked if the safety assessment had been completed prior to the surveyor's observation of the medication pass earlier that day and she responded, "No." LN #4 proceeded to provide the surveyor with a Medication Self-Administration Review sheet, dated 10/23/13, that documented Resident #2 had been determined to be safe to self-administer the DuoNeb breathing treatment and a physician's order, dated 10/23/13, that documented, "May self administer inhalant medication after nurse set[up]. Is able to administer [without] problems." On 10/23/13 at 6:15 p.m., the Administrator and DON were informed of the medication pass observation. However, no further information or documentation was provided that resolved the issue.	F 176	Monitoring to ensure deficiency does not recur Nurse Managers will do medication pass audits 1x/week for 3 months to ensure that duoneb treatments are being administered correctly. DON will bring results of audits to QA/PI meeting monthly times 3 months. Ongoing audits/education to be scheduled based on trends. Audits to begin 11/15/13. Date of Compliance 11/29/13	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of the facility's abuse policies and procedures, staff personnel files, and staff interviews, it was determined the facility failed to operationalize its abuse policies and procedures when the facility failed to verify abuse history with the State Nurse Aide Registry for 3 of 5 aides hired. This practice created the potential to place	F 226	Corrective Action for Specific Residents No specific residents were identified. Other Residents Affected All residents have the potential to be affected by this practice. The facility is committed to ensuring that residents are provided care by individuals that are certified or licensed with an acceptable level of competence and no history of patient abuse. <u>Current CNA and Licensed Nurses Verifications have been audited and printed out.</u>	

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F 226	<p>Continued From page 3</p> <p>residents at risk for and subject to abuse, neglect, or misappropriation of property. Findings included:</p> <p>The facility abuse policy and procedures under the section entitled Registry of Nursing Assistants/Abuse Registry dated 3/25/10, documented the following: "To ensure a safe environment, the facility is responsible for ensuring that individuals who claim to be CNAs indeed have their certifications and have no history of patient abuse. It is ideal that the check be made before the employment offer is presented to the applicant, but an offer can be made contingent on the results...Therefore, this information is ideally gathered from the State Registry before the employment offer is made; however, an offer can be made contingent upon results."</p> <p>On 10/23/13 at about 2:15 PM, three nurse aide employee personnel files were reviewed for the State Nurse Aide Registry Verification Report. Staff A who was hired on 8/1/13 did not have a copy of the State Nurse Aide Registry Verification Report in her personal file.</p> <p>On 10/23/13 at 2:30 PM the Payroll Manager was interviewed regarding where the registry verification report was located in the personal file and she stated she was not sure they even checked the registry, but would find out.</p> <p>On 10/23/13 at 3:50 PM the Payroll Manager gave the surveyor a copy of Staff A's State Nurse Aide Registry Verification Report. Upon review it was determined the verification was dated 10/23/13, indicating the registry was checked that day. The surveyor then asked for two more</p>	F 226	<p>What measures will be put into place/systemic changes to prevent recurrence.</p> <p>The payroll manager, director of nursing, executive director, staff development coordinator and staffing coordinator have been in-serviced on the abuse policy and procedure and the need for documentation of the verification for nurse and cna registry. The Nurse Aide Registry Verification Report and the Idaho Board of Nursing Registry is run and printed for the employee file by the staffing coordinator. The report will be placed in the applicant's personal file.</p> <p>Monitoring to ensure deficiency does not recur</p> <p>The Executive Director or Business office Manager will audit all new hire C.N.A's and Licensed Nurses personal files weekly for 3 months to ensure that the Nurse Aide Registry Verification Report or Idaho State Board of nursing Registry has been printed and is present.</p>	

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F 226	<p>Continued From page 4</p> <p>verification reports for Staff B and C, hired on 8/21/13 and 8/1/13 respectively.</p> <p>On 10/23/13 at 4:50 PM the Payroll Manger and the Staffing Coordinator brought the surveyor Staff B and C's State Nurse Aide Registry Verification Reports both dated 10/23/13, indicating the registry was checked that day. The Payroll Manager stated in the six years of doing her job she had, "never been asked for the registry (verification report)." The Staffing Coordinator stated, "I always check the registry to see if they have findings for abuse or neglect," but have never printed the results.</p> <p>Note: Verification Reports dated 10/23/13 for Staff A-C did not document any abuse findings.</p> <p>On 10/23/13 at 5:45 PM the Payroll Manager and the Regional Vice-President brought the surveyor a copy of Staff A's background check provided by a third party company, which contracted with the facility and contained a section entitled Services Ordered and documented under the heading Service Name and Location, "Abuse or Other Health Care Provider Registry ID." When asked how the facility would know if the third party company actually checked with the State Nurse Aide Registry, the Regional Vice-President said he assumed they did. The background check also documented, "[Third Party Background Check Company Name] does not guarantee the accuracy or truthfulness of the information as to the subject of the investigation, but only that it is accurately copied from public records."</p> <p>Guidelines at F226 specified: "I. Screening (483.13(c)(1)(ii)(A)&(B): Have procedures to screen potential employees for a history of abuse, neglect or mistreating residents</p>	F 226	<p>Executive Director will bring the results of audits to QA/PI for review. Ongoing audits or education will be based on trends identified. Audits to begin <u>11/15/13</u>.</p> <p>Date of Compliance 11/29/13</p>

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F 226	Continued From page 5 as defined by the applicable requirements at 483.13(c)(1)(ii)(A) and (B). This includes attempting to obtain information from previous employers and/or current employers, and checking with the appropriate licensing boards and registries." On 10/24/13 at 5:30 PM, the Administrator, DON, the Regional Vice-President, and the Regional Director of Clinical Services were informed of the issue. No further information was provided.	F 226			
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to maintain residents' dignity by referring to those residents who required assistance with dining as feeders. This affected 1 of 11 (#8) sampled residents and 12 of 12 (#s 21-32) random residents who required assistance with dining in the Grand dining room. This practice created the potential to negatively affect the residents' self-worth and self-esteem. Findings included: On 10/21/13 at 5:32 p.m. during an observation of the dinner meal, the surveyor asked LN #5 about the trays located on a cart near resident tables in the Grand dining room. The LN stated, "These trays come out on a cart for the feeders, those	F 241	Corrective Action for Specific Residents Residents #8, 21-32 are receiving ✓ dining services provided with dignity. Other Residents Affected Other residents who require assistance ✓ in the grand dining room could be affected and are receiving dignified dining service. What measures will be put into place/systemic changes to prevent recurrence. Nursing staff have been in-serviced on ✓ dignity, specifically not using titles or names that could potentially negatively affect the residents' self-worth or self-esteem.		

TG 11/20/13

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON		STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID 83501		
(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 241	<p>Continued From page 6 who require assistance with dining."</p> <p>On 10/23/13 at 6:12 p.m., the surveyor informed the Administrator and the DON of LN #5 referring to residents who required assistance with dining in the Grand dining room as "feeders." The Administrator and the DON, both, said the use of the word feeders was, "a dignity concern."</p> <p>On 10/24/13 at 4:28 p.m., the Administrator provided the surveyor with a list of residents who required assistance dining in the Grand dining room.</p> <p>On 10/25/13 at 9:30 a.m., the Administrator and the DON were informed of the finding. The facility did not provide any additional information related to the observation.</p>	F 241	<p>Monitoring to ensure deficiency does not recur</p> <p>The grand dining room will be monitored by Department managers or <u>Nursing Managers 3x/week for 4 weeks then 2x/week for 2 months</u> to ensure residents are receiving dining services with dignity and without using names/titles that could potentially negatively affect the residents. Director of Nurses will bring these audits to QA/PI monthly times 3 months. Additional education and audits will be based on trends. Audits begin 11/15/13</p>	
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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</p>	F 280	<p>Date of Compliance 11/29/13</p> <hr/> <p>Corrective Action for Specific Residents</p> <p>Resident #4 adaptive equipment for meals was discontinued due to resident choice and careplan has been updated. Resident #4's care plan & orders have had the monitoring of antidepressant discontinued. ✓</p>	

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F 280	<p>Continued From page 7 each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure care plans were revised for 1 of 15 sampled residents (#4). The care plan did not reflect revisions for the use of adaptive equipment at meal times and the monitoring of effectiveness/side effects of an antidepressant the resident was no longer receiving. This had the potential to result in harm if the resident did not receive appropriate care due to lack of direction in the care plan. Findings included:</p> <p>Resident #4 was admitted to the facility on 1/26/10 and readmitted on 3/16/12 with multiple diagnoses which included osteoarthritis, dementia, depressive disorder, and Parkinson's disease.</p> <p>Resident #4's most recent quarterly MDS assessment, dated 9/11/13, documented in part: * Cognitively intact with a BIMS score of 15; * Extensive assist with one person for bed mobility, transfers, dressing, toilet use, and personal hygiene; * Supervision with setup help only for eating; * Functional limitation in range of motion with impairment on both sides of the upper extremities and impairment on one side of the lower extremities; * Mood Total Severity Score of 0 and absence of behaviors; and,</p>	F 280	<p>Other Residents Affected</p> <p>Other residents who have adaptive equipment for meals and who receive antidepressants could be affected by this practice. Residents with adaptive equipment have been audited to ensure care plan has been updated. Audits of residents on antidepressants have had MARS, behavior monitors and careplans audited to ensure they match. ✓</p> <p>What measures will be put into place/systemic changes to prevent recurrence. The interdisciplinary team including nursing, dietary, therapy, social services, activities and licensed nurses ✓ have been in-serviced to the importance of keeping care plans up to date and to reflect the residents' current status for antidepressants and adaptive equipment for meals.</p>	

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F 280 Continued From page 8

- * No antipsychotic, antianxiety, hypnotic, or antidepressant medication received during the last 7 days.

a. Resident #4's ADL/Self Care Deficit Care Plan, dated 10/7/11, documented in part:

- * Resident has special adaptive equipment for meals and eats with her left hand secondary to tremors to her right hand.

On 10/23/13 at 12:15 p.m., Resident #4 was observed during the lunch meal using regular eating utensils with her left hand. No adaptive equipment or utensils had been provided.

On 10/23/13 at 2:20 p.m., Resident #4 was interviewed. When asked about the adaptive equipment to be used at meals the resident stated, "It [adaptive equipment] didn't seem to work any better. I have to use my left hand." Resident #4 said that if she has trouble eating staff will help her.

On 10/23/13 at 3:00 p.m., LN #4 was asked if Resident #4 used adaptive equipment at meal times at which she replied, "No, she refused to. She doesn't like to be singled out," and acknowledged the care plan needed to be revised.

b. Resident #4's October 2013 recapitulated Physician's Orders documented in part:

- * 3/16/12 - Monitor every shift for side effects of antidepressant[ant].

Resident #4's Mood Care Plan, dated 9/28/12, documented in part:

- * Problems - Resident has diagnosis of dementia and depression with the potential for alteration in

F 280 **Monitoring to ensure deficiency does not recur**

Residents with discontinued antidepressants will have behavior monitors, careplans, and MARS audited to ensure discontinuation of monitoring occurs on all forms. Audits will occur weekly times 3 months at behavior management meeting by Social Services or Unit Manager. ✓

Adaptive equipment at meals will be audited one time per week for 3 months to ensure equipment in use matches careplan. ✓ Audits will be done by the Nurse Managers or Dining room manager.

The DNS will bring the audit findings to QA/PI monthly times 3 months.. Additional education/reviews will be based on trends. Audits for both antidepressants and adaptive equipment for meals to begin 11/20/13.

Date of Compliance 11/29/13

TG 11/20/13

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F 280	Continued From page 9 mood state; * Approaches - Observe effectiveness/side effects of medications as ordered. On 10/23/13 at 9:40 a.m., LN #4 was asked which medication for mood was being monitored for effectiveness and side effects as indicated on Resident #4's care plan. The LN stated, "She doesn't have any. We're not observing for psychotropic medication," and added, "[We] keep [it] in place in case we need it." When asked if it was necessary to have the monitoring of effectiveness and side effects on the care plan since Resident #4 was not taking an antidepressant, LN #4 stated, "Probably not." On 10/24/13 at 5:32 p.m., the Administrator and DON were informed of the care plan issue. However, no further information or documentation was provided that resolved the issue.	F 280	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, it was determined the facility failed to ensure professional standards of quality were maintained. This was true for 1 of 8 residents (#33) during the medication pass observation when an LN discarded a medication in the trash receptacle connected to the medication cart, and when a medication was initialed prior to administration. Failure to adhere	F 281	Corrective Action for Specific Residents Resident #19 will have medication signed for after administration. ✓ Resident #33 will have medication wasted per facility policy. ✓ Other Residents Affected All residents who take medications have the potential to be affected. ✓ Residents will have their medications administered and wasted per professional standards and facility policy.

TG 11/20/13

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F 281 Continued From page 10
to professional standards created the potential for harm should a resident retrieve the discarded medication out of the trash, and unrelieved pain if the Gabapentin for Resident #19 had not been administered. Findings included:

a. On 10/23/13 at 11:03 a.m., LN #1 was observed as she took a Tab-A-Vite tablet in a medicine cup into Resident #33's room to administer it to the resident. The resident requested to have the medication with her lunch meal. The LN left the room and placed the Tab-A-Vite tablet and medication cup into the trash receptacle attached to the side of the medication cart. LN #1 was asked if she had just thrown away the tablet in the trash receptacle at which she replied, "I did, yes."

On 10/24/13 at 9:36 a.m., the DON provided the surveyor with a Disposal/Destruction of Expired or Discontinued Medication policy, most recent revision date 7/27/11, that documented in part:
* Wasted single doses of medications for disposal may be placed in the trash, or Sharp's container, if permitted by Facility policy and Applicable law. Note: The policy states medications may be placed in the trash, if permitted by facility policy. Therefore, the DON was asked to provide the facility's policy for medication wasting or disposal.

On the afternoon of 10/24/13 the DON provided a Medication Destruction policy, date not included, that documented in part:
* Ointments, creams, and similar substances are placed in trash receptacles in the medication room. Tablets, capsules, and liquids are washed down the toilet/sink or disposed of in another acceptable manner. The provider pharmacy is contacted if the facility is unsure of proper

F 281

What measures will be put into place/systemic changes to prevent recurrence.
Nursing staff in-serviced on standard of practice for medication administration in particular to not initial MAR prior to giving medication and to use the dot system. Also in-serviced on facility policy and procedure of disposal of medication. ✓

Monitoring to ensure deficiency does not recur
SDC, Nurse Managers will do medication pass audits to ensure documentation is occurring after medication is given and medication is disposed of correctly. These audits will be done 1x/week x3 months. The Director of Nurses will bring the audits to QA/PI monthly times 3 months. Additional education/audits will be based on trends. Audits to begin 11/15/13.

Date of Compliance
11/29/13
DON/DNS 11.27.13 3:30 PM

TG 11/20/13

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F 281	<p>Continued From page 11 disposal methods for a medication provider.</p> <p>b. Resident #19's October 2013 recapitulated Physician's Orders documented in part: * Gabapentin 600 mg tablet: Give 2 tablets (1200 mg) orally 3 times a day.</p> <p>On 10/23/13 at 11:00 a.m., LN #1 was observed as she prepared medication for Resident #19 which included Gabapentin. It was observed on the MAR (Medication Administration Record) that the LN had initialed the medication as administered prior to actually administering the medication to Resident #19. The LN was asked when she had initialed the medication as administered at which she said she marked a dot when she pulled out the medication and then, "Initialed when I put it in the cup."</p> <p>Note: Informational Letter #97-3, dated April 16, 1997: The Medication Distribution Technique Clarification To Informational Letter, 96-14, from the Bureau of Facility Standards, stated, "The issue arose when the Board of Nursing received information that long term care facility staff were signing medications as given at the time of the medication preparation, not after the resident actually received the medication. ...the Board's expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do."</p> <p>On 10/23/13 at 6:15 p.m., the Administrator and DON were informed of the medication pass observations. However, no further information or documentation was provided that resolved the issue.</p>	F 281		

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F 309 F 309 SS=D	Continued From page 12 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure physician's orders were followed for 1 of 6 (#4) sampled residents reviewed for moderate to severe pain, when an order for pain medication for Resident #4 was not followed. This failed practice created the potential for residents to not receive appropriate treatment for their specific conditions and for unrelieved pain should the resident not receive ordered pain medication. Findings included: Resident #4 was admitted to the facility on 1/26/10 and readmitted on 3/16/12 with multiple diagnoses which included osteoarthritis, dementia, depressive disorder, and Parkinson's disease. Resident #4's most recent quarterly MDS assessment, dated 9/11/13, documented in part: * Cognitively intact with a BIMS score of 15; * Extensive assist with one person for bed mobility, transfers, dressing, toilet use, and personal hygiene; * Functional limitation in range of motion with	F 309 F 309	Corrective Action for Specific Residents Resident #4 has had a pain assessment completed and MD orders are followed. Tylenol 500mg prn and Advil prn were discontinued. Other Residents Affected Other residents with pain medication ordered have the potential to be affected by this practice and Licensed Nurses are following MD orders for pain medication. What measures will be put into place/systemic changes to prevent recurrence. Licensed Nurses inserviced on following and processing physician orders correctly for pain medications. New orders reviewed by IDT at standup daily for proper processing of orders.		

TG 11/20/13

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F 309	<p>Continued From page 13</p> <p>impairment on both sides of the upper extremities and impairment on one side of the lower extremities;</p> <p>* Resident received or was offered as needed pain medication in the last 5 days; and,</p> <p>* Frequently experienced moderate pain.</p> <p>A Medical Conditions Care Plan for Resident #4, dated 10/7/11, documented in part:</p> <p>* Problems - Several medical conditions of osteoporosis, Alzheimer's, Parkinson's, and pain;</p> <p>* Approaches - Administer medications as ordered. Evaluate effectiveness of interventions in place to relieve pain. Notify MD if further orders are indicated.</p> <p>A Fax Order Request/Notification Form, dated 9/25/13, for Resident #4 documented in part:</p> <p>* Clinical Observation/Request Action: Ear pain apparently 2 hours to TMJ (Temporomandibular Joint) discomfort. Recommend symptomatic treatment with analgesics;</p> <p>Note: TMJ is a condition that causes pain and dysfunction in the jaw joint and muscles that control jaw movement.</p> <p>* Telephone Orders - Tylenol 500 [mg] or Advil 400 [mg] PO (by mouth) every 4 hours PRN (as needed) pain.</p> <p>Note: The order was noted by a Registered Nurse and dated 9/25/13.</p> <p>On 10/23/13 at 9:40 a.m., LN #4 was asked about the aforementioned order.</p> <p>Note: The order for Tylenol 500 mg or Advil 400 mg was not on the October 2013 recapitulated physician orders or MAR (Medication Administration Record) for Resident #4. Additionally, there were no orders to discontinue the medications.</p>	F 309	<p>Monitoring to ensure deficiency does not recur</p> <p>Nurse Managers are auditing new pain medication orders for proper processing <u>2 times per week times 1 month and then 1 times per week times 2 months.</u></p> <p>Director of Nurses will bring results of audits to QA/PI monthly times 3 months. Additional education/reviews will be based on trends.</p> <p>Audits will start on <u>11/15/13.</u></p> <p>Date of Compliance 11/29/13</p>	
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TG 11/28/13

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F 309	Continued From page 14 LN #4 stated, "I don't have an answer for you," and proceeded to say the doctor had come in and told the LN that Resident #4 had too many Tylenol orders. The LN said she would look in the records. On 10/23/13 at 1:53 p.m., LN #4 told the surveyor that a physician had come in and reviewed the Tylenol orders for Resident #4 and wrote new orders on a telephone order fax sheet, dated 10/23/13 with a time of 11:30 a.m., that documented in part: * Clarification of Tylenol order: DC (discontinue) all previous Tylenol orders prior to 9/18/13. DC Tylenol 500 mg orally, DC Advil, Continue Tylenol 325 mg tab[let] [every] 8 [hours]. Note: The facility did not follow physician orders, nor did the facility address Resident #4's pain to the greatest extent possible and did not provide a clinically pertinent rationale why this was not done. On 10/23/13 at 2:20 p.m., the surveyor asked Resident #4 if she experienced pain. The resident stated, "Yes," and said she had headaches quite often. The resident added, "Staff provide pain relief medications and they are effective." On 10/24/13 at 5:32 p.m., the Administrator and DON were informed of the physician order issue. However, no further information or documentation was provided that resolved the issue.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314	Corrective Action for Specific Residents Resident #7 pressure ulcer is healed ✓ and staff are following plan of care.	

TG 11/20/13

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F 314	<p>Continued From page 15</p> <p>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, record review and staff interview, it was determined the facility failed to provide the necessary nursing care to promote healing of a Stage 2 Pressure Ulcer. This was true for 1 of 3 (#7) sampled residents reviewed for pressure ulcers. This created the potential for skin breakdown when the facility failed to implement care plan directions for positioning to provide pressure relief. Findings included:</p> <p>Resident #7 was originally admitted to the facility on 2/28/13, and readmitted on 9/23/13, with multiple diagnoses including Pneumonia, Sepsis, and Dementia.</p> <p>Record review of Resident #7's previous admission, documented a Weekly Skin Integrity Data Collection sheet, dated 9/11/13, which indicated the resident's skin was intact.</p> <p>Resident #7's Significant Change MDS assessment, dated 9/30/13, documented in part: *Cognition was severely impaired with a BIMS score of 3. *Extensive assistance needed of 1 person for bed mobility, transfers, location off the unit, toileting, hygiene and bathing.</p>	F 314	<p>Other Residents Affected</p> <p>Other residents that have a healing pressure ulcer or specific orders to lay side to side only have the potential to be effected. Staff are following the careplan for positioning for these residents.</p> <p>What measures will be put into place/systemic changes to prevent recurrence. Nursing staff in-serviced on the importance of following the care plan and or MD orders in regards to positioning and pressure relief for residents with healing pressure ulcers.</p> <p>Monitoring to ensure deficiency does not reeur Nurse Managers or Wound nurse to audit residents with healing pressure ulcers 2x per week times one month then 1 x per week times 2 months for repositioning per plan of care.</p> <p>DNS to take audit findings to QA/PI monthly times three months. Additional education/audits will be based off of findings. Audits to begin 11/15/13.</p> <p>Date of Compliance 11/29/13</p>	
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F 314	<p>Continued From page 16</p> <p>*1 unstageable pressure ulcer, present on admission.</p> <p>Resident #7's Initial Data Collection Tool/Nursing Service, dated 9/23/13 at 1:30 PM, documented Resident #7 had an open SDTI (Suspected Deep Tissue Injury) on her coccyx on admission from a local hospital.</p> <p>Resident #7's Admission Orders, dated 9/23/13, documented an order to "cleanse SDTI on coccyx with NS, apply skin prep and cover with Mepilex Border Foam, change every 3 days and PRN if lose/soiled."</p> <p>Resident #7's nursing notes, dated 9/23/13 at 3:01 PM, documented "[woundcare nurse at a local hospital] reports that this SDTI is from rsdt's (resident's) refusal to get off of a bedpan while at the hospital."</p> <p>Nursing notes (progress notes), dated 10/2/13 at 3:21 PM, documented the resident was being followed by the wound nurse related to unstageable pressure ulcer to coccyx/sacral area which was new on admit.</p> <p>A Pressure Ulcer Status Record, dated 9/23/13, filled out by LN #7, documented an unstageable pressure ulcer to the coccyx/sacral area. However, there was no documentation in the Description of Stages area, where there were three boxes, next to the Unstageable description. Wound descriptions were documented as follows:</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Stage</th> <th>Width</th> <th>Length</th> </tr> </thead> <tbody> <tr> <td>*9/23/13</td> <td>Unstageable</td> <td>6 cm</td> <td>x 4 cm</td> </tr> </tbody> </table>	Date	Stage	Width	Length	*9/23/13	Unstageable	6 cm	x 4 cm	F 314		
Date	Stage	Width	Length									
*9/23/13	Unstageable	6 cm	x 4 cm									

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F 314	<p>Continued From page 17</p> <p>Small amount of sero-sanguineous drainage (thin, watery & pale red in color)</p> <p>*9/25/13 Unstageable 4 cm x 1.8 cm None</p> <p>*10/2/13 Unstageable 1.7 cm x 1 cm None</p> <p>*10/9/13 Unstageable 1 cm x 1.5 cm None</p> <p>*10/14/13 Unstageable 1 cm x 0.5 cm None</p> <p>*10/21/13 Stage II 1 cm x 0.2 cm None</p> <p>The Physician's Orders (recapitulation) with a start date of 9/23/13, documented to "turn side to side in bed - No back Lying."</p> <p>A Treatment Record, dated 9/23/13, documented the resident be "turned side to side in bed - no back laying."</p> <p>The Care Plan for Skin At Risk, dated 10/4/13, documented interventions for the resident when she was in bed. However, there was not a care plan which addressed interventions when the resident was not in bed. The interventions on the care plan included:</p> <ol style="list-style-type: none"> 1) Reposition from side to side only when in bed at this time. 2) Staff to assist with repositioning, needs frequently for pressure relief and comfort. She has cane rails on her bed to assist. 3) Pressure reducing mattress and cushion in place. <p>On 10/22/13 at 9:00 AM, Resident #7 was</p>	F 314		

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F 314	<p>Continued From page 18</p> <p>observed to be in bed sleeping. A sign above the resident's bed instructed staff to "Turn Side To Side, No Back in Bed."</p> <p>On 10/22/13 at 2:40 PM, the surveyor observed Resident #7 being assisted to lay down for a nap by CNA #6.</p> <p>On 10/22/13 at 3:25 PM, Resident #7 was observed to be laying flat on her back in bed.</p> <p>On 10/22/13 at 3:30 PM, CNA #6 stated he put the resident to bed on her back and did not notice the sign on the wall. CNA #6 stated "me bad, that's what I get for normally working weekends." CNA #6 was observed to wake up Resident #7 from her nap. He readjusted the resident on her left side with a pillow to her back which he used for positioning.</p> <p>On 10/23/13 at 11:22 AM, RN #7 stated she placed the sign above Resident #7's bed when the resident returned to the facility from a local hospital on 9/23/13.</p> <p>On 10/24/13 at 4:15 PM, CNA #6 stated, to the surveyor, he thought he had put Resident #7 down for a nap approximately 2:25 or 2:30 PM and was sorry he had not noticed the sign above her bed.</p> <p>On 10/24/13 at 5:30 PM, the Administrator and DON were informed Resident #7 had been observed to be on her back when in bed. A sign above Resident #7's bed instructed staff to reposition the resident on her side and not on her back, it was listed as an intervention on the care plan, and there was an MD order. The DON stated understanding and produced a handwritten</p>	F 314		

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F 314	Continued From page 19 note given to her by CNA #6 where he apologized for laying Resident #7 down for a nap on her back.	F 314		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure residents received adequate supervision to prevent falls with injuries. This was true for 2 of 6 (#s 1 & 8) residents sampled for falls. Resident #8 was harmed when the resident fell and suffered a fracture of the right distal femur. Additionally, the facility failed to comprehensively assess Resident #1's falls. Findings included: Resident #8 was admitted to the facility on 7/8/13, due to surgical intervention for a right hip and proximal fracture which resulted from a fall, with diagnoses of aftercare for healing of a traumatic fracture of the right upper leg, muscle weakness, dysphagia, pain and anemia. The resident's Admission MDS, dated 7/15/13, documented in part: *Cognition was moderately impaired, BIMS Score of 9.	F 323	<p>Corrective Action for Specific Residents</p> <p>Resident #8 has had the fall risk assessment updated with care plan changes as needed. Adequate supervision in the form of hourly rounding is being provided and documented to reduce the risk of falls. The increased supervision will be evaluated weekly at fall meetings to ensure it is meeting the residents needs.</p> <p>Resident #1 has had the Fall risk assessment updated and care plan changes as needed. The facility has reviewed the residents' fall history and fall assessment and she was moved to a room closer to the nurses station to provide increased supervision.</p> <p>Other Residents Affected</p> <p>Other residents who have multiple falls have the potential to be affected. The facility ensures that a resident receives adequate supervision and assistive devices based on an individual assessment to reduce the risk of injuries and that falls are thoroughly investigated.</p>	

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F 323	<p>Continued From page 20</p> <ul style="list-style-type: none"> *Extensive assist of 2+ persons for bed mobility, transfer and toilet use. *Extensive assist of 1 person for dressing, personal hygiene and bathing. *Functional limitation of range of motion in the lower extremity. *Frequently incontinent of bladder. *Always continent of bowel. <p>The resident's Significant Change MDS, dated 9/22/13 (after a fall with injury), documented in part:</p> <ul style="list-style-type: none"> * Cognition was severely impaired, BIMS Score of 5. * Extensive assist of 2+ persons for toilet use. * Total dependence with assist of 2+ persons for transfers and bathing. * Extensive assist of 1 person for bed mobility and dressing. * Balance during transitions and walking was not steady, only able to stabilize with staff assistance for moving on and off toilet and surface-to-surface transfer (transfer between bed and chair on wheelchair). * Functional limitation of range of motion in the lower extremity. * Frequently incontinent of bladder * Always incontinent of bowel. * Weight loss of 5% or more in the last month but not on physician-prescribed weight-loss regimen. <p>In the three months since the resident was admitted to the facility, she experienced declines in mental functioning, ADL assistance, bowel incontinence and weight loss.</p> <p>Resident #8's medical record documented the</p>	F 323	<p>What measures will be put into place/systemic changes to prevent recurrence.</p> <p>Nursing Staff, Fall Committee have been in-serviced to the importance of completing thorough, timely and complete investigations. Nursing staff were inserviced on thoroughly completing the updated Fall Scene Investigation Report and Incident report. Nursing Staff and nurse Managers will complete an assessment of the root cause of the fall and ensure appropriate interventions are in place. Nursing staff has been in-serviced to the 4 P's (potty, positioning, pain and placement of equipment) and what to look for when doing rounds. Nursing staff also inserviced on what could constitute increased supervision and the need to document and careplan the supervision provided.</p> <p>Monitoring to ensure deficiency does not recur</p> <p>The Fall Committee will audit completion of Fall Scene Investigation 3x/week for 3 months. This will include review of documentation, Incident Management report, careplan and audit of resident and or residents room to ensure that the interventions implemented are working for the resident.</p>

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F 323	<p>Continued From page 21 following falls since her admission to the facility: 8/18/13, 9/11/13 and 10/15/13.</p> <p>The resident's Fall Risk Evaluation documented the resident was at risk for falls when the score of 10 or higher and interventions should be initiated. Resident #8's Fall Risk Evaluation documented a score of 22 on 7/7/13, 8/18/13 and 9/11/13. A score of 24 was documented on 10/15/13.</p> <p>Resident #8's Fall Risk Evaluation, dated 7/8/13, documented the following interventions were effective and did not require follow-up:</p> <ol style="list-style-type: none"> 1) Low bed; 2) Non-skid footwear, and 3) Audible alarms. <p>Resident #8's ADL Care Plan, dated 7/24/13, documented the resident "requires up to a one (1) person extensive assist with all ADLs requiring her to transfer, stand or walk."</p> <p>Resident #8's ADL Care Plan was updated on 9/17/13 to include:</p> <ol style="list-style-type: none"> 1) Decline in ADL's R/T (related to) right femur fracture - non-weight bearing status. 2) Requires Hoyer lift for all transfers. 3) Non-weight bearing to right leg. 4) Keep right leg immobilizer in place at all times. <p>An Incident Report for Resident #8, dated 8/18/13 at 12:45 PM, documented: Resident #8 was found on her knees next to the bed attempting to self transfer from her wheelchair to the bed. The resident had compression stockings on and removed the non-skid socks prior to transfer. Resident #8 demonstrated the ability to remove the pull tab</p>	F 323	<p>Audits will be done by Fall Committee on resident's who are care planned to have increased supervision <u>weekly times 3 months</u> to determine if it is adequately meeting their needs and that it is documented and careplanned.</p> <p>The Director Of Nursing will bring the results of these audits to QA/PI meeting. Ongoing education/audits will be scheduled based on trends.</p> <p>Audits will begin on <u>11/21/13</u>.</p> <p>Date of Compliance: 11/29/13</p>	
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F 323	<p>Continued From page 22</p> <p>alarm despite it being placed on her lower back. The bed was at the proper height. No injuries were noted and a MDS significant change was not required. The report documented "unknown" when the resident was last toileted.</p> <p>Resident #8's Fall Risk Evaluation, dated 8/18/13, was updated to include the following interventions were not effective and required follow-up:</p> <ol style="list-style-type: none"> 1) Low bed; 2) Non-skid foot wear; 3) Audible alarms; and 4) Requested pressure pads from restorative. <p>A social service note, dated 9/10/13 at 4:06 PM, documented "Completed 60 Day MDS per PPS guidelines. Rsdrt shows for no overall significant changes in the areas followed by SS. Rsdrt's BIMS screen scored a 8/15."</p> <p>An Incident Report for 9/11/13 documented: Resident #8 fell attempting to self transfer from her bed, her feet slipped and she slid to the floor. Non-skid foot wear were in place. ROM (range of motion) was completed with assist from an aide to bend the resident's leg to her chest without difficulty. In the AM, Resident #8 complained of pain in her ankle but denied pain in her hip, leg or knee, however, the knee was slightly swollen.</p> <p>Resident #8 was sent to (a local hospital) for evaluation related to an acute fracture of the right distal femur. The resident returned to the facility with orders for NWB (non-weight bearing) and an immobilizer to her right leg. However, surgery was not planned. The report documented Resident #8 had been toileted prior to her son's visit and the son did not inform staff of his</p>	F 323		

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F 323	<p>Continued From page 23</p> <p>departure. There was documentation a MDS significant change was not required.</p> <p>Resident #8's Fall Risk Evaluation, dated 9/11/13, was updated to include the following interventions:</p> <ol style="list-style-type: none"> 1) Bed alarm - pressure; 2) Non-skid socks; 3) Bed at appropriate height; and 4) 4 P's with rounding (potty, pain, positioning if needed and place of equipment). <p>NOTE: Frequency of rounding was not listed.</p> <p>A nursing note, dated 9/11/13 at 9:27 PM, documented "This evening resident had apparently self transferred to her bed and then was attempting to get up without assist. She slid off the bed and was found sitting on the floor with her back against the bed. No apparent injury."</p> <p>A nursing note, dated 9/12/13 at 7:21 AM, documented the resident complained of right leg pain from mid thigh, knee to ankle but denied hip or foot pain. The right leg was swollen and pain increased with weight bearing.</p> <p>Resident #8 was sent to the ER (Emergency Room) for evaluation and treatment on 9/12/13. The final X-Ray report, dated 9/12/13, documented "Acute fracture of right distal femur just above distal tip of intra-medullary rod, with minimal displacement."</p> <p>A nursing note, dated 9/12/13 at 9:18 PM, documented the resident returned from the hospital to the facility with an immobilizer brace on</p>	F 323		
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F 323	<p>Continued From page 24</p> <p>her right leg, ordered to see an orthopedic physician and to be NWB (non-weight bearing).</p> <p>A nursing note, dated 9/17/13 at 10:03 AM, documented Resident #8 required a Hoyer lift for transfers, was not able to ambulate and was set up for an MDS significant change in status assessment which was E-Signed by the MDS Coordinator.</p> <p>The medical record documented a social service note E-Signed by the SS Designee, dated 9/30/13 at 8:03 AM, "SS Significant Change Assessment: This Rsd (resident) slid out of bed on 9-12-2013 and later that day c/o (complained of) leg pain.</p> <p>The medical record included a Plan of Treatment for Occupational Therapy (OT) dated 10/3/13. Documentation included the resident previously received therapy after admission to the facility on 7/8/13 for an ORIF (Open Reduction Internal Fixation) of right femur fracture and was discharged from OT services on 8/23/13. The Plan of Treatment included Resident #8 had a recent fall with femur fracture and was changed to NWB status on her right lower extremity which significantly changed her transfer and ADL care. The resident needed to be transferred by Hoyer. There was documentation the Skilled OT assessment was needed to determine if Resident #8 could develop the ability to transfer with FWW (front wheeled walker) safely with the new NWB status.</p> <p>Resident #8's dietary note, dated 10/8/13 at 10:48 AM, documented the resident was reviewed for significant weight loss changes, down 5% in 30 days, with weight loss likely related to the 9/11/13 fall with fractured hip and pain changes.</p>	F 323			

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F 323	<p>Continued From page 25</p> <p>An Incident Report for Resident #8, dated 10/15/13 at 1:45 AM, documented: The resident was found on the floor beside her bed. The resident removed the pull tab alarm and stated she got up to use the bathroom when she slipped, fell, and then pulled the call light. The resident was found with bare feet, her Attends halfway on, and the side of the bed and floor were wet with urine. The Follow-Up section documented the facility discontinued the personal pull tab alarm. Motion alarms were placed at bedside with recommendations to use a bedside commode at night. Resident #8 was last toileted at 11:30 PM. However, the CNA's recreation of the last three hours before the fall documented the CNA checked on the resident, who was dry, and when asked if she needed to go to the bathroom, the resident said "no, I'm okay."</p> <p>Resident #8's Fall Risk Evaluation, dated 10/15/13, was updated to include the following interventions:</p> <p>1) Bedside commode at night; and 2) Audible motion alarms to bathroom and bedside.</p> <p>A nursing note, dated 10/15/13 at 8:11 AM, documented the resident was found on the floor at 1:45 AM, had taken the pull tab alarm off and stated "I had to go to the bathroom in a hurry, I got up and slipped." The resident could not get up and turned the call light on. No injuries were noted at that time.</p> <p>On 10/24/13 at 2:10 PM, RCM #12 was</p>	F 323		
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F 323	<p>Continued From page 26</p> <p>interviewed regarding Resident #8's falls and the interventions which were implemented on 8/18/13, 9/11/13 and 10/15/13 after each fall. The surveyor asked RCM #12 about adding increased supervision for Resident #8. RCM #12 stated, the resident was already being monitored approximately every 1 hour for the 4 P's and she didn't think the facility could have done anything different.</p> <p>NOTE: There was no documentation in the resident's medical record about rounding with the 4 P's.</p> <p>On 10/28/13 the facility faxed additional information to the Bureau of Facility Standards for Resident #8's Incident Report (in-depth A&I) for 9/11/13, Weight Tracking Sheet, showing weights had stabilized, and information pertaining to the 9/11/13 MDS Significant Change assessment. The SS Designee stated, in a handwritten note, the BIMS screens were all completed in Resident #8's room, with the exception of the BIMS screen on 9/11/13, in which the resident scored a "5." The SS Designee stated the BIMS screen on 9/11/13 was given in the common area, off the Snake River Nurses station, after lunch. The SS Designee stated the resident was HOH (hard of hearing) and environmental noises in a common area could potentially affect the score. The fax contained additional information, however, the information did not resolve the concern of adequate supervision to prevent falls with injuries.</p> <p>Federal guidance at F-323 states, "Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is defined by the type and frequency of supervision, based on the individual resident's assessed</p>	F 323		
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F 323	<p>Continued From page 27</p> <p>needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident. Tools or items such as personal alarms can help to monitor a resident's activities, but do not eliminate the need for adequate supervision."</p> <p>Resident #8 experienced 3 falls in 3 months, since admission to the facility. The resident experienced a major injury which produced a MDS Significant Change assessment in the resident's mental and physical functioning. The facility failed to increase supervision as needed for the resident's condition. The resident experienced a fall, after the intervention of the 4 P's, and the facility did not increase the frequency of supervision.</p> <p>2. Resident #1 was admitted to the facility on 12/29/09 with multiple diagnoses including muscle weakness, depressive disorder, respiratory abnormality, and dementia with behavioral disturbance.</p> <p>The resident's 5/19/13 quarterly MDS coded severely impaired cognition, required one person supervision for most ADLs with the exception of bathing which was one person limited assistance, continent of bowel and bladder, and two falls with no injuries.</p> <p>The resident's 7/24/13 significant change MDS coded moderately impaired cognitive skills, required one person extensive assistance for most ADLs with the exception of walk in corridor which occurred one to two times, occasionally incontinent of bowel and frequently incontinent of bladder, and two falls one with no injury, one with</p>	F 323		
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F 323	<p>Continued From page 28 injury but not major injury.</p> <p>The resident's 5/6/13 Fall Risk Evaluation form documented the resident's fall risk was 21. The form documented a score of 10 or higher was at risk. Subsequent Fall Risk Evaluations documented the resident's fall risk ranged from a total score of 18 to 34 from 5/6/13 to 10/14/13.</p> <p>The resident's Fall Risk Care Plan (CP) identified the 9/9/11 problem of, multiple falls in the past related to weakness, impaired dynamic balance, dementia with impaired decision making, unsteady gait, impulsivity, Res (resident) was anticipated to have further declines related to disease process. The problem goal was, will have no injury falls noted with interventions in place thru (through) 90 day follow up, 11/01/13. Problem approaches included, in part, the following:</p> <ul style="list-style-type: none"> - Document fall in progress notes and notify MD and family - Hip guard waiver signed 12/29/11 - Encourage to wear non skid footwear when out of bed in room and when ambulating - Supervise gait for any unsafe actions, provide verbal cues for safety - If (Resident #1) should have any falls or signs and symptoms (s/sx) of declines, assess for s/sx of infection, assess meds (medications), obtain vital signs, and request a c&s (culture & sensitivity) on urine from MD - FYI MD (For Your Information) was aware of (Resident #1) significant decline and history of falls with need for additional help with ADL functions - Has rocking chair, monitor for safety sitting in and getting up from rocker - Bed against wall to accommodate personal 	F 323		

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F 323	<p>Continued From page 29</p> <p>space and homelike environment</p> <ul style="list-style-type: none"> - Keep room free of clutter - Request verbal cues and reminders on blood sugars (BSs) & insulin injections and reassurance BSs were being managed - Fall Risk Assessment to be completed per facility protocol - Audible alarms in place, staff to respond quickly when sounding - Bed at correct height at all times for safety - Keep call light visible for assistance <p>Note: Federal guidance at F323 specified, "...Implement interventions, including adequate supervision, consistent with resident's needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident...Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is defined by the type and frequency of supervision, based on the individual resident's assessed needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident."</p> <p>The facility's Incident Follow-Up Recommendation Form and Fall Scene Investigation Reports [Incident and Accident (I&A) Reports] contained, in part:</p> <ul style="list-style-type: none"> -A section titled, Follow-Up. -A section titled, Describe initial interventions to prevent future falls. This section will be referred to as Intervention(s). -A section titled, "Re-Creation of Last 3 Hours Before Fall." This section contained pre-printed instructions for staff, "Below, the primary Nursing Assistant who observed and/or assisted the resident during the three hours prior to the fall will 	F 323		

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F 323	<p>Continued From page 30</p> <p>write a description to re-create the life of the resident before the fall:" This section also included an area for staff to enter their name. This section will be referred to as Re-Creation.</p> <p>Review of the facility's I&A reports revealed from 5/8/13 through 10/14/13 Resident #1 sustained 6 falls while in her room.</p> <p>*5/8/13 at 8:05 a.m., found sitting on floor beside her bed. --Follow-Up: changed type mattress due to surface being slick --Intervention(s): Nonskid footwear placed on both feet, remind to use call light, mattress changed --Re-Creation: "Took the residents {sic} breakfast tray in, she was still kind of asleep in bed and told me she was slowly waking up." This handwritten entry was signed by a CNA. Note: The Re-Creation section did not include the last 3 hours before the fall, from 5:05 a.m. to 8:05 a.m.</p> <p>*7/19/13 at 8:00 p.m., found on floor, tried to ambulate to bathroom (BR), lost balance and fell, was using a cane. A different section in the report documented, unknown what the resident was doing during or just prior to fall. --Follow-Up: Has safe, new Front Wheeled Walker in place at this time. --Intervention(s): Bed in lowest position, non-skid footwear, frequent checks, and alert charting Note: The Report documented frequent checks however the Fall CP did not include frequent checks as an approach or any type of supervision as an approach. --Re-Creation: "Resident had reported hard lump along It [left] jawline that was painful, eat dinner in</p>	F 323		
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F 323	<p>Continued From page 31</p> <p>room, rested." This handwritten entry was signed by a RN.</p> <p>Note: The ReCreation section did not include the last 3 hours before the fall from 5:00 p.m. to 8:00 p.m.</p> <p>The resident was sent to a local hospital emergency room for left jaw and neck evaluation. It was determined the resident's parotid gland was infected, the MD ordered, and the resident received antibiotic therapy.</p> <p>*7/23/13 at 8:20 a.m., found on back in BR, lost balance and fell.</p> <p>--Follow-up: care planned to have audible alarms at all times</p> <p>--Intervention(s): Nonskid footwear, bed at appropriate height, audible alarms at all times, and transfers with assist of one person</p> <p>--Re-Creation: "5:30 am assisted rsdt [resident] to bathroom, returned to bed was sleeping at 6 am [6:00 am] report given to next shift CNAs." This handwritten entry was signed by a CNA.</p> <p>Note: The Re-Creation section did not include the last 3 hours before the fall. The nightshift CNA provided information however the report did not contain information from the next shift (dayshift) CNAs, from 6:00 a.m. to 8:20 a.m.</p>	F 323			
	<p>*8/21/13 at 12:35 p.m., attempted to self transfer from wheelchair (wc) to bed, found sitting on the floor in front of wc.</p> <p>--Follow-up: audible alarms in place, frequent checks, reminded to use call light and wait for assistance. Rsdt demonstrated appropriate use of call light and verbalized will call for assistance.</p> <p>--Intervention(s): Remind to use call light</p> <p>--Re-Creation: "Rsdt had just eaten lunch & was toiletied at 1200 noon." This handwritten entry was not signed.</p>				

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F 323	<p>Continued From page 32</p> <p>Note: The Re-Creation section did not include the last 3 hours before the fall from 9:35 a.m. to 12:00 p.m.</p> <p>*9/21/13 at 11:00 p.m., found sitting on floor at the foot of bed, RsdT complained of left hip pain, not wearing proper footwear, audible alarms sounding</p> <p>--Follow-up: Chemistry strip within normal limits, alarms in place, nonskid footwear in place, ensure 4 p's (frequent toileting, positioning, pain assessment and placement of equipment)</p> <p>--Intervention: Remind to use call light and wait for assist, alarm in use and working, nonskid footwear, use of assistive device walker, wheelchair, SBA (standby assist), bed at correct height</p> <p>--ReCreation: "Resident was in bed at 10:00 pm with alarm on. Checked at 10:50 pm, still in bed with alarm on. Resident got up at 11:00 pm and was found sitting on floor next to bed A. Alarm was on." This handwritten entry was signed by a CNA.</p> <p>Note: The Re-Creation section did not include the last 3 hours before the fall. A CNA provided information from 10:00 to 11:00 a.m. however the report did not contain information from 8:00 a.m. to 10:00 a.m.</p> <p>--The resident's 9/21/13 Pain Assessment contained a handwritten entry on the back of the form, "9/21/13 sent to [name of hospital] ER for Eval & tx [emergency room for evaluation and treatment]." The 9/22/12 local hospital x-ray findings were no fracture or other significant osseous (of, relating to, or composed of bone) abnormality.</p> <p>*10/14/13 at 1:15 p.m., found on floor next to bed, RsdT sent to local hospital for evaluation. RsdT</p>	F 323		
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F 323	<p>Continued From page 33</p> <p>positive for UTI - started antibiotic therapy. A section titled, What appears to be the root cause of the fall, contained a handwritten entry, "Rsd self transferred & her pull tab alarm was not attached to her. (she removes it)."</p> <p>--Follow-up: audible alarms to wheelchair discontinued, Rsd moved to [room number] closer to nurses station and bathroom motion alarm to bathroom. Rsd continued with antibiotic related to UTI, to end 10/22/13.</p> <p>--Intervention: change alarm to pressure pad, move Rsd closer to nursing station</p> <p>--Re-Creation: "Rsd has urgency & [and] had been up & down to the bathroom which is normal for her." This handwritten entry was signed by a LPN.</p> <p>Note: The Re-Creation section did not include the last 3 hours before the fall from 10:15 a.m. to 1:15 p.m.</p> <p>Note: The resident's chart contained a 10/14/13 local hospital radiology report which documented, Dizziness with fall. One of the findings was, Probably 5 mm [millimeter] chronic subdural hematoma along the left cerebral convexity. One of the Impressions was, no acute intracranial abnormality.</p> <p>On 10/24/13 at 11:20 a.m., the surveyor and RN #9 discussed Resident #1's I&A reports. The resident sustained 6 falls from 5/8/13 to 10/14/13 and the Re-Creation section of the reports did not provide the reader with the last 3 hours of the resident's life before the falls and the I&As do not provide comprehensive information to make appropriate interventions/approaches or determinations. The RN stated, "We added interventions after each fall and added the 4 p's (frequent toileting, positioning, pain assessment and placement of equipment) on 9/21/13."</p>	F 323		
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F 323	Continued From page 34 Note: The resident's Fall CP did not include frequent toileting or positioning. The Bowel and Bladder (B&B) CP contained an approach, Rsdt required every 2-3 hour prompted toileting and prn resident request in attempt to decrease urinary incontinence. The B&B CP did not include frequent toileting. On 10/25/13 at 9:30 a.m., the Administrator and the DON were informed of the concern. On 10/28/13 at 1:37 p.m., the facility faxed additional information related to Resident #1's 10/14/13 fall. However, the faxed information did not resolve the concern of the resident sustaining 6 falls from 5/8/13 to 10/14/13 and the I&A reports did not provide comprehensive information to make appropriate interventions or determinations.	F 323		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364	Corrective Action for Specific Residents Individually interviewed all sampled residents to update food preferences and identify food and dining concerns *Established a resident food/dining/menu committee and invited those residents affected during the survey. *Conducted the first food/dining/menu committee meeting on November 7, 2013, and addressed all resident concerns brought up during that meeting *The fish served on the menu on 10/23 was discarded and a new, higher quality fish product will be procured *Meals served in residents rooms utilize a heat retaining system for hot foods. *Steam tables in the kitchen and dining room were adjusted to ensure proper temperatures are held	
	This REQUIREMENT is not met as evidenced by: Based on Resident Council Meeting Minutes, the Resident Group Interview, Family Interview, test tray evaluation and staff interview, it was determined the facility failed to prepare palatable food. This affected 4 of 6 residents who attended the Resident Group Interview, 11 of 15 sampled residents (#'s 1, 2, 4-11, 14 and 15) and had the			

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F 364	<p>Continued From page 35</p> <p>potential to affect other residents who dined in the facility. This failed practice created the potential to negatively affect the resident's nutrition status and psychosocial well-being related to unpalatable food. Findings included:</p> <p>On 10/22/13 at 10:00 AM, Resident Council Meeting Minutes were reviewed and documented the following concerns: -7/17/13 at 3:30 PM, "Kitchen: The council expressed a concern about the evening meal being served on the halls are sometimes cold and need reheated [sic]. On some occasions the meals have been served without a hot plate." -8/20/13 at 3:00 PM, "OLD BUSINESS: The council discussed meal service and food temp[erature]. The council continues to voice concerns about food temps. The dietary department has been tracking food temps with positive outcome...NEW BUSINESS: Dietary... [DM Name] will also investigate further the food temperature concern." -9/17/13 at 2:30 PM, "Old Business: The council discussed food temps overall there has been an improvement for Breakfast and Lunch. Some of the evening meals continue to be served cold." -10/15/13 no time given, "Old Business: The council discussed food temps with continued concerns, as some meals have been served cold. [DM Name] the dietary supervisor discussed with the council that the kitchen staff will be starting what is called batch cooking. The steam tables will also be turned up in an effort to keep the food warmer. The council agreed that this would be a good solution."</p> <p>On 10/22/13 at 11:00 AM, during the Resident Group Interview, 4 out of 6 residents said the food was still served cold.</p>	F 364	<p>Identification of other residents having the potential to be affected and what corrective action will be taken:</p> <ul style="list-style-type: none"> *All residents receiving an oral diet have the potential to be affected *All approaches noted in #1 above were completed to ensure no other residents were negatively affected. <p>Measures and systemic changes to prevent recurrence:</p> <p>The dietary manager and/or RD has educated the kitchen production staff on the following:</p> <ul style="list-style-type: none"> *Following standardized recipes *Batch cooking for vegetables and appropriate entree items *Proper use of the steamtable and plate lowrater *Appropriate use of the heat retaining system for hot holding *Correct temperature range for cooking and hot holding of food *Proper method for taking and recording food temperatures *Appropriate method for tasting of all foods prior to service to the residents *Interviewing residents at the end of the meal service to obtain feedback <p>The following has also been completed:</p> <ul style="list-style-type: none"> *Review of food items being purchased to ensure they meet Life Care's quality food standards *Maintenance has checked proper functionality of the steamtable, plate lowrater and hot palate system. *Each resident will be interviewed in conjunction with their quarterly nutrition review. ✓ *Residents will be invited to a monthly food/dining/menu committee meeting to discuss the food/meal satisfaction and address any concerns with the meal service. 	
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TG 11/20/13

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON		STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID 83501	
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F 364	<p>Continued From page 36</p> <p>On 10/23/13 at 11:15 AM, during an interview with a resident's family member, a concern regarding food was voiced. The family member stated some foods were overcooked and were, "boiled to death."</p> <p>On 10/23/13 at 12:25 PM, a lunch meal test tray was evaluated by the survey team, the DM, and the RD. The test tray included baked fish with a temperature of 115 Fahrenheit (F) and cauliflower with a temperature of 130 F. The fish was determined to be unpalatable and gritty in consistency. The cauliflower was determined to be unpalatable and mushy in consistency, indicating the cauliflower was overcooked.</p> <p>On 10/23/13 at 12:28 PM, the DM was asked what she thought about the fish and she stated, "it should have been hotter...temps should have been better." The DM was then asked about the cauliflower and she said the cauliflower was normally served soft because of resident complaints.</p> <p>On 10/23/13 at 6:15 PM, the Administrator and DON were informed of the issue. No other information was provided by the facility.</p>	F 364	<p>Monitoring corrective action for sustained corrections:</p> <p>*The Director of Food and Nutrition Services will complete the Food and Nutrition Department Review twice a month for 3 months then monthly thereafter, which critically audits all aspects of food production and service, including food production, temperature control, palatability and service. ✓</p> <p>*A test tray will be done at least 4 times per week by administration and/or the RD for the next 3 months and education provided. ✓</p> <p>Further audits and education will be based on trends identified.</p> <p>*The RD will complete a monthly food service comprehensive review of food palatability, temperature control and meal satisfaction. ✓</p> <p>*Administration and the monthly QA/PI committee will review audits and meeting minutes for the next 3 months to ensure ongoing substantial compliance. Further audits and education will be based on trends identified.</p> <p>Completion date: November 29, 2013</p> <p>Other Residents Affected</p> <p>What measures will be put into place/systemic changes to prevent recurrence. Monitoring to ensure deficiency does not recur</p>
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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</p>	F 431	<p>Date of Compliance <u>11/29/13</u></p> <p>Corrective Action for Specific Residents</p> <p>Resident #20 is receiving Coumadin at the same time every day at 1600. ✓</p> <p>Pharmacy label audited to ensure label is correct and that label does not contradict time given. ✓</p>

Audits begin 11.20.13
11.27.13 3:30 telephone DMS/DON

meal satisfaction will be fed back from residents. Bring form

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F 431	<p>Continued From page 37 reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure medication labels were accurate for 1 of 8 residents (#20) during the medication pass observation. The mislabeled medication had the potential for harm should the resident not receive the medication at the same time daily. Findings included: Resident #20's October 2013 Admission Orders</p>	F 431	<p>Other Residents Affected Other residents who receive Coumadin have the potential to be affected by this practice and have had their Coumadin medication labeling audited to ensure there are no discrepancies in the time of dose. ✓</p> <p>What measures will be put into place/systemic changes to prevent recurrence.</p> <p>Licensed Nurses, Nurse Managers have been in-serviced to ensure pharmacy Coumadin labels do not contradict time given of 1600. LN inserviced if there is any discrepancy between the MAR and label to notify pharmacy to report the error and ask pharmacy to satellite the medication or the nurse should retrieve the correct dose of Coumadin from the pyxis. ✓</p>

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F 431	<p>Continued From page 38 documented in part: * Coumadin 2 mg tablet 1 tablet by mouth daily for 30 days.</p> <p>The MAR (Medication Administration Record) for Resident #20, date not included, documented in part: * Coumadin 2 mg 1 tablet PO on Tuesday, Wednesday, Thursday, Friday, Saturday, Sunday. The Hour to be given was documented as 1600 (4:00 p.m.).</p> <p>On 10/23/13 at 4:15 p.m., LN #2 was observed dispensing medication for for Resident #20 from a bubble pack card. The label on the bubble pack card read, "Warfarin Sodium 2 mg tablet: give 1 tablet orally daily at bedtime." The LN read the label out loud, noted the incorrect label of "bedtime" and stated, "I shouldn't have said anything."</p> <p>On 10/25/13 at 9:35 a.m., the DON provided a Coumadin Process procedure sheet, date not included, that documented in part: * Nursing administration/designee will check the medication cart daily for the appropriate Coumadin dose before the 4:00 p.m. to 5:00 p.m. medication administration time.</p> <p>On 10/23/13 at 6:15 p.m., the Administrator and DON were informed of the medication pass observation. However, no further information or documentation was provided that resolved the issue.</p>	F 431	<p>Monitoring to ensure deficiency does not recur Unit Managers will audit the Coumadin medication labeling process for discrepancies. Audits will be performed <u>2x/week times 3 months.</u></p> <p>DNS will bring audits to QA/PI for review monthly times 3 months. . Ongoing education/audits will be scheduled based on trends. Audits to begin <u>11/15/13</u></p> <p>Date of Compliance 11/29/13</p>	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	<p>Continued From page 39</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 441	<p>Corrective Action for Specific Residents Residents #19 and #2 are being provided a sanitary environment to prevent the transmission of infection. ✓</p> <p>Other Residents Affected Other residents have the potential to be affected by this practice and are being provided a sanitary environment to prevent the transmission of infection. ✓</p> <p>What measures will be put into place/systemic changes to prevent recurrence.</p> <p>Nursing staff in-serviced on food handling and how to decrease the chance of contamination particularly not to touch residents food with bare hands. ✓</p> <p>Licensed staff in-serviced on the principles of cross contamination with medication passes specifically not to take something out of the garbage and reuse. ✓</p>

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F 441	<p>Continued From page 40</p> <p>Based on observation and staff interview, it was determined the facility failed to provide a sanitary environment to prevent the transmission of infection for 1 of 12 (#19) random residents observed during dining, when a CNA used bare hand contact with Resident #19's food. Additionally, when a medication cap was retrieved from the trash and placed back on the medication container. Failure to follow standard infection control measures placed the residents at risk for infections. Findings included:</p> <p>a. On 10/21/13 at 6:30 p.m., during a dinner meal observation in the grand dining room, CNA #8 was observed using bare fingers to hold open a soft tortilla shell while using a utensil in the other hand to scoop taco ingredients inside the tortilla shell for Resident #19.</p> <p>On 10/21/13 at 6:45 p.m., CNA #8 was asked about the aforementioned observation and stated, "I touched the tortilla with my fingers."</p> <p>b. On 10/23/13 at 11:20 a.m., LN #1 was observed preparing an insulin injection of Novolog for Resident #2. The insulin vial was stored inside a pill bottle container with a cap. After the Novolog insulin had been drawn up into the syringe, the LN noticed she had thrown the pill bottle container cap into the trash receptacle on the side of the medication cart. LN #1 remove the cap from the trash receptacle and placed it back on the pill bottle container with the insulin vial inside. When the LN was asked if she had taken the cap out of the trash and placed it back on the pill bottle container storing the insulin vial she stated, "Oh shoot. It didn't touch anything. It was cap up."</p>	F 441	<p>Monitoring to ensure deficiency does not recur</p> <p>Nurse Managers, DNS, Dietary Manager, or Executive Director are auditing the dining room 2x/week for 3 months to ensure that the staff are not touching residents' food with bare hands. Audits to begin <u>11/15/13</u>.</p> <p>Nurse Managers, DNS, will do medication pass audits 1x/week times 3 months to ensure that licensed nurses are not taking objects out of the trash and reusing. Audits to begin 11/15/13.</p> <p>Director of Nursing will bring audits to QA/PI for review monthly times 3 months. Ongoing education/audits will be scheduled based on trends.</p> <p>Date of Compliance <u>11/29/13</u></p>	
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F 441 F 514 SS=D	<p>Continued From page 41</p> <p>On 10/23/13 at 6:15 p.m., the Administrator and DON were informed of the infection control observations. However, no further information or documentation was provided that resolved the issues.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident review, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices to ensure records were complete and accurate. This was true for 3 of 15 (#s 4, 7, & 8) sampled residents when there was incomplete documentation for prompted voiding and inaccurate documentation for the monitoring of an antidepressant. This deficient practice increased the risk for medical decisions to be based on incomplete or inaccurate information and increased the risk for complications due to</p>	F 441 F 514	<p>Corrective Action for Specific Residents</p> <p>Resident #4, #7, #8 toileting plan has been reviewed by the restorative nurse and cnas are documenting prompted voiding per toileting plan. Resident #4's care plan & orders have had the monitoring of antidepressant discontinued.</p> <p>Other Residents Affected</p> <p>Other residents on prompted toileting will have their plans reviewed and will have prompted toileting documentation completed per plan of care. Other residents who have their antidepressants discontinued will have the side affect monitoring discontinued also.</p>	

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F 514	<p>Continued From page 42</p> <p>inappropriate care or interventions. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 1/26/10 and readmitted on 3/16/12 with multiple diagnoses which included osteoarthritis, dementia, depressive disorder, and Parkinson's disease.</p> <p>Resident #4's most recent quarterly MDS assessment, dated 9/11/13, documented in part:</p> <ul style="list-style-type: none"> * Cognitively intact with a BIMS score of 15; * Extensive assist with one person for bed mobility, transfers, dressing, toilet use, and personal hygiene; * Functional limitation in range of motion with impairment on both sides of the upper extremities and impairment on one side of the lower extremities; * On a toileting program for bladder and bowel; * Frequently incontinent of bladder and always continent of bowel; * Mood Total Severity Score of 0 and absence of behaviors; and, * No antipsychotic, antianxiety, hypnotic, or antidepressant medication received during the last 7 days. <p>a. A Bowel and Bladder Care Plan, dated 2/12/10, documented in part:</p> <ul style="list-style-type: none"> * Problems - Resident was unable to transfer on/off toilet without assist of one, required extensive assist of one with hygiene tasks, resident was frequently incontinent of bladder, has had history of bowel incontinence, constipation, and Parkinson's; and * Approaches - Provide every 3 hour toileting to keep resident clean and dry. Resident can pivot on/off toilet with assist of one. Staff to toilet 	F 514	<p>What measures will be put into place/systemic changes to prevent recurrence.</p> <p>CNAS inserviced on process of documenting prompted toileting correctly under Prompted Voiding and which residents are on prompted voiding. Licensed Staff and Social Services inserviced on discontinuing the side effect monitoring on the orders and the careplan when the antidepressant is discontinued.</p> <hr/> <p>Monitoring to ensure deficiency does not recur</p> <p>Social Services and Unit Managers audited residents on antidepressants to ensure careplan matches MAR. Audits to will occur <u>weekly times 3 months with behavior management meeting.</u></p>	
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F 514	<p>Continued From page 43</p> <p>resident every morning daily for scheduled bowel movements after breakfast.</p> <p>On 10/23/13 at 10:10 a.m., LN #10 was interviewed regarding Resident #4's prompted voiding program. When asked how she knows staff are providing prompted voiding attempts for the resident she said she interviews the resident and staff, and assesses the resident's needs and desires quarterly. The LN pulled up the Rita program (electronic documentation program for facility staff) on the computer and stated, "Should be marking here" and showed the surveyor where the staff should be marking they completed the prompted voiding task on a Bladder Monthly Flow Report. When asked if the CNAs were documenting the task as complete LN #10 stated, "No, the CNAs aren't."</p> <p>The Bladder Monthly Flow Report for October 2013 for Resident #4 had a section for staff to document Bladder, Bladder Retraining, and Prompted Voiding. The section for Prompted Voiding had one check mark for the date of 10/6/13 on the night shift. No other dates or shifts had check marks in them indicating staff had completed the task.</p> <p>A Progress Note for Resident #4, dated 9/13/13 and written by LN#10, documented in part: * "Resident's assessment shows resident is continent of bowel and remains frequently incontinent of urine. Resident has refused bladder retraining program and denies s/s [signs and symptoms] urinary retention or infection. Resident prefers [every] 3 hour prompted toileting and [every] AM and PM scheduled toileting in attempt to decrease urinary incontinence and remain continent of bowel."</p>	F 514	<p>Prompted Voiding Documentation audits will be done by Restorative Nurse or Designee to ensure accuracy and completeness <u>3 days per week times 1 month then 2 days per week times 1 month then 1 day per week times 1 month.</u> ✓</p> <p>Audits to begin on <u>11/15/13</u></p> <p>Director of Nursing will bring audits to QA/PI for review monthly times 3 months. Ongoing education/audits will be scheduled based on trends.</p> <p>Date of Compliance 11/29/13</p>	
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F 514	<p>Continued From page 44</p> <p>Note: The MDS assessment indicated Resident #4 was frequently incontinent of bladder. The care plan documented that the resident was to be prompted to void every 3 hours. The assessment completed by LN #10 in the Progress Notes documented the resident preferred to be prompted to void every 3 hours. However, it was unclear if the prompted voiding was occurring because of incomplete documentation.</p> <p>b. Resident #4's October 2013 recapitulated Physician's Orders documented in part: * 3/16/12 - Monitor every shift for side effects of antidepress[ant].</p> <p>Resident #4's Mood Care Plan, dated 9/28/12, documented in part: * Problems - Resident has diagnosis of dementia and depression with the potential for alteration in mood state; * Approaches - Observe effectiveness/side effects of medications as ordered.</p> <p>The October 2013 MAR (Medication Administration Record) for Resident #4 documented in part to "Monitor every shift for side effects of antidepress[ant]," dated 3/16/12. The night, day, and evening shift boxes from 10/1/13 through 10/22/13 all had LN initials which indicated they had completed the task of monitoring for side effects of an antidepressant.</p> <p>On 10/23/13 at 9:40 a.m., LN #4 was asked which antidepressant medication was being monitored for Resident #4 at which she replied, "She's not on one."</p> <p>Note: Resident #4 was not receiving any</p>	F 514		
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TG 11/20/13

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

PRINTED: 11/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON		STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID 83501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 45</p> <p>antidepressant medication. However, LNs documented they were monitoring for side effects of an antidepressant medication.</p> <p>On 10/24/13 at 5:32 p.m., the Administrator and DON were informed of the inaccurate and incomplete documentation. However, no further information or documentation was provided that resolved the issue.</p> <p>2. Resident #7 was originally admitted to the facility on 2/28/13, and readmitted on 9/23/13, with multiple diagnoses including Pneumonia, Sepsis, and Dementia.</p> <p>Resident #7's MDS Significant Change assessment, dated 9/30/13, documented in part: *Cognition was severely impaired with a BIMS score of 3. *Extensive assistance needed of 1 person for bed mobility, transfers, location off the unit, toileting, hygiene and bathing. *Balance during transitions and walking was not steady, only able to stabilize with staff assistance for moving from seated to standing position, moving on and off toilet and surface-to-surface transfers (transfer between bed and chair or wheelchair). *On current bladder toileting program. *Frequently incontinent of bladder.</p> <p>Resident #7's Bowel & Bladder Care Plan, dated 9/27/13, documented in part: * Problems - Resident requires assist of one with transfers on/off toilet due to generalized weakness/deconditioning due to pneumonia, extensive assist with hygiene tasks secondary to</p>	F 514		

TG 11/24/13

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

PRINTED: 11/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID 83501		
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F 514	<p>Continued From page 46</p> <p>memory loss, mixed/functional frequent urinary incontinence and history of frequent bowel incontinence, constipation.</p> <p>*Approaches - Provide every 2-3 hour prompted toileting during waking hours and PRN (as needed) resident request in an attempt to decrease urinary incontinence.</p> <p>Resident #7's Restorative Nursing note, dated 10/1/13 at 11:40 AM, documented, "Resident to continue with Q (every) 2-3 hour prompted toileting during waking hours and PRN resident request in attempt to decrease urinary incontinence."</p> <p>On 10/24/13 at 10:00 AM, LN #10 was interviewed regarding Resident #7's prompted toileting program. LN #10 confirmed Resident #7 was on a toileting program and printed the resident's Bladder Monthly Flow Report in the computer for the month of October. LN #10 showed the surveyor the flow report, which documented just two (2) day shift and two (2) evening shift boxes marked for the month of October. LN #10 stated, "CNA staff should be marking the boxes in the prompted voiding section but they aren't doing it. If the box isn't checked then it wasn't done that shift." LN #10 stated "Resident #7's daughter is very involved and will check to see when the resident was last toileted."</p> <p>3. Resident #8 was admitted to the facility on 7/8/13, due to surgical intervention of a right hip and proximal femur fracture, which resulted from a fall, with diagnoses of aftercare for healing of a traumatic fracture of right upper leg, muscle weakness, dysphagia, pain and anemia.</p>	F 514			

TG 11/20/13

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON		STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID 83501		
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F 514	<p>Continued From page 47</p> <p>Resident #8's most recent Significant Change MDS assessment, dated 9/22/13, documented in part:</p> <ul style="list-style-type: none"> * Cognition was severely impaired, BIMS Score of 5. * Extensive assist of 2+ persons for toilet use. * Total dependence with assist of 2+ persons for transfers and bathing. * Extensive assist of 1 person for bed mobility and dressing. * Balance during transitions and walking was unsteady, only able to stabilize with staff assistance for moving on and off toilet and surface-to-surface transfer (transfer between bed and chair on wheelchair). * Functional limitation of range of motion in the lower extremity. * Frequently incontinent of bladder. * On current toileting program. * Always incontinent of bowel. <p>Resident #8's Bowel & Bladder Care Plan, dated 9/16/13, documented in part:</p> <ul style="list-style-type: none"> * Problems - Resident requires assist of two persons with Hoyer lift for all transfers on/off toilet secondary to right femur fracture, constipation, frequent bowel and bladder incontinence. * Approaches - Provide Q 2-3 hour prompted toileting in attempt to decrease urinary incontinence. **Resident may refuse, if this occurs provide scheduled check and change, to keep clean and dry upon arising, before and after meals, HS (bedtime) and PRN. - Notify Restorative LN if any change of bowel and or bladder pattern. - Restorative LN to assess per facility protocol. <p>On 10/24/13 at 3:25 PM, LN #10 was interviewed</p>	F 514		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	<p>Continued From page 48</p> <p>regarding Resident #8's prompted toileting program. LN #10 stated Resident #8 was toe touching weight bearing, hopping gait and confirmed the resident was on a toileting program. LN #10 printed the resident's Bladder Monthly Flow Report for the month of October. LN #10 showed the surveyor the flow report, which documented just four (4) evening shift boxes marked for the month of October. However, there was no documentation for the day shift for the month of October. LN #10 stated, "CNAs are not charting or they don't understand what the appropriate charting is for this intervention. This shows I need to do some inservices."</p> <p>On 10/24/13 at 5:32 PM, the Administrator and DON were informed of the documenting issues with the toileting program. No further information was provided.</p>	F 514		

TG 11/20/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001410	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2013
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NAME OF PROVIDER OR SUPPLIER: STREET ADDRESS, CITY, STATE, ZIP CODE

LIFE CARE CENTER OF LEWISTON **325 WARNER DRIVE**
LEWISTON, ID 83501

(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
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C 000 16.03.02 INITIAL COMMENTS

The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.

The following deficiencies were cited during the State licensure survey of your facility.

The surveyors conducting the survey were:

Karen Marshall, MS, RD, LD Team Coordinator
Bradley Perry, LSW, BSW
Lauren Hoard, RN, BSN
Rebecca Thomas, RN

Survey Definitions:

DON/DNS = Director of Nursing/Director of Nursing Services

C 000

RECEIVED
NOV 21 2013
FACILITY STANDARDS

C 099 02.009 CRIMINAL HISTORY AND BACKGROUND CHECK REQUIRE

01. Criminal History and Background Check. A skilled nursing and intermediate care facility must complete a criminal history and background check on employees and contractors hired or contracted with after October 1, 2007, who have direct patient access to residents in the skilled nursing and intermediate care facility. A Department check conducted under IDAPA 16.05.06, " Criminal History and Background Checks, " satisfies this requirement. Other criminal history and background checks may be accepted provided they meet the criteria in Subsection 009.02 of this rule and the entity conducting the check issues written findings. The entity must provide a copy of these written findings to both the facility and the employee.

C 099

Corrective Action for Specific Residents

There were no specific residents affected ✓

Other Residents Affected ✓

All residents in the facility had the potential to be affected by this practice and the facility is checking and retaining the criminal history checks with in 21 days of hire. Current employee files have been audited to ensure file contains copy of criminal history check.

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Mary Hall

Executive Director

11/20/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001410	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID 83501
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C 099	<p>Continued From page 1</p> <p style="text-align: right;">(3-26-08)</p> <p>02. Scope of a Criminal History and Background Check. The criminal history and background check must, at a minimum, be a fingerprint-based criminal history and background check that includes a search of the following record sources: (3-26-08)</p> <p>a. Federal Bureau of Investigation (FBI); (3-26-08)</p> <p>b. Idaho State Police Bureau of Criminal Identification; (3-26-08)</p> <p>c. Sexual Offender Registry; (3-26-08)</p> <p>d. Office of Inspector General List of Excluded Individuals and Entities; and (3-26-08)</p> <p>e. Nurse Aide Registry. (3-26-08)</p> <p>03. Availability to Work. Any direct patient access individual hired or contracted with on or after October 1, 2007, must self-disclose all arrests and convictions before having access to residents. The individual is allowed to only work under supervision until the criminal history and background check is completed. If a disqualifying crime as described in IDAPA 16.05.06, "Criminal History and Background Checks," is disclosed, the individual cannot have access to any resident. (3-26-08)</p> <p>04. Submission of Fingerprints. The individual's fingerprints must be submitted to the entity conducting the criminal history and background check within twenty-one (21) days of his date of hire. (3-26-08)</p> <p>05. New Criminal History and Background Check. An individual must have a criminal history and background check when: (3-26-08)</p> <p>a. Accepting employment with a new employer; and (3-26-08)</p>	C 099	<p>What measures will be put into place/systemic changes to prevent recurrence.</p> <p>All staff were inserviced on Abuse ✓ and Neglect including the screening policy. The Payroll Manager, Staffing Coordinator, Executive Director, Business Office Manager, Director of Nurses, and Staff Development Coordinator have been inserviced on their roll in the hiring process in particular C099 Criminal History and Background Check Requirements. The inservice included the requirement to retain the documentation showing that the employees fingerprints were checked within 21 days of hire.</p> <p>Monitoring to ensure deficiency does not recur</p> <p>The Executive Director or Business office Manager will audit new hire ✓ <u>personal files weekly for 3 months to ensure that the criminal history checks were checked within 21 days of hire and there is a copy in the employee file.</u></p>	

TG 11/20/13

Bureau of Facility Standards

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C 099	<p>Continued From page 2</p> <p>b. His last criminal history and background check was completed more than three (3) years prior to his date of hire. (3-26-08)</p> <p>06. Use of Criminal History Check Within Three Years of Completion. Any employer may use a previous criminal history and background check obtained under these rules if: (3-26-08)</p> <p>a. The individual has received a criminal history and background check within three (3) years of his date of hire; (3-26-08)</p> <p>b. The employer has documentation of the criminal history and background check findings; (3-26-08)</p> <p>c. The employer completes a state-only background check of the individual through the Idaho State Police Bureau of Criminal Identification, and (3-26-08)</p> <p>d. No disqualifying crimes are found. (3-26-08)</p> <p>07. Employer Discretion. The new employer, at its discretion, may require an individual to complete a criminal history and background check at any time, even if the individual has received a criminal history and background check within the three (3) years of his date of hire. (3-26-08)</p> <p>This Rule is not met as evidenced by: Based on review of the facility's abuse policies and procedures, staff personnel files, and staff interviews, it was determined the facility failed to ensure criminal history checks for staff were checked within 21 days of hire. This affected 3 of 5 (A, D, & E) staff reviewed for criminal history checks. Findings included: The facility abuse policy and procedures under</p>	C 099	<p>Executive Director will bring the results of audits to QA/PI for review. Ongoing audits or education will be based on trends identified. Audits to begin <u>11/15/13</u>.</p> <p>Date of Compliance <u>11/29/13</u></p>	

TG 11/20/13

Bureau of Facility Standards

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C 099	<p>Continued From page 3</p> <p>the section entitled Background Checks dated 3/25/10, documented in part the following: "[Facility Company Name] conducts post-offer background checks on all new associates. These background checks include the following...Criminal history search for the last seven years based on counties of residence."</p> <p>On 10/24/13 at 6:00 AM five employee personnel files were reviewed for Idaho Criminal History Unit background checks. It was determined all five had a Notice of Clearance letter and a screen print of the Idaho Criminal History Unit Applicant Status webpage, all dated 10/23/13, indicating the criminal history checks were completed a day prior.</p> <p>On 10/24/13 at 10:55 AM the Staffing Coordinator along with the Payroll Manager, Office Manager, Regional Vice-President, and Regional Director of Clinical Services were interviewed regarding criminal history checks. When asked if the facility checked with the Idaho Criminal History Unit within 21 days of hire, the Staffing Coordinator said they did. When asked if they kept a copy of the original Notice of Clearance letter as proof of clearance, she stated, "No, because I keep a log."</p> <p>On 10/24/13 at 12:00 PM the Payroll Manager provided a facility document entitled Criminal History Background Check Worksheet New Hires (log) as of October 1, 2005. The worksheet contained handwritten staff names of the five staff in question with dates of criminal history checks conducted with the word "cleared" next to each name under the heading Applicant Status.</p> <p>On 10/24/13 at 1:25 PM the Payroll Manager provided documented proof for two of the staff in</p>	C 099		
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C 099	Continued From page 4 question, but could not provide documentation for Staff A, D, or E to resolve the concern. Dates of Hire were: Staff A 8/1/13, Staff D 9/26/13, and Staff E 9/26/13. On 10/24/13 at 5:30 PM, the Administrator, DON, the Regional Vice-President, and the Regional Director of Clinical Services were informed of the issue. No further information was provided.	C 099		
C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please refer to F241 as it related to referring to residents who require assistance with dining as feeders.	C 125	C125 Refer to F241	
C 311	02.107,07 FOOD PREPARATION AND SERVICE 07. Food Preparation and Service. Foods shall be prepared by methods that conserve nutritive value, flavor and appearance, and shall be attractively served at proper temperatures. This Rule is not met as evidenced by: Refer to F364 as it related to low food temperatures and overcooked cauliflower.	C 311	C311 Refer to F364	
C 669	02.150,03 PATIENT/RESIDENT PROTECTION 03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance	C 669	C669 Refer to F441	

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C 669	Continued From page 5 in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Refer to F441 as it related to infection control to prevent spread of infection.	C 669		
C 745	02.200,01,c Develop/Maintain Goals/Objectives c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Refer to F281 as it related to initialing a medication as administered prior to administration and discarding a medication in the trash receptacle.	C 745	C745 Refer to F 281	
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: Refer to F280 as it related to care plan revision to reflect resident's current status.	C 782	C782 Refer to F 280	
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to:	C 784	C 784 Refer to F 309	

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C 784	Continued From page 6 This Rule is not met as evidenced by: Refer to F309 as it related to following physician orders to provide necessary care.	C 784		
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 related to pressure ulcers.	C 789	C789 Refer to F 314	
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F323 as it related to accidents/falls.	C 790	C 790 Refer to F323	
C 832	02.201,02,f Labeling of Medications/Containers f. All medications shall be labeled with the original prescription legend including the name and address of the pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.) This Rule is not met as evidenced by: Refer to F431 as it related to accurate labels on	C 832	C832 Refer to F431	

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Bureau of Facility Standards

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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 832	Continued From page 7 medications.	C 832		
C 835	02.201,02,i Meds in Possession of Resident Limitations i. No medication shall be in the possession of the patient/resident unless specifically ordered by the physician on the patient's/resident's medical record, and in no case shall exceed two (2) units of dosage. All such medications shall be individually packaged by the pharmacist in units of dose, labeled with the patient's/resident's name, unit of dose, and date of distribution. The charge nurse shall maintain an inventory of these drugs on the patient's/resident's medical record. This Rule is not met as evidenced by: Refer to F176 as it related to leaving a resident unattended during a nebulizer breathing treatment.	C 835	C835 Refer to F176	
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 as it related to complete and accurate medical records.	C 881	C881 Refer to F514	

TG 11/20/13