



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

FILE COPY

CERTIFIED MAIL: 7012 3050 0001 2125 5976

November 19, 2014

Jason D. Jensen, Administrator
Riverview Rehabilitation
3550 West Americana Terrace,
Boise, ID 83706-4728

Provider #: 135139

Dear Mr. Jensen:

On **November 5, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Riverview Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 2, 2014**. Failure to submit an acceptable PoC by **December 2, 2014**, may result in the imposition of civil monetary penalties by **December 22, 2014**.

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

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

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

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

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

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

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 5, 2015**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare &

Jason D. Jensen, Administrator
November 19, 2014
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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 Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **December 2, 2014**. If your request for informal dispute resolution is received after **December 2, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor
Long Term Care

LKK/dmj
Enclosures

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

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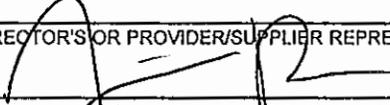
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2014
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 WEST AMERICANA TERRACE BOISE, ID 83706
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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>This report reflects changes resulting from the January 15, 2015 Informal Dispute Resolution (IDR) process.</p> <p>The surveyors conducting the survey were: ----Lauren Hoard, RN BSN -Team Coordinator Judy Atkinson, RN Sherri Case, LSW QMRP Susan Gollobit, RN Kirsti Stephenson, RN BSN</p> <p>The survey team entered the facility on 11/3/14 and exited on 11/5/14.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse LPM = Liters Per Minute MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed RD = Registered Dietician SLP = Speech Language Pathologist TAR = Treatment Administration Record</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Riverview Rehabilitation does not admit that the deficiencies listed on HCFA 2567 exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies".</p>	
F 154 SS=D	<p>483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS</p> <p>The resident has the right to be fully informed in</p>	F 154	<p><u>F 154</u></p> <p>Resident #2 discharged from the facility.</p>	12/8/14

RECEIVED
FEB - 9 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	12/02/2014

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

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F 154	<p>Continued From page 1</p> <p>language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</p> <p>The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.</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 residents were informed of the FDA Black Box warning for the use of an anticonvulsant medication. This was true for 1 of 6 residents (# 2) sampled for medication use. The deficient practice had the potential to cause harm when the resident was not provided with the opportunity to make informed decisions about the risks and benefits of the use of the medications. Findings included:</p> <p>Wolters Kluwer Nursing 2015 Drug Handbook, page 1439, documented for divalproex sodium: "Black Box Warning. Cases of life-threatening pancreatitis have been reported in children and adults receiving valproate shortly after initial use, as well as after several years use..."</p> <p>Resident #2 was admitted to the facility on 10/11/15 with diagnoses which included seizure disorder.</p> <p>Resident #2's Order Summary Report for 10/11/14 through 11/30/14 included an order for Divalproex Sodium Tablet Delayed Release (anticonvulsant) 500 mg at bedtime for seizures</p>	F 154	<p>All patients on medications with black box warnings have the potential to be affected.</p> <p>In-service conducted regarding, notification and education of patients on medications with black box warnings. Education included written and verbal education to be provided to patients upon admission and change in medication regimen.</p> <p>Will sustain compliance by adding verbal and written education to patient upon nursing admission process. Further, nurse will provide written and verbal education to patient with introduction of black box warning medications.</p> <p>Black Box warning education audit tool implemented. Audit will be conducted by DON or designee 3 patients per week for 2 months. Changes will also be brought to weekday stand up meeting.</p>		

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F 154	Continued From page 2 with an order date of 10/11/14. Resident #2's record did not document the resident had been informed of the potential for life threatening pancreatitis (Black Box warning) for the use of the medication On 11/4/14 at 3:05 PM, the DON stated the facility informed residents of the Black Box warning for antipsychotic medication but was unaware the resident had to be informed of Black Box warnings for all medications. On 11/5/14 at 4:05 PM, the Administrator and DON were informed of these findings. The facility offered no further information.	F 154	Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for	F 156	<u>F 156</u> All current residents were notified that they had the right to review the results of the most recent survey of the facility. All residents have the potential to be affected. The facility's admission agreement was updated with the resident's right to review the results of the most recent survey of the facility.	12/8/14	

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F 156	<p>Continued From page 3</p> <p>which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control</p>	F 156	<p>Administrator or designee will conduct a random weekly audit on 3 new admission (or all admissions for the week if less than 3) per week for 1 month to ensure that new residents were informed of their right to review the facilities most recent survey.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p>	
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F 156	<p>Continued From page 4</p> <p>unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility's Admissions Agreement and staff interview, it was determined the facility did not inform residents of all of their rights at the time of admission. This was true for any resident admitted to the facility. Findings included:</p> <p>The facility's Admission Agreement did not include the Resident had the right to review the results of the most recent survey of the facility. An Attachment D-Residents' Rights, included with the Admit Agreement, listed 23 rights, however it did not include the resident had the right to review the most recent survey.</p> <p>On 11/4/14 at 4:30 p.m. the Administrator and the</p>	F 156			

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F 156	Continued From page 5 DON were informed of the above concern. The facility provided no further information.	F 156		
F 226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview it was determined the facility failed to ensure employees were trained on appropriate interventions to deal with aggressive and/or catastrophic reactions of residents. This was true for 4 of 5 staff interviewed (A, B, C and D) and had the potential for harm when staff were not trained on how to intervene when residents had a physical/verbal altercation. Findings included.</p> <p>Guidance at F 226 included the facility must have procedures to train employees, through orientation and on-going sessions, on appropriate interventions to respond to residents with aggressive and/or catastrophic reactions.</p> <p>The facility's 004 Abuse Prevention Program Policy documented staff would be trained on how to respond to violent behavior or catastrophic reactions.</p> <p>On 11/3/14 and 11/4/14, five staff representing all shifts were interviewed about training on what to do if residents were having a catastrophic</p>	F 226	<p><u>F 226</u></p> <p>All current staff were educated on the facilities policy and procedure on appropriate interventions to deal with aggressive and/or catastrophic reactions of residents. Education not completely understood by all staff members, and implemented appropriately.</p> <p>All residents have the potential to be affected.</p> <p>The facility's staff were educated on the facilities policy and procedure on appropriate interventions to deal with aggressive and/or catastrophic reactions of residents. New hire checklist to include written and verbal education regarding aggressive and/or catastrophic events per policy and procedure, and CMS guidelines has been instituted.</p>	12/8/14

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F 226	Continued From page 6 reaction such as two residents in a physical altercation. Two of the five staff interviewed stated they had not been trained by this facility, but had been trained when employed by another facility. Two other staff stated they would not intervene but report the resident to resident altercation to a nurse or nursing staff. On 11/4/14 at 3:05 PM, the DON stated if any staff observed a resident to resident altercation the staff should separate the residents and use the call light to get assistance. On 11/4/14 the Administrator stated the facility provided training on how to intervene in a resident to resident altercation during orientation and at "all -staff" meetings. Later that day, the Administrator provided an "Employee Orientation Checklist" which documented abuse reporting was reviewed. The form did not specify training was received on what to do when a resident was having a catastrophic reaction. The Administrator also provided a 9/25/14 Mandatory "All-Staff Meeting" agenda with general agenda topics. The agenda documented "cleanliness and patient care" training but did not include any information regarding resident to resident altercations or abuse.	F 226	Administrator or designee will conduct a random weekly audit on 3 staff per week for 2 months to ensure that they know appropriate interventions to deal with aggressive and/or catastrophic reactions of residents. Meetings throughout the year will provide real life examples and education regarding said events. Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279	<u>F 279</u> Resident #2 and 6 have discharged from the facility. All residents have the potential to be affected. Sufficient	12/8/14	

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F 279	<p>Continued From page 7</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</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 comprehensive care plans included interventions used to prevent pressure ulcers and incontinence care. This was true for 2 of 9 (#s 2 & 6) sampled residents. This created the potential for skin breakdown when staff did not have direction to ensure a pressure reducing cushion was in Resident #2's wheelchair, and created the potential for Resident #6 to acquire urinary tract infections, skin breakdown and decreased bladder function. Findings included:</p> <p>1. Resident #6 was admitted to the facility on 10/1/14 with multiple diagnoses which included specified rehabilitation procedure and acute kidney failure.</p>	F 279	<p>education regarding specifics of appropriate care planning was lacking</p> <p>Nursing staff were educated on properly updating resident care plans to include interventions used to prevent pressure ulcers and incontinence care. DON or designee will conduct a random weekly audit on 3 resident care plans per week for 2 month to ensure that comprehensive care plans have been updated to include interventions used to prevent pressure ulcers and incontinence care.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN. Nursing meetings throughout year will address ongoing care planning education.</p>		

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F 279	<p>Continued From page 8</p> <p>The admission MDS assessment, dated 10/8/14, documented Resident #6 was cognitively intact with a BIMS of 15, required extensive assistance of 1 person for transfers and toileting, and had occasional bladder incontinence with no toileting program in place.</p> <p>The Care Plan for Resident #6, dated 10/1/14, documented a focus area of occasional bladder incontinence related to impaired mobility. The interventions included:</p> <ul style="list-style-type: none"> * Monitoring/documenting/reporting to physician possible medical causes of incontinence, * Monitoring/documenting signs and symptoms of a urinary tract infection, and * Encouraging use of the call light to request assistance with toilet use. <p>A Nursing Admit Assessment, dated 10/1/14, documented Resident #6 used the toilet for voiding, was continent and dribbled at times.</p> <p>On 11/3/14 at 10:30 a.m., the DON was asked what was done for Resident #6's bladder incontinence and he stated, "I don't know, I'll get back to you. I'm sure we're doing something." The DON reviewed the resident's care plan and did not find toileting instructions. The DON said the resident would alert staff of the need to void at times and, "Generally will be checked on during rounds." After the DON reviewed CNA documentation in the computer system he said the resident was prompted to toilet every 2 hours and, "I must have forgot to put it on there [care plan]." The DON provided CNA documentation in which the resident was prompted to toilet.</p> <p>On 11/4/14 at 4:25 p.m., the Administrator and DON were informed of the care plan concerns</p>	F 279			

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F 279	Continued From page 9 related to bladder incontinence interventions. No further information or documentation was provided. 2. Resident #2 was admitted to the facility on 10/11/15 with diagnoses which included a wound to the left ankle. The resident's 10/14/14 Care Plan documented an unstageable pressure ulcer on her left ankle. Interventions included: Pressure relieving mattress; Nutritional supplements; Medications as ordered; Assess wound healing; and Report changes to physician. On 11/3/14 at 10:10 a.m. and 11:45 a.m., the resident was observed sitting in her wheelchair, which had a pressure relieving cushion. On 11/4/14 at 3:05 p.m., the DON stated the resident used a pressure relieving cushion and it should be in the care plan.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280	<u>F 280</u> Resident #4's care plan was updated to remove interventions no longer in place. All residents have the potential to be affected. More detailed	12/8/14

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F 280	<p>Continued From page 10 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 each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure the care plan was updated for 1 (#4) of 9 residents reviewed for care plans. The deficient practice had the potential to cause more than minimal harm when resident #4's care plan was not updated to reflect interventions no longer in place. Findings include:</p> <p>Resident #4 was admitted to the facility on 9/2/14 with diagnoses that included streptococcus infection and depression.</p> <p>The resident's current physician orders documented: *Citalopram Hydrobromide (antidepressant) 20 mg by mouth one time a day. The order status documented the medication was "discontinued." *Monitor for depression: The order status</p>	F 280	<p>education on care planning specifics has been instituted. Continued education regarding appropriate care planning will occur in nursing meetings</p> <p>Nursing staff were educated on properly updating resident care plans to remove interventions no longer in place. DON or designee will conduct a random weekly audit on 3 resident care plans per week for 2 months to ensure that comprehensive care plans have been updated to remove interventions no longer in place.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p>		

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F 280	<p>Continued From page 11</p> <p>documented the medication was "discontinued." *Keflex (antibiotic) 500 mg (milligrams) by mouth three times a day. The end date was 10/13/14. *Penicillin G Potassium (antibiotic) 20 million units intravenously one time a day. The end date was 9/15/14. *Cipro tablet (antibiotic) 500 mg by mouth two times a day. The order status documented the medication was "discontinued."</p> <p>The resident's care plan documented: *Focus plan for being treated for a group G streptococcus infection with interventions that included give antibiotics as ordered; give antipyretics and analgesics for comfort measures and document side effects. Date initiated on 9/3/14. *Focus plan for resident uses Citalopram for depression and trazadone for sleep with interventions which included give antidepressant medications ordered by the physician; monitor side effects of the medication and ongoing signs and symptoms of depression. Date initiated on 9/3/14.</p> <p>On 11/4/14 at 2:35 PM, the DON was asked if the resident was still on antibiotics for an infection and why was it still on the care plan. The DON stated the resident was not on an antibiotic and the focus and interventions should have been resolved. The DON was asked if the resident was still on an antidepressant and whether she was supposed to be monitored as the care plan documented. The DON stated the focus of depression with trazadone for sleep with the interventions of giving the medication for depression, and for monitoring signs and symptoms of depression and side effects of the antidepressant should have been resolved.</p>	F 280		

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F 280	Continued From page 12	F 280			
F 281 SS=D	<p>On 11/5/14 at 4:30 PM, the Administrator and DON were notified of the findings. No additional information was provided.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, it was determined the facility failed to notify a resident ' s physician of a skin wound, performed an unauthorized invasive procedure to that wound, and then failed to notify the physician that the procedure had been performed.</p> <p>This was true for 1 of 9 (#5) residents sampled for physician notification when a resident had a change in condition which required treatment. The deficient practice had the potential to cause more than minimal harm if resident #5 continued to experience changes without an evaluation by a physician. Findings included:</p> <p>Resident #5 was admitted to the facility on 9/12/14 with diagnoses that included other specified rehabilitation procedure, aftercare healing traumatic fracture other bone, and rheumatoid arthritis.</p> <p>The resident's admission MDS, dated 9/19/14, documented the resident's cognition was intact.</p> <p>The Resident's initial Care Plan (CP) documented</p>	F 281	<p><u>F 281</u></p> <p>Resident #5's status of the wound to the left heel and performing of the invasive procedure was reported to medical provider. Licensed nurse failed to receive order prior to implementing intervention.</p> <p>All residents have the potential to be affected.</p> <p>Nursing staff were educated on properly notifying physician of skin wounds and getting orders to perform invasive procedures to those wounds. Nurses will notify provider, receive order, ensure order is within nursing scope of practice, implement procedure if within scope of practice, and notify provider of completion of intervention. This was found to be a sentinel event and all nursing staff was re-educated on correct policy and procedure. One-to-one education was provided to nurse involved in cited event.</p>	12/8/14	

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F 281	<p>Continued From page 13</p> <p>on 9/12/14, a focus for "pressure ulcer or potential for pressure ulcer development r/t (related to) immobility and bladder incontinence." Interventions include:</p> <p>*Monitor/document/report to MD PRN changes in skin status: appearance, color, wound healing, s/sx (signs and symptoms) of infection, wound size, stage. Date initiated 9/12/14.</p> <p>The resident's Skin Assessment's documented as follows: *Initial Assessment 9/12/14: "pink area on heel .50cm (centimeter) x .50cm, fully blanch-able" on left heel.</p> <p>The resident's LNP (Licensed Nurse Progress Notes), dated 10/25/14 at 10:32 PM, documented, "Patient c/o (complaint of) left heel tenderness this evening. I removed her sock and found a large dry/callous and an open area that measures approximately 2cm x 2.5cm in size. Scant amount pinkish drainage, no odor, no s/s (signs and symptoms) infection noted. Periwound skin is pink and dry. Cleansed wound with cleanser, applied antibiotic ointment, and covered with coversite dressing. Will continue to monitor."</p> <p>NOTE: The facility staff failed to notify the physician of the changes to the skin status of the resident's left heel.</p> <p>On 11/4/14 at 2:00 PM, the DON was interviewed regarding the physician orders for treatment, which was provided to Resident #5 on 10/25/14. The DON stated, "I wasn't aware she had a wound, but we have standing orders to treat wounds."</p>	F 281	<p>DON or designee will conduct a random weekly audit on physician notification for 2 resident's changes to skin wounds and orders for 2 months. Audit will ensure nurse will provide intervention within scope of practice and policy and procedure is followed appropriately.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p>		

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F 281	Continued From page 14 On 11/5/14 at 8:35 AM, the DON provided a copy of the facility's Standing Orders which documented as follows: *May apply antibiotic ointment to wounds PRN signs/symptoms of infection. On 11/5/14 at 11:15 AM, LN #3 was observed to assess the left heel of Resident #5. During the assessment, LN #3 explained, "They cut the skin flap off last week because it was just hanging there and we didn't want the skin to tear." When asked if this treatment was documented, LN #3 responded, "Not by me, I didn't cut the flap off, the MDS coordinator is the one who did it." On 11/5/14 at 11:55 AM, the MDS Coordinator was interviewed regarding treatment to the left heel of Resident #5. He stated, "I cut it off last week, Tuesday, Wednesday, or Thursday, I don't remember but it was within the last week. I should have documented it, but I don't know if I did. [LN#3] dressed the wound with Optifoam." When asked if there was an order to remove the skin and whether the physician notified, he stated, "No, there wasn't an order and the physician was not notified." NOTE: There was no documentation to indicate the physician was notified of the open wound or the necessity to provide treatment. Additionally, there was no physician's order to perform an invasive procedure to the wound on the resident's left heel. On 11/5/14 at 4:25 PM, the Administrator and the DON were notified of the findings. No additional information was provided.	F 281			
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309	<u>F 309</u> Resident #3 and 10 have discharged from the facility.		12/8/14

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F 309 SS=D	<p>Continued From page 15 HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure Physician's Orders were followed for physician notification of weight changes overnight and the Frazier Free Water Protocol. This was true for 2 of 10 (#s 3 & 10) sampled residents. This created the potential for harm when Resident #2 lost 4 pounds overnight and the physician was not notified, and when Resident #10 did not receive thin liquids one time per day as ordered per the Frazier Free Water protocol. Findings included:</p> <p>1. Resident #3 was admitted to the facility on 9/2/14 with multiple diagnoses which included cerebrovascular disease and cardiomyopathies.</p> <p>The admission MDS assessment, dated 9/8/14, documented Resident #3 was cognitively intact with a BIMS of 15, had range of motion impairments on one side of the upper and lower extremities and no weight loss or gain.</p> <p>The October 2014 TAR for Resident #3 documented an order for daily weights and to notify the physician of a weight change greater than 2 to 3 pounds overnight or 5 pounds in 1</p>	F 309	<p>All residents have the potential to be affected. Deficient practice found: insufficient weighing procedures and lack of documentation regarding Frazier Free Water Protocol. There was found to be lack of education for staff to understand policy and procedure and to perform procedures accordingly.</p> <p>Nursing staff were educated on properly notifying physician of weight changes and properly documenting when thin liquids are given per the Frazier Free Water protocol. Weighing procedures modified for consistency and reliability, and systems put into place for weight verification and provider reporting.</p> <p>DON or designee will conduct a random weekly audit on 4 resident's changes to weight and 1 resident on the Frasier Free Water protocol (if a resident has the Frasier Free Water protocol) for 3 months.</p>		

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F 309	<p>Continued From page 16</p> <p>week. On 10/24/14 the weight was documented as 140 pounds. The following day, on 10/25/14, the weight was documented as 136 pounds.</p> <p>On 11/4/14 at 9:35 a.m., the Dietary Director was interviewed and said when one weight was significantly higher or lower she notified the DON for follow-through.</p> <p>On 11/4/14 at 9:43 a.m., the DON said when he was notified of a weight change he would inform the provider and RD and follow the resident in NAR (Nutrition At Risk) meetings. When asked if he was notified of the 4 pound weight change for Resident #3 he stated, "I don't remember anyone notifying me." After the DON reviewed information on the computer system he stated, "I don't have a nurse's note to that effect."</p> <p>Resident #3 lost 4 pounds overnight and there was no documented evidence the physician had been notified.</p> <p>On 11/4/14 at 4:25 p.m., the Administrator and DON were informed of the failure to follow Physician's Orders. No further information or documentation was provided.</p> <p>2. Resident #10 was admitted to the facility on 6/25/14 with multiple diagnoses which included vascular dementia and dysphasia.</p> <p>The Medication Review Report (MRR) for Resident #10 documented the order, "Frazier free water protocol. Thin water okay between meals. Meds to be administered with nectar thick liquids. nectar thick liquids at meals. one time a day..." with a start date of 7/1/14.</p>	F 309	<p>Audit will include; verification of weight consistency, significant losses reported accordingly, and interventions put into place to prevent further weight loss. Documentation of Frazier Free Water Protocol is charted in standard nursing progress note and medication administration record.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p>		

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F 309	<p>Continued From page 17</p> <p>The Frazier Free Water Protocol (FFWP) provided by the facility documented, "...It is the allowance of unrestricted water intake between meals and again 30 minutes after a meal in order to promote hydration for patients who are on thickened liquids...Oral care is important to clean bacteria from their mouth and promote good oral hygiene...This is to allow any residue from the meal to clear. Otherwise the food may be washed down into their lungs by the water...All patients are screened with water...Aggressive oral care should be provided to those patients who are unable to clean their own teeth and mouths, so that pathogenic bacteria are less likely to contaminate secretions..."</p> <p>The Care Plan for Resident #10 had an intervention, dated 7/16/14, for the Frazier Free Water Protocol to be observed and supervised by the therapist and SLP, per SLP recommendations.</p> <p>The June 2014 through August 2014 MAR and TAR did not contain documentation the FFWP was provided.</p> <p>Speech Therapy Encounter Notes for Resident #10 documented the FFWP occurred during therapy. On 7/6/14, 7/12/14 and 7/13/14 there was no documentation the FFWP had been provided during therapy.</p> <p>On 11/5/14 at 7:50 a.m., the Administrator and DON were interviewed about the FFWP. They said for people who had dysphasia with possible silent aspiration the SLP evaluated the patient and aggressive oral care would be provided before thin water was provided, and the FFWP would be closely monitored during its</p>	F 309		

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F 309	Continued From page 18 implementation. For Resident #10, the SLP stated she wanted to supervise the FFWP to recognize small changes the resident may have displayed. The Administrator and DON said the FFWP was not to occur without the SLP present. On 11/5/14 at 10:50 a.m., the SLP was interviewed. She said the FFWP involved nursing staff giving thin liquids if oral care was provided. For Resident #10 the SLP did not have CNA staff providing the FFWP to ensure resident safety, but the LNs and therapists could implement the protocol without SLP supervision. On 11/5/14 at 4:00 p.m., the Administrator and DON were informed of the concerns with the FFWP implementation. No further information or documentation was provided.	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 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interview, it was determined the facility failed to provide necessary care for residents at risk for developing pressure ulcers.	F 314	<u>F 314</u> Resident #5's care plan was updated for current skin conditions. All interventions were put into place per physician order. All residents have the potential to be affected if care plan is not updated and ordered interventions are not planned or resolved. The root cause analysis revealed lack of education of care planning interventions and resolution of care plan line.	12/8/14	

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F 314	<p>Continued From page 19</p> <p>This was true for 1 of 3 (#5) sampled residents reviewed for pressure ulcers. The deficient practice had the potential to cause more than minimal harm to resident #5 when the facility failed to implement interventions to prevent the development of pressure ulcers. Resident #5 was admitted with redness to the left heel which developed into an open pressure sore. Findings Include:</p> <p>Resident #5 was admitted to the facility on 9/12/14 with diagnoses that included other specified rehabilitation procedure, aftercare healing traumatic fracture other bone, and rheumatoid arthritis.</p> <p>The Resident's admission MDS Assessment, dated 9/19/14, documented: *Cognition intact *Determination of Pressure Ulcer Risk using Braden Scale and clinical assessment documented the resident is at risk for developing pressure ulcers but did not score for having any unhealed pressure ulcers. *Skin and Ulcer Treatments documented only a pressure reducing device for bed.</p> <p>The Resident's initial Care Plan (CP) documented on 9/12/14 a focus for "pressure ulcer or potential for pressure ulcer development r/t (related to) immobility and bladder incontinence." Interventions included:</p> <p>*Monitor/document/report to MD PRN changes in skin status: appearance, color, wound healing, s/sx (signs and symptoms) of infection, wound size, stage. Date initiated: 9/12/14.</p> <p>*The resident's Nursing Admit Assessment, dated</p>	F 314	<p>Nursing staff were educated on use and updating care plans for pressure relieving devices, risks for further skin issues from improper fitting shoes. Skin nurse will be doing rounding, documentation, and follow up on other nurses documentation and orders. Ensure compliance through revision of policy and procedure to reflect skin nursing rounds.</p> <p>DON or designee will conduct a random weekly audit on 2 residents care plans for 2 months, who are at risk for skin issues, for proper interventions. Audit will ensure resolution of care plan lines and orders. Further, audit will ensure proper interventions are in place to meet client condition.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p>		

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F 314	<p>Continued From page 20</p> <p>9/12/14, documented a score of 13, indicating a Moderate Risk on the Braden Scale for Predicting Pressure Sore Risk.</p> <p>The Resident ' s initial skin assessment documented on 9/12/14, "Left heel pink area on heel .50cm x .50cm, fully blanch-able."</p> <p>A faxed physician order, dated 9/12/14, (no time) documented, "May use Prevalon boots prn for skin prophylaxis."</p> <p>NOTE: Prevalon boots were not included on the CP.</p> <p>Facility Standing Orders include: *Open wounds, "...dress with Mepitel covered with Telfa or Gauze with Tegaderm or Steristrips. Change dressing every 5 days and PRN." *May apply antibiotic ointment to wounds PRN (as needed) signs/symptoms (s/s) of infection.</p> <p>The resident' s Weekly Skin Assessments (WSA) and License Nurse Progress Note (LNP) documented: *9/19/14 WSA, "Left heel .5cm x .5cm pink area on heel fully blanch-able no c/o (complaint of) pain on palpation." *9/26/14 WSA, "Left heel light pink, fully blanch-able .5cm x .5cm area." *10/3/14 WSA, "left heel continues to present with 1.5 cm x 1.5cm area of purple/pink callused area r/t past D/U (decubitus ulcer) that was present on admit - fully blanch-able, no c/o pain." *10/3/14 LNP, "Small purple/pink callus area on left heel 1.5cm x 1.5cm from prior D/U present on admit, blanch-able, no c/o pain, staff and patient re-educated to float heels with pillow during sleep to prevent any skin break down..."</p>	F 314		
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F 314	<p>Continued From page 21</p> <p>*The resident's CP was updated on 10/7/14 to add a pressure relieving mattress after a change in skin integrity to the left heel.</p> <p>NOTE: 10/3/14 WSA and LNPB documented a skin integrity change. The CP did not document interventions to 'float heels at night.'</p> <p>*10/10/14 WSA, 10/17/14 WSA, and 10/31/14 WSA, did not document an assessment of the left heel.</p> <p>*10/10/14 LNPB, "...patient re-educated to make frequent changes in body position while up in chair to help prevent skin issues..."</p> <p>*10/17/14 WSA, "weekly Skin check done. No reddened areas noted. Skin dry/intact."</p> <p>*10/24/14 WSA, "Left heel L)2cm x W)2.5cm area noted, presents as 75%scabbed, 25% red, not fully able to assess blanch-ability due to scabbed area, however, red area noted is fully blanch-able, patient states discomfort on palpation, wound present on admit, patient currently on low air loss mattress [sic], cushion while up in chair and floating heels at night."</p> <p>*10/24/14 WSA, a second assessment, "Heel with dry/callous skin. Open area approximately 2cm x 2.5cm in size noted. Scant amount pink drainage, no odor, no s/s infection. Periwound skin pink and dry. Patient c/o tenderness to touch."</p> <p>*10/25/14 LNPB, "Patient c/o left heel tenderness this evening, I removed her sock and found large dry/callous and an open area that measures</p>	F 314		
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F 314	<p>Continued From page 22</p> <p>approximately 2cm x 2.5cm in size. Scant amount pinkish drainage, no odor, no s/s infection noted. Periwound skin is pink and dry. Cleansed wound with cleanser, applied antibiotic ointment, and covered with coversite dressing. Will continue to monitor."</p> <p>*10/27/14 LNP, "...dressing changed to left heel, no discharge noted, no s/s infection, no c/o pain, - patient encouraged to continue to float heels while in bed to prevent skin breakdown."</p> <p>On 11/3/14 at 9:45 AM, the surveyor observed the resident reclining in the chair in her room, the foot rest was up and extended. The resident had both feet resting directly on the foot rest. The resident had socks and closed heel slip-on shoes on both feet. Left foot was resting on the heel, the right foot was in a lateral position. Surveyor observed Prevalon boots lying on the floor behind a chair across the room. During this visit, when the resident was asked if she was using the Prevalon boots at night, the resident stated, "They gave me those for my left heel that was dry. I used them once and didn't like them. The Velcro was sticking to the bedding. It was very uncomfortable."</p> <p>The resident and Prevalon boots were observed in the same location and almost identical position on 11/3/14 at 1:08 PM and 1:30 PM; and on 11/4/14 at 9:15 AM.</p> <p>On 11/4/14 at 10:20 AM, the surveyor observed the resident eating breakfast in her room. She was seated in the recliner chair with both feet on the floor. The surveyor observed Prevalon boots lying on the floor under a chair across the room.</p> <p>On 11/4/14 at 2:00 PM, the DON was interviewed</p>	F 314			

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F 314.	<p>Continued From page 23 regarding inconsistent documentation on wound assessment, treatment and care. When questioned about treating wounds without an order, the DON replied, "We have Standing Orders signed by the doctor, I can get a copy for you." When questioned about inconsistent documentation on wound assessment and care, the DON stated, "I identified we had a deficit in skin assessment and wound care about 6-8 weeks ago. I noticed there were inconsistencies. I would go down and talk to the nurses about their documentation. I am not a wound care nurse and so I needed education also. I did an in-service here on 10/14/14 called 'Defensive Documentation' from our wound care supplier. They came in and showed us how to document accurately. They showed us proper verbiage, they showed what pressure ulcers look like, venous ulcers and stasis ulcers. I have identified an RN who will do wound rounding and documentation. Obviously she won't be here all the time so the nurses will be doing documentation also." When asked what he knew about the wound to the resident, the DON stated, "I believe it is resolved right now. I would be glad to go assess it."</p> <p>On 11/5/14 at 9:50 AM, the surveyor observed the resident ambulating with a physical therapist in the east hall using a FWW (front wheeled walker). The surveyor observed the resident's shoes slipping at her heels. When asked if she thought the resident's shoes might be too big, the therapist stated, "Yeah, a little." When asked if the shoes might be slipping on the resident's heels, the therapist stated, "Yeah, they do but she seems to like them."</p> <p>On 11/5/14 at 11:15 AM, the surveyor observed LN#3 assess the left heel of Resident #5. During</p>	F 314			

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F 314	<p>Continued From page 24</p> <p>the assessment, LN#3 stated the heel was "pink and blanch-able." LN#3 explained, "They cut the skin flap off last week because it was just hanging there and we didn't want the skin to tear." When asked if this treatment was documented, LN#3 responded, "Not by me, I didn't cut the flap off, the MDS coordinator (MDSC) is the one who did it." On surveyor observation of the heel, there were two light brown scabs on the heel with the surrounding skin pink in color. When LN#3 was asked if she identified the scabs, she stated, "No, it is difficult to see anything back there." LN#3 stated she didn't know how to read the measurements on the paper tape, noting, "Is it centimeters or millimeters?" and was instructed by the surveyor on how to read the measuring tape. On further assessment by LN#3, the scabs were measured at .4 cm x .2 cm and .5 cm x .4 cm. LN#3 was then asked what the plan of care should be for this resident. LN #3 stated, "The heels need to be elevated on a pillow when in the chair and when in bed. Also cream on the heel. The NP (nurse practitioner) will be in today and I will discuss this with her."</p> <p>On 11/5/14 at 11:15 AM, when the resident was asked about floating her heels while in bed, she responded, "I use a couple of bed pillows under my legs at night." When the resident was asked about her shoes appearing to be too big, she stated, "I know they do, these are so nice and lose." LN#3 then put the resident's sock and shoe on and placed a pillow under the calf of the resident's left leg with the heel floating, and the right heel in direct contact with the foot rest.</p> <p>NOTE: The CP did not include the application of cream to the heel.</p>	F 314			

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F 314	Continued From page 25 11/5/14 at 11:55 AM, the MDSC was interviewed regarding treatment to and documentation of, the left heel of Resident #5. The MDSC stated, "I cut it off last week, Tuesday, Wednesday, or Thursday, I don't remember but it was within the last week. The skin was dead and looked like a callus. The skin on the heel looked like normal dermal tissue, the same as the surrounding tissue. I should have documented it but I don't know if I did. [LN#3] dressed the wound with Optifoam. I don't typically do wound interventions, I normally consult on wounds but not necessarily every wound in the house." When asked if there was an order to remove the skin and whether the physician was notified, he stated, "No, there wasn't an order and the physician was not notified." The MDSC was then asked if he was aware the resident had a PRN order for Prevalon boots, to which he responded, "I don't know anything about the boots." When asked if he was aware resident #5 had two scabs on her left heel, the MDSC stated, "No, I wasn't aware of that."	F 314			
F 323 SS=D	On 11/5/14 at 4:25 PM, the Administrator and the DON were notified of the findings. No additional information was provided. 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.	F 323	<u>F 323</u> Resident #2 discharged from the facility. Resident #4 has had a side rail assessment completed. Nursing side rail safety assessment was synced into nursing admission assessment. An alert will populate to ensure nursing completion of side rail safety assessment. All residents using side rails have the potential to be affected. Nurses had potential	12/8/14	

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F 323	<p>Continued From page 26</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 2 of 6 (#2 & #4) sampled residents who were identified for the use of side rails were safe with the use side rails. The deficient practice had the potential to cause more than minimal harm should the side rails have been assessed to be unsafe for the resident, who could become entangled in the side rail and incur injury. Resident #2 and #4 both used side rails without a documented side rail safety assessment. Findings include:</p> <p>1. Resident #4 was admitted to the facility on 9/2/14 with diagnoses that included other specified rehabilitation, acute illness and cerebrovascular disease.</p> <p>The resident's physician orders dated 11/4/14 documented bilateral quarter side rails to assist with bed mobility.</p> <p>The resident's care plan documented risk for pressure ulcer development and documented the resident was to be encouraged to use bed rails to assist in turning.</p> <p>On 11/4/14 at 2:35 PM, the DON was asked for the resident's side rail assessment which documented the resident was safe to use side rails. The DON stated the facility had recently implemented a new assessment and noted, "No this one does not say it (side rails) is safe."</p> <p>On 11/5/14 at 11:35 AM, the resident was observed in bed with bilateral quarter side rails up.</p>	F 323	<p>to forget side rail safety assessment as it was a separate assessment from the nursing admission assessment.</p> <p>Nursing staff were educated on performing a side rail safety assessment on patients with side rails.</p> <p>DON or designee will conduct a random weekly audit on 2 resident's, for 2 months, for side rail safety assessment.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p>	
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F 323	Continued From page 27 On 11/5/14 at 4:25 PM, the Administrator and DON were informed of the findings. No additional information was provided. 2. Resident #2 was admitted to the facility on 10/11/15 with diagnoses which included seizure disorder, Parkinson disease and paralysis. On 11/3/14 at 7:00 a.m. Resident #2 was observed in bed with both 1/4 side rails in the upraised position. A restraint consent signed by the resident on 10/11/14 documented the use of bilateral quarter side rails. The resident's record did not include the resident had been assessed and determined to be safe with the use of the side rails. On 11/4/14 at 3:05 the DON stated there was no documentation the resident had been assessed to be safe with the use of the side rails. On 11/4/14 at 4:25 p.m., the DON and the Administrator were informed of the above concern. The facility provided no further information.	F 323			
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325	<u>F 325</u> Resident #1 has discharged from the facility.	12/8/14	

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F 325	<p>Continued From page 28</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to identify weight loss trends and failed to implement interventions in a timely manner after the resident's weight loss became significant. This failed practice harmed 1 of 9 residents (#1) sampled for weight loss. The resident was harmed when she experienced severe weight loss of 10% within the first 3 months of admission to the facility. Additionally, this failed practice had the potential to harm any resident who experienced a compromised nutritional status. Findings included:</p> <p>Resident #1 was admitted to the facility on 6/4/14 with diagnoses of cerebral artery occlusion with infarct, dysphasia, hypothyroidism and aphasia.</p> <p>The resident's Admission MDS Assessment, dated 6/10/14, documented:</p> <p>*Required limited assistance of one person for eating.</p> <p>* Weight 141 pounds and height 65 inches.</p>	F 325	<p>All residents have the potential to be affected. Insufficient weighing procedures and lack of documentation resulted in staff not understanding policy and procedure and inhibited performing procedure appropriately.</p> <p>Policy and procedure was updated for resident weights being done on same day each week, nurse will notify physician of weight changes, and nurse will refer weight changes for review and follow up through weekly NAR (nutrition at risk) meeting. Weighing procedures modified for consistency and reliability. Systems in place for weight verification and provider report.</p> <p>DON or designee will conduct a random weekly audit on 4 resident's, for 3 months, weights and interventions for proper documentation, notifications, and interventions. Audit to include verification of weight consistency, significant losses/gains reported</p>	

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F 325	<p>Continued From page 29</p> <p>The resident's most recent Quarterly MDS Assessment, dated 9/10/14 documented: *Required set up help only for eating. *Weight 139 pounds and height 65 inches</p> <p>The resident's Weight and Vitals Summary, dated 6/4/14 through 9/3/14, documented the resident experienced a 15 pound weight loss during her first 3 months of admission. The resident's Weight and Vitals Summary documented, in part, the following: 6/4/14 147.4 lbs (pounds) 7/2/14 139.6 lbs -5.0% change. 7/30/14 132.8 lbs - 7.5% change. 9/3/14 132.4 lbs -10% change.</p> <p>Guidance at F-325 documented greater than 5% weight loss in a 1 month period was considered significant and 7.5% weight loss in a 3 month period was considered severe</p> <p>The resident's Phone Communication (physicians order) dated, 6/4/14, documented: "Boost or Equivalent three times a day for nutritional supplement. Regular diet, mechanical soft texture, nectar consistency." In addition, the resident's record contained the following orders: 6/25/14- discontinue regular diet, mechanical soft texture. 6/25/14- (Begin) regular diet, regular texture. 8/8/14- Boost or equivalent one time a day for supplement dietary to mix in milkshake form (strawberry flavor) per patient's request and serve with dinner. Start date: 8/9/14. 8/21/14- Discontinue Boost or equivalent one time a day. Due to patient refusing. 9/3/14- Two-cal or equivalent (supplement) two times a day. 9/12/14, D/C (discontinue) 2 cal (Two-cal)</p>	F 325	<p>accordingly, and appropriate weight loss interventions instituted.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/05/2014
NAME OF PROVIDER OR SUPPLIER RIVERVIEW REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 WEST AMERICANA TERRACE BOISE, ID 83706		
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F 325	Continued From page 30 supplement due to refusal. The resident's Care Plan documented, in part: *Focus areas: Dysphagia related to CVA (cardio vascular accident) and potential for alteration in nutrition related to unable to verbalize preferences. Date initiated: 6/13/14. *Goals: Demonstrate safe intake of highest recommended diet levels and she maintain weight and nutritional balance through the review date. Date initiated: 6/13/14. Target date: 12/7/14. *Intervention: All staff to be informed of resident's special dietary and safety needs. Regular diet to be followed as prescribed. Regular diet. Family providing snacks in room and favorite foods for example milkshakes. Ensure proper set up. Family member insisting on making her food preferences when many times she did not want what he ordered. Continue to observe and document meal food and fluid intakes. Weight and document weekly. The resident's Dietary Note, dated 9/22/14 at 9:24 AM, documented, "Quarterly review - [Resident's name] is in [on] a regular diet with regular textures. She has eaten on average 76-100% of her meals and consumed on average 950 cc [milliliter] with meals. She has accepted 8 out of 10 snacks. She has gained 6 lbs [pounds] in the last 2 weeks. She has had no significant weight loss/gain. She is receiving 2 cal [two-cal] or equivalent BID [twice a day] given by nursing." However, the resident's Weights and Vitals Summary documented a weight loss of 2 pounds during the two weeks prior to 9/22/14 and a 15.2 pound weight loss since admission. Also, the Physicians Orders, dated 9/12/14, stated, "D/C [discontinue] 2 cal supplement due to refusal."	F 325			

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F 325	<p>Continued From page 31</p> <p>The resident's MAR dated 6/4/14, included an order for Boost. The MAR and the progress notes provided no evidence that Boost was administered or offered 3 times a day until 10:00 AM, on 8/6/14 before it was discontinued on 8/8/14. The resident's MAR also included an 6/4/14 order for I&O (Intake and output) every day and night shift. The MAR provided evidence that the I&O was not documented 28 times (10 times in 6/14, 14 times in 7/14 and 4 times in 8/14) before it was discontinued on 8/13/14. The resident's progress notes of 8/3/14 documented: "I&O every day and night shift, this is no longer occurring. Patient is still Incontinent and can not (sic) be measured."</p> <p>On 6/11/14, the resident's RD/CDM Nutritional Evaluation documented in the weight history section, "No significant weight change." The Calculations of Estimated Needs section documented, "Calories, 1363." On 11/4/14 at 3:10 PM, when the RD was asked whether that calorie intake was sufficient to maintain the resident's admission weight, she stated, "Yes I do." The Nutritional Summary, dated 6/11/14, documented, " Husband indicates...UBW [usual body weight] is 145 [pounds]. Monitor intakes, wt's [weights] and advancement with therapies ..."</p> <p>The resident's Intake records were reviewed from 8/1/14, through 10/31/14 and it was documented that the resident refused the "Brunch" 10:00 AM meal 9 times, the "Siesta" 1:00 PM snack 14 times, and the "HS" 8:00 PM bedtime snack 63 times.</p> <p>Review of the resident's medical record did not provide evidence of nutritional interventions</p>	F 325		

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F 325	Continued From page 32 except for Boost, Two-cal for 10 days during the month of 9/14 and a diet change to "Regular" texture and fluid consistency. The resident was observed on 11/3/14 and 11/4/14 at 10:25 AM (both days) during the "Brunch" meal. Family and others were present at her table in the resident's dinning room. Resident #1 was observed to consume 100% of both meals severed. On 11/3/14 at 7:55 AM, the CDM was asked for information on any resident with significant weight loss. She stated, "We do not have any significant weight loss at this time. I check the weights every Monday morning. I just checked and there are no [residents with] weight loss." During an interview on 11/4/14 at 1:45 PM, the RD, when asked about Resident #1's diet, stated, "Before the diet change [to regular] on 6/25/14 her eating was hit and miss." During a second interview with the RD on 11/5/14 at 11:50 AM, the RD was informed that the Boost was not documented as being offered from 6/4/14 to 8/6/14. When informed of the facility's lack of consistent I&O documentation, the RD stated "Not being in the MAR is a concern, I am not denying we have a problem [with weight loss] and need to get it under control." On 11/5/14 at 4:00 PM, the Administrator and DON were made aware of the concern regarding weight loss. No further information was provided by the facility.	F 325			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328	<u>F 328</u> Resident #2 and 6 have discharged from the facility.	12/8/14	

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F 328	<p>Continued From page 33</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy and procedure review and staff and resident interview, it was determined the facility failed to ensure the oxygen humidifier and tubing were connected to the oxygen concentrator. This was true for 2 of 3 sampled residents (#s 2 & 6) reviewed for oxygen therapy. This created the potential for an increase in respiratory problems if the residents' respiratory needs were not met. Findings included:</p> <p>The Oxygen Administration Policy and Procedure, revised March 2004, documented the humidifier bottle was a necessary piece of equipment to perform the procedure and steps in the procedure included,"...12. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through...14. Periodically re-check water level in humidifying jar..."</p>	F 328	<p>All residents on oxygen have the potential to be affected. Lack of education regarding importance and quantity of humidifier and tubing placement checks was found to be the root cause.</p> <p>Staff were educated on properly checking humidifiers and concentrators for tubing and humidifiers to be in place. Staff will check humidifier and tubing placement every shift and upon entry into patient room.</p> <p>DON or designee will conduct a random weekly audit on 5 resident's for 2 months, who are using oxygen, for tubing and humidifiers being in place.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p>		

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F 328	<p>Continued From page 34</p> <p>1. Resident #6 was admitted to the facility on 10/1/14 with multiple diagnoses which included acute and chronic respiratory failure, acute kidney failure and pneumonia.</p> <p>The admission MDS assessment, dated 10/8/14, documented Resident #6 was cognitively intact with a BIMS of 15.</p> <p>Resident #6's Care Plan documented, "Oxygen therapy as ordered," with a date of 10/1/14.</p> <p>The Order Summary Report for Resident #6 documented, "Oxygen per nasal cannula @ 2L [liters per minute] continuous. Check oxygen saturations every 12 hours. May increase up to 4 liters to keep saturations above 90%...", with a start date of 10/6/14.</p> <p>The October 2014 MAR documented the order for Resident #6 to receive oxygen via nasal cannula at 2 lpm every day and night shift related to acute and chronic respiratory failure and pneumonia.</p> <p>The November 2014 MAR and TAR did not contain the oxygen order for Resident #6.</p> <p>On 11/3/14 at 6:25 a.m., Resident #6 was observed by the surveyor to be lying in bed with the nasal cannula in place, and the oxygen concentrator was located in the bathroom set at 4 lpm. The oxygen tubing was connected to the humidifier and both were on the floor near the bathroom door, disconnected from the concentrator. The resident was asked if she had shortness of breath or any difficulties breathing and the resident said, "Having a little trouble." At 6:40 a.m., LN #3 was asked to retrieve a pulse</p>	F 328			

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F 328	<p>Continued From page 35</p> <p>oximeter to check the resident's oxygen saturation. At 6:43 a.m., the LN returned to the room with the pulse oximeter and received a reading of 80 to 83 % with a single jump to 84%. The LN went into the bathroom and stated, "The concentrator is at 4 [lpm] but it doesn't look like it's hooked up, it's on the floor. Let me fix it." At 6:55 a.m., the LN reported Resident #6's oxygen saturation was at 95% after the humidifier and oxygen tubing were connected to the concentrator, and that she received report the resident's oxygen saturations were in the 90's during the previous night.</p> <p>On 11/3/14 at 7:06 a.m., LN #3 reported Resident #6's vital signs at 12:08 a.m. documented an oxygen saturation of 94% with the nasal cannula in place. The LN said there was not an option in the charting to document the liter flow.</p> <p>On 11/3/14 at 8:00 a.m., LN #3 was asked if she had reported the aforementioned incident to the DON, and she said, "No."</p> <p>On 11/3/14 at 9:25 a.m., Resident #6 was observed sitting in a chair with the nasal cannula in place. The oxygen tubing was connected to the concentrator without a humidifier.</p> <p>On 11/3/14 at 10:50 a.m., the DON was asked what Resident #6's oxygen order was on the MAR or TAR for November 2014, and he said it would be the same as the October 2014 MAR. After reviewing the November MAR and TAR the DON said the order was changed in writing but it didn't populate on the MAR, and he fixed the MAR to show the oxygen order.</p> <p>On 11/3/14 at 1:40 p.m., the DON and Registered</p>	F 328			

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F 328	Continued From page 36 Dietician were informed of the concerns with oxygen therapy. No further information or documentation was provided which resolved the issue. 2. Resident #2 was admitted to the facility on 10/11/15 with diagnoses which included seizure disorder and chronic obstructive pulmonary disease. A 10/28/14 Physician Order documented the resident was to receive oxygen at 2 liters per minute (lpm) via nasal cannula continuously. On 11/4/14 at 7:50 a.m., Physical Therapist #1 (PT #1) was observed transferring the resident's nasal cannula from the oxygen concentrator to a portable canister. The humidifier tank was documented to be empty. PT#1 stated there should be water in the tank for the humidifier on the concentrator. On 11/4/13 at approximately 8:10 a.m., a CNA stated she had noticed the humidifier tank was empty and had informed the nurse. On 11/4/14 at 4:25 p.m., the Administrator and the DON were informed of the above concern. The facility provided no other information.	F 328		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329	<u>F 329</u> Resident #2 has discharged. Resident #5 has non-pharmacological interventions added to care plan and being offered by nursing staff for pain. Also nursing is documenting on pain prior to medications being given and post for efficacy.	12/8/14

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F 329	<p>Continued From page 37</p> <p>without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, and resident interview, it was determined the facility failed to monitor pain medications for efficacy. The facility also failed to provide alternative non-pharmacological interventions such as position change, massage, hot/warm or cold compresses to address the resident's pain or discomfort. This was true for 2 of 9 residents sampled for medications. Findings include:</p> <p>Resident #5 was admitted to the facility on 9/12/14, with diagnoses that included other specified rehabilitation procedure, aftercare healing traumatic fracture other bone, and rheumatoid arthritis.</p>	F 329	<p>All residents using pain medications have the potential to be affected.</p> <p>Nursing staff were educated on properly documenting pain prior to medicating and post for efficacy of pain medications, offering/providing non-pharmacological interventions for pain, and properly documenting on specifics of how behaviors being displayed and the interventions for these specific behaviors.</p> <p>DON or designee will conduct a random weekly audit on 5 residents for 2 months who are using pain medications for proper documentation in care plan and progress notes for offering non-pharmacological interventions and efficacy of pain medications, and behaviors being displayed and interventions.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p>		

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F 329	<p>Continued From page 38</p> <p>The Resident's initial MDS Assessment, dated 9/19/14, documented: *Cognition intact *Pain Assessment Interview scored 'Yes' for pain in the previous 5 days. *Pain Frequency scored 'Frequently' for pain in the previous 5 days. *Pain intensity scored '10' on the 00-10 pain scale for pain in the previous 5 days.</p> <p>The Resident's initial Care Plan (CP) documented on 9/12/14, "Pain r/t (related to) pelvic fracture and rheumatoid arthritis." Goals included: *Provide reassurance that pain is time limited. Encourage to try different pain relieving methods i.e. positioning, relaxation therapy, progressive relaxation, bathing, heat and cold application, muscle stimulation. Date initiated: 9/12/14. *Resident is able to call for assistance when in pain, ask for medication, communicate how much pain is experienced, identify what increases or alleviates pain. Date initiated: 9/12/14.</p> <p>NOTE: After review of License Nurse Progress Note (LNPN), alternative pain relief measures were not documented as offered according to CP to Resident #5 from 9/12/14 to 10/3/14.</p> <p>On 11/3/14 at 9:45 AM, Resident #5 was asked if her pain was controlled. She responded, "I think my pain is OK. Sometimes I have to wait for pain medication because the staff is busy. It is hard to control my pain because I am so sensitive to narcotics."</p> <p>Medication Administration Records (MAR) and LNPN from 9/12/14 to 10/3/14, documented:</p>	F 329		
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F 329	<p>Continued From page 39</p> <p>*Lidocaine patches, scheduled daily, applied topically one time a day to sacrum for pelvic pain and remove per schedule (ordered 9/19/14). *MAR documented the lidocaine patch was removed twice a day at 8:00 AM and 8:00 PM on 9/20/14 through 9/30/14. Application of the lidocaine patch was not documented 9/20/14 through 9/30.</p> <p>*MAR documented the lidocaine patch was applied at 10:30 AM on dates 10/18/14 through 10/31/14. Removal of the lidocaine patch was documented at 8:00 AM on dates 10/1/14 through 10/17/14, and 8:00 PM from 10/1/14 through 10/31/14. Additionally, dates 10/20/14 through 10/23/14 were checked as being administered but did not document the Licensed Nurse (LN) responsible for the entries.</p> <p>NOTE: On 10/31/14, LNPN documented the resident refused the application of the lidocaine patch. LNPN were not documented with the pain severity scale prior to application. Additionally, response to treatment and progress toward therapeutic goal was not documented on the MAR or LNPN.</p> <p>*Acetaminophen (APAP) tablet, 650 mg by mouth four times a day for pain. APAP was administered to Resident #5 on 9/13/14, 9/16/14, 9/18/14 (twice on this day), 9/19/14 (twice on this day), 9/20/14, 10/6/14, 10/12/14, 10/19/14, and 10/23/14. The LNPN was not documented with the pain severity scale prior to administration. Additionally, response to treatment and progress toward therapeutic goal was not documented on the MAR or LNPN on dates 10/6/14 and 10/23/14. Response to treatment and progress toward therapeutic goal was documented on 10/24/14, six hours after dosing the medication.</p>	F 329			

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F 329	<p>Continued From page 40</p> <p>*Dilaudid Tablet 2 MG, 1 tablet by mouth every 4 hours as needed for pain for 7 days. Dilaudid was administered to Resident #5 on 9/13/14, 9/14/14 (twice on this day), and 9/15/14. The LNP was not documented with the pain severity scale prior to administration.</p> <p>*Tramadol HCl Tablet 50 MG, 1 to 2 tablets by mouth every 4 hours as needed for pain. Tramadol was administered to Resident #5 on 9/20/14, 9/21/14, 9/22/14, 10/24/14, and 10/26/14. The LNP was not documented with the pain severity scale prior to administration.</p> <p>*LNP dated 9/24/14 at 4:25 PM, documented, "Medicated with Norco per PRN with good effect." Resident #5 did not have a physician's order for Norco.</p> <p>On 11/5/14 at 4:25 PM, the Administrator and the DON were notified of the findings. No additional information was provided.</p> <p>2. Resident #2 was admitted to the facility on 10/11/15 with diagnoses which included seizure disorder, anxiety state and bipolar disorder.</p> <p>The resident's 10/11/14-11/3/14 Order Summary Report included an order for Olanzapine (antipsychotic) 10 mg every night at bedtime with a start date of 10/11/14. Additionally, the orders included instructions to, "Monitor for signs and symptoms of psychosis including but not limited to auditory and visual hallucinations, fear, paranoia."</p> <p>On 11/3/14 at 9:10 a.m., 10:10 a.m. and 11:45 a.m., the resident was observed in her room watching television with the lights off and the</p>	F 329		
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3550 WEST AMERICANA TERRACE BOISE, ID 83706		
(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 329	<p>Continued From page 41 blinds drawn.</p> <p>On 11/4/14 LN #3 stated she would frequently ask the resident if she wanted the blinds open to let in light, but the resident preferred to sit in her room in the dark with the door closed.</p> <p>The resident's 10/14/14 Care Plan for anxiety and bipolar disorder included in the intervention section to record and report to the physician "acute episode feelings of sadness, loss of pleasure and interest in activities, feelings of worthlessness or guilt, changes in appetite, eating habits ... signs and symptoms of mania or hypomania, racing thoughts or euphoria, increased irritability, frequent mood changes, pressured speech, flight of ideas, marked change in need for sleep, agitation, or hyperactivity."</p> <p>The Care Plan did not describe how acute episode feelings of sadness, feelings of worthlessness or guilt were displayed (such as crying, making statements of being useless or apologizing for behavior). Additionally, LN #3 stated that staying in a dark room and not interacting was normal behavior for the resident.</p> <p>The Care Plan did not include what staff were to do when the behaviors occurred, such as redirect, talk with the resident, reassure the resident, etc.</p> <p>Note: Although the physician Order Summary Report included to monitor for auditory and visual hallucinations, fear, and paranoia, the Care Plan did not include any information regarding the physician identified behaviors.</p>	F 329		

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F 329	Continued From page 42 The Medication Administration Record (MAR) included to monitor for signs and symptoms of psychosis, including but not limited to auditory and visual hallucinations, fear, and paranoia. The MAR had a small box to write the number of incidents each day, however it did not provide enough space to document if the behaviors were auditory or visual hallucinations, or if the resident expressed fear or paranoia. The MAR did not include an area to document the behaviors identified in the Care Plan (feelings of sadness; loss of pleasure, and interest in activities). On 11/4/14 at 3:05 PM, the DON stated the Care Plan for Resident #2 did not include specifics of how behaviors were displayed, or interventions to address the specific behaviors.	F 329			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure 1 (#12) random resident was provided medications safely. The deficient practice had the potential to cause more than minimal harm when 3 of the medications administered to the resident at the same time could have caused adverse side effects when administered together. The facility's medication error rate was 10%. Findings include: On 11/4/14 at 8:30 AM, LN #4 was observed to	F 332	<u>F 332</u> Resident #12 has discharged from the facility. All residents have the potential to be affected. Admitting nurse failed to enter and identify possible drug interaction and appropriate medication pass times. Nursing staff were educated on giving omeprazole and levothyroxine at separate times. Also if patient requests for these medications to be given together physician will be	12/8/14	

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F 332	<p>Continued From page 43</p> <p>administer medications to Resident #12. The medications administered included enteric coated aspirin, levothyroxine, and omeprazole.</p> <p>The resident's physician orders dated 11/5/14, documented medications as follows: * Synthroid tablet 50 mcg (micrograms) 1 tablet by mouth 1 time a day. *Aspirin (salicylate) tablet 325 mg (milligram) 1 tablet by mouth two times a day. (NOTE: The order did not document enteric coated, which was administered to the resident.) *Omeprazole (antacid) tablet delayed release 20 mg by mouth one time a day.</p> <p>The 2104 Nursing Drug Handbook, 34th Edition, page 829-830 and page 1025-1027, documented: * Levothyroxine, page 829-830: Drug to drug interactions documented the use of antacids (Omeprazole) may impair Levothyroxine absorption. Separate doses by 4 to 5 hours. *Omeprazole, page 1025- 1027: Drug to drug interactions documented the use of salicylates (aspirins) in the enteric coated form may dissolve faster, increasing risk of gastric adverse effects. Use cautiously.</p> <p>On 11/5/14 at 9:55 AM, LN #4 was asked to explain why resident #12 was administered levothyroxine, omeprazole and an enteric coated aspirin at the same time with the adverse side effects this could cause. LN #4 stated the resident had been a pharmacist before and when she was admitted to the facility the LN had reviewed the resident's MAR (medication administration record) with the resident. The MAR was changed to the way the resident wanted her medications, and the NP (Nurse Practitioner) was aware of and approved it. The LN was asked to</p>	F 332	<p>notified and patient will be educated on possible adverse side effects.</p> <p>DON or designee will conduct a random weekly audit on 3 resident's medication pass, one time of the day, to following medication administration protocols. Audits will verify the six rights of medication administration are being conducted appropriately</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p>		

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F 332	Continued From page 44 provide documentation the NP was aware and in agreement with the medication administration regimen. On 11/5/14 at 1:00 PM, the DON was asked for the documentation that the physician was aware the resident received the 3 medications together and the drug to drug interactions that could occur. The DON looked on the computer and verified the order for aspirin was not for an enteric coated aspirin. The DON stated he did not see anything on the computer that the physician was aware of the 3 medications being given together, but that he would look into it. No further documentation was provided. On 11/5/14 at 4:25 PM, the Administrator and the DON were notified of the findings. No additional information was provided.	F 332			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	<u>F 431</u> Resident #13 has discharged from the facility. Expired medications were removed from the medication carts. All residents have the potential to be affected. Nursing staff were educated on properly checking expiration dates of medications. DON or designee will conduct a random weekly audit on both	12/8/14	

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F 431	<p>Continued From page 45</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure non-expired medication was readily available for 1 random resident (#13) and any resident who would use facility stocked medications. The deficient practice had the potential to cause more than minimal harm when medications were outdated and residents may not receive the full benefit of the medication. Resident #13's nebulized inhalant medication was outdated, and one medication on the East wing medication cart had an expired over the counter (OTC) medication. Findings include:</p> <p>On 11/5/14 at 10:40 AM, the East wing medication cart was observed with LN #3 for outdated medications. The cart contained the following outdated medications:</p>	F 431	<p>medication carts 2 times a month for 2 months.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p>		

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F 431	Continued From page 46 *Resident #13's respiratory medication: Levalbuterol HCL (hydrochloride) 1.25 mg (milligrams) / 3 ml (milliliters) inhalant. The package contained 11 doses and expired on 8/14. * Medication Stock drawer: Calcium with Vitamin D tablets 500 mg with D., 300 tablets. The bottle was partially used and had expired on 8/14. When asked if resident #13 still used the inhalant medication, LN #3 stated the resident still used the medication and that she would contact the resident's family to bring in more. LN #3 was asked to explain the facility's system to ensure outdated medications did not remain in use. LN #3 stated she checked when she dispensed the medication, but did not know of a specific system in place to check for outdated medications. On 11/5/14 at 1:00 PM, the DON was asked what system the facility had in place to check for outdated medications. The DON stated, the LN is supposed to check for outdated medications when the medications are dispensed, and the pharmacy staff had performed an "audit" and recently stocked the cart. When asked when the pharmacy staff had been in to do the audit, the DON stated, "I will look in to it." On 11/5/14 at 4:25 PM, the Administrator and the DON were notified of the findings. No additional information was provided.	F 431			
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side.	F 468	<u>F 468</u> Residents # 4, 5, 7, 8, and 9 have discharged. Resident #1, 2, 3, and 6 will have a handrails added to the area outside the restrooms on the East side of the main entrance hallway.	12/8/14	

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F 468	<p>Continued From page 47</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure all corridors were equipped with handrails. This affected 9 of 9 (#1, 2, 3, 4, 5, 6, 7, 8 and 9) sampled residents and had the potential to affect other residents who frequented the corridor without handrails. This practice created the potential for residents not to have a handrail for stability when needed. Findings included:</p> <p>On 11/3/14 at 5:15 AM, 7 feet of handrails was observed to be missing on the east side of the main entrance hallway, outside the women's and men's restrooms.</p> <p>On 11/3/14 at 9:25 AM, during the environmental tour, the Maintenance Supervisor was shown the missing handrails and he stated, "I never thought about it and I don't know why they didn't do it [add handrail], you will have to ask [Administrator's name]."</p> <p>On 11/5/14 at 7:45 AM when shown the missing handrails, the Administrator stated, "I don't know, it must have been something with the architect. We encourage residents to use the restrooms in their room."</p> <p>On 11/5/14 at 4:15 PM, the Administrator and DON were informed of the issue. No other information was provided.</p>	F 468	<p>All residents have the potential to be affected.</p> <p>Handrails were ordered and will be installed as soon as delivered added to the area outside the restrooms on the East side of the main entrance hallway.</p> <p>Administrator or designee will conduct a random weekly audit on 2 handrails, per week, for being firmly secured for 1 month.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p>	
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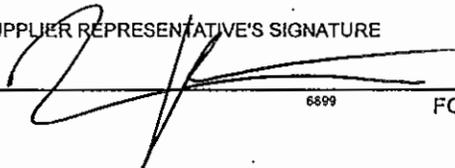
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001665	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/05/2014
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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the State licensure survey of your facility. The surveyors conducting the survey were: Lauren Hoard, RN BSN -Team Coordinator Judy Atkinson, RN Susan Gollobit, RN Sherri Case, LSW QMRP Kirsti Stephenson, RN BSN	C 000		
C 117	02.100,03,c,i Fully Informed of Rights i. Is fully informed, as evidenced by the patient's/resident's written acknowledgement, prior to or at the time of admission and during his stay, of these rights and of all rules, regulations and minimum standards governing patient/resident conduct and responsibilities. Should the patient/resident be medically or legally unable to understand these rights, the patient's/resident's guardian or responsible person (not an employee of the facility) has been informed on the patient's/resident's behalf; This Rule is not met as evidenced by: Please refer to F 156 as related to the residents being informed of their right to review the most recent survey of the facility.	C 117	C 117 02.100,03,c,i Refer to F 156	12/3/14
C 119	02.100,03,c,iii Informed of Medical Condition by Physician iii. Is fully informed, by a physician, of his medical condition unless medically contraindicated (as	C 119	C 119 02.100,03,c,iii	12/18/14

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FACILITY STANDARDS

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



TITLE

Administrator

(X6) DATE

12/22/14

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C 119	Continued From page 1 documented, by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research; This Rule is not met as evidenced by: Please refer to F154 as related to Black Box Warning.	C 119		
C 179	02.105,01,c Continuing Inservice Training c. Continuing in-service training for all employees which is consistent with patients'/residents' needs and services offered. A minimum of twenty-four (24) hours of training per year shall be provided to nursing staff; This Rule is not met as evidenced by: Please refer to F 226 as it related to staff training.	C 179	<u>C 179</u> 02.105,01,c Refer to F 226	12/8/14
C 389	02.120,03,d Sturdy Handrails on Both Sides of Halls d. Handrails of sturdy construction shall be provided on both sides of all corridors used by patients/ residents. This Rule is not met as evidenced by: Please refer to F 468 as related to handrails.	C 389	<u>C 389</u> 02.120,03,d Refer to F 468	12/8/14
C 781	02.200,03,a,iii Written Plan, Goals, and Actions iii. Written to include care to be given, goals to be accomplished, actions necessary to attain the goals and which service is responsible for	C 781	<u>C 781</u>	12/8/14

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C 781	Continued From page 2 each element of care; This Rule is not met as evidenced by: Refer to F279 as it relates to including interventions on the initial care plan for incontinence and pressure ulcer prevention.	C 781	02.200,03,a,iii Refer to F 279	
C 782	02.200,03,a,iv Reviewed and Revised iv: Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F280 as it relates to Care Plan revision.	C 782	<u>C 782</u> 02.200,03,b,iv Refer to F 280	12/8/14
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F309 as it relates to following Physician's Orders for the Frazier Free Water Protocol, weight change notification and delivery of oxygen therapy.	C 788	<u>C 788</u> 02.200,03,b,iv Refer to F 309	12/8/14
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:	C 789	<u>C 789</u> 02.200,03,b,v Refer to F 314	12/8/14

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C 789	Continued From page 3 Please refer to F314 as relates to prevention and treatment of pressure ulcers.	C 789		
C 792	02.200,03,b,viii Comfortable Environment viii. Maintenance of a comfortable environment free from soiled linens, beds or clothing, inappropriate application of restraints and any other factors which interfere with the proper care of the patients/residents; This Rule is not met as evidenced by: Please refer to F323 as related to siderail safety assessments.	C 792	<u>C 792</u> 02.200,03,b,viii Refer to F 323	12/8/14
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Please refer to F281 as it relates to professional standards of practice.	C 798	<u>C 798</u> 02.200,04,a Refer to F 281	12/8/14
C 811	02.200,04,g,vii Medication Errors Reported to Physician vii. Medication errors (which shall be reported to the charge nurse and attending physician.	C 811	<u>C 811</u>	12/8/14

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C 811	Continued From page 4 This Rule is not met as evidenced by: Please refer to F332 as related to medication error rate.	C 811	02.200,04,g,vii Refer to F 332	
C 821	02.201,01,b Removal of Expired Meds b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days. This Rule is not met as evidenced by: Please refer to F431 as related to timely disposal of outdated medications.	C 821	<u>C 821</u> 02.201,01,b Refer to F 431	12/8/14
C 856	02.201,04,c Documentation of Use and Results c. Reasons for administration of a PRN medication and the patient's/resident's response to the medication shall be documented in the nurse's notes. This Rule is not met as evidenced by: Please refer to F329 as related to monitoring antibiotics, pain medications, and psychotropic medication therapy for efficacy,	C 856	<u>C 856</u> 02.201,04,c Refer to F 329	12/8/14



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

January 15, 2015

Justin Polson, Administrator
Riverview Rehabilitation
3550 West Americana Terrace
Boise, ID 83706-4728

FILE COPY

Provider #: 135139

Dear Mr. Polson:

On **November 5, 2014**, a Complaint Investigation survey was conducted at Riverview Rehabilitation. Kirsti Stephenson, RN, Judy Atkinson, RN, Susan Gollobit, RN, Lauren Hoard, RN, and Sherri Case, LSW, QIDP, conducted the complaint investigation.

The complaint was investigated in conjunction with the facility's Recertification and State Licensure survey conducted on November 3-5, 2014.

The following observations were completed:

- Response to call lights throughout the survey.
- The room occupied by the resident during her stay.
- A sample tray during a 10:00 a.m. brunch.

The following documents were reviewed:

- The entire medical record of the identified resident;
- Six other residents' records were reviewed for quality of care concerns;
- The facility's grievance file from August 2014; and
- The facility's Incident and Accident reports from May - October 2014.

The following interviews were completed:

- Several residents and family members were interviewed regarding quality of care concerns;

- The Director of Nursing (DoN) and the Administrator were interviewed regarding various quality of care concerns;
- The Dietary Manager was interviewed regarding dietary services;
- The Director of Rehabilitation was interviewed regarding therapy concerns; and
- A licensed practical nurse (LPN) was interviewed regarding residents' safety concerns.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006654

ALLEGATION #1:

The complainant stated that the beds were hard to navigate around, especially for those in wheelchairs.

FINDINGS:

The identified resident was no longer residing in the facility at the time the complaint was investigated.

The room where the identified resident had resided was observed and an LPN was interviewed regarding the position of the bed in the room and if it could be moved within the room. She stated, "I would just have to get an order to move the bed and care plan it for better mobility." There was no evidence this concern had been addressed with the facility while the resident was in the facility. Residents interviewed during the survey did not express concerns with the location of the bed.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated all food was cold and the quality was poor.

FINDINGS:

On November 4, 2014, a sample brunch tray, which included scrambled eggs, was obtained for the surveyors to taste. The food was warm and flavorful. Random residents interviewed stated, "the food was tasty." The facility had no grievances related to the taste or temperature of the

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated staff would not call the physician to clarify orders of oxycodone when the resident said she was getting too much.

FINDINGS:

On August 22, 2014, after the resident stated her dose and scheduling of Oxycodone was making her "loopy," this information was relayed to the physician. On August 23, 2014, the order was changed to reduce the Oxycodone to twice a day. The resident's medication record documented that she was getting the Oxycodone as ordered by the physician.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated that she was told the resident had dementia.

FINDINGS #4:

The identified resident's progress notes, Admission Record, Order Summary Report and care plan provided no mention of dementia as conveyance of such by the interested party. Federal regulations do not regulate staff from misspeaking.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated staff refused to change the surgical dressing.

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FINDINGS:

The identified resident's progress notes of August 24, 2014, at 2:01 p.m., documented, "Incision cleansed, more steri-strips applied for extra support and bandage applied," as per the physicians order and treatment records.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated staff refused the resident use of her own leg mobility machine (CPM).

FINDINGS:

The identified resident's physical therapy notes were reviewed and an interview was conducted with the Director of Physical Therapy who stated, "In my six and a half years that I have worked as a Physical Therapist, I have never had someone ask to use their own CPM." Also, there was no documentation in the physical therapy notes that the resident had requested to use her own machine. Federal regulations would potentially prohibit the use of personal equipment due to infection control concerns.

Based on records reviewed and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The complainant stated it took, on average, forty-five minutes to answer the resident's call light.

FINDINGS:

During the initial tour and throughout the remainder of the survey, call lights and staff attentiveness were observed. No problems were noted in these areas.

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CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

The complainant stated staff told the identified resident that if she left against medical advice (AMA), Medicare would not pay her bill.

FINDINGS:

The facility provided copies of the facility's "Early Departure Request," signed by the identified resident; discharge checklist; Physician Order for Patient Discharge and the Referral to Home Health. This information included proper notice that discharge from the facility without a physician's order could result in non-payment by Medicare. It could not be determined that the resident discharged AMA.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,



LORENE KAYSER, Supervisor
Long Term Care

LKK/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- Governor
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December 12, 2014

Justin M. Polson, Administrator
Riverview Rehabilitation
3550 West Americana Terrace
Boise, ID 83706-4728

Provider #: 135139

Dear Mr. Polson:

On **November 5, 2014**, a Complaint Investigation survey was conducted at Riverview Rehabilitation. Kirsti Stephenson, R.N., Judy Atkinson, R.N., Susan Gollobit, R.N., Lauren Hoard, R.N. and Sherri Case, L.S.W., Q.I.D.P. conducted the complaint investigation. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted on November 3 - 5, 2014.

The following documents were reviewed:

- The entire medical record of the identified resident;
- Six other resident's records for Quality of Care concerns;
- The facility's grievance files from May 2014 to November 2014;
- The facility's incident and accident reports from May 2014 to November 2014;
- The facility's Frazier Free Water Protocol (FFWP); and,
- The facility's oxygen policy and procedure.

Interviews were conducted with multiple staff, including but not limited to, the Administrator, the Administrator in Training, the Director of Nursing Services (DNS), the Registered Dietician, the Dietary Manager, the Speech Language Pathologist (SLP), a Physical Therapist, licensed nurses and Certified Nurse Aides (CNAs).

Individual interviews were conducted with five different residents. Family interviews were

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conducted with family members of two different residents.

Observations were made of staffing levels during the night shift, call light response times, assistance during dining of two meals and other Quality of Care areas.

The complaint allegations, findings and conclusions are as follows:

Complaint #6590

ALLEGATION #1:

The complainant stated that the identified resident needed to be on a Frazier Free Water Protocol, but the facility refused to comply.

The complainant did not know if the Frazier Free Water Protocol was ever ordered.

FINDINGS #1:

Based on the review of the Physician's Orders and care plan of the identified resident's and interviews with the SLP and DNS, it was determined the resident did not receive the FFWP as ordered.

The facility was cited at F309 for non-compliance related to following physician's orders.

CONCLUSIONS:

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

ALLEGATION #2:

The complainant stated a physical therapist was autocratic and demanding with the identified resident and would not assist the resident's feet into the exercise equipment stirrups for therapy.

FINDINGS #2:

Physical Therapy Treatment Encounter Notes and Progress Notes were reviewed for the identified resident. The medical record lacked evidence that the identified physical therapist was autocratic and demanding towards the resident and lacked evidence that the physical therapist would not assist the resident with foot placement on therapy equipment.

The identified physical therapist was interviewed, and she said it was her practice to allow

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residents to do as much for themselves as possible, in order to reach therapy goals. If the resident was unable to place extremities into the therapy equipment, the physical therapist would assist.

Based on records reviewed and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the DNS and therapy staff tried to discharge the resident because there was nothing more they could do. An appeal was requested, and the facility messed it up, resulting in a longer stay at the facility. The identified resident's primary care provider was going to contact the facility to let them know it wasn't in the resident's best interest to be discharge.

The complainant stated the facility's physician was never seen.

FINDINGS #3:

Review of progress notes for the identified resident revealed the Administrator in Training and DNS spoke with the resident's Durable Power of Attorney (DPOA) on several occasions regarding discharge planning, the reason for discharge due to a lack of progress with therapy and the paperwork necessary to discharge the resident to a local facility where the resident could receive additional therapy services. Health and Welfare approved the resident's appeal and discharge was delayed due to the facility's inability to acquire the necessary signatures needed for transfer and the determination of where the resident would be discharged to, if not to another local facility.

Review of progress notes revealed the facility was in communication with the identified resident's primary care provider in regards to the resident's discharge plan; who expressed concern of the resident being discharged to a hotel rather than a facility that could accommodate the resident's needs.

Review of Physician and Nurse Practitioner dictation notes revealed the identified resident was seen by the facility's physician after admission, and the nurse practitioner saw the resident on two occasions thereafter.

The Administrator, Administrator in Training and the DNS were interviewed. They said the identified resident's primary care provider was concerned with a discharge to a hotel. The

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discharge process was moving forward until the facility was unable to attain signed documents necessary for transfer.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated the resident's oxygen saturation level dropped into the 70's when exercising or walking. Oxygen was ordered but usually was not in place when the resident exercised with the therapist. The oxygen saturation level was not checked until after the resident stopped the activity and was seated.

FINDINGS #4:

The identified resident's medical record was reviewed and provided evidence that the resident received oxygen during therapy and maintained oxygen saturations within normal limits.

The physical therapist was interviewed and said that the identified resident received oxygen during therapy initially; oxygen was not used further into the stay as a therapeutic goal or to maintain oxygen saturations within normal limits. The physical therapist said after therapy the resident would receive oxygen as a safety measure and oxygen saturations remained within normal limits.

The resident's medical record did not provide evidence that the resident's oxygen saturations dropped into the 70's during therapy or when not in therapy.

Although the survey team was unable to determine deficient practice for the identified resident, the facility was cited at F328 for failure to meet the respiratory needs of other residents.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

The complainant stated there was not enough staff on the night shift, and several CNAs complained about it.

The complainant stated one night, nursing staff was found listening to the radio, on the other side of the building.

The complainant stated a request was made by phone asking for assistance to take care of the identified resident because the facility was short staffed.

FINDINGS #5:

Progress notes for the identified resident were reviewed related to a phone call to the DPOA requesting assistance in caring for the resident due to low staffing levels. There was insufficient evidence to determine any deficient practice.

The Administrator, Administrator in Training and the Director of Nursing Services were interviewed regarding a phone call to the DPOA, requesting assistance in caring for the resident and the alleged incident. They said the DPOA requested to be a part of the resident's care due to a long history of caring for the resident and knowledge of the resident's preferences and communication methods. They said the DPOA was not called in to provide resident care because of low staffing levels. They had no recollection of staff listening to a radio on the other side of the building.

Based on observations, records reviewed and staff, family and resident interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated staff falsify records, and the identified resident fell because the alarm had been turned off or there wasn't enough staff to respond to alarms.

The complainant stated a licensed nurse said other residents complained about the alarm sounding frequently, and the day nurse turned off the alarm but documented that the alarm was on.

FINDINGS #6:

Progress notes and Incident and Accident reports were reviewed for the identified resident and documented the tab alarm was in place and functioning at the time of the resident's fall out of bed in July 2014.

The Administrator and Director of Nursing Services were interviewed regarding the identified resident's fall and the use of a tab alarm. They said the alarm was on and functioning at the time

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of the resident's fall.

Based on records reviewed and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The complainant stated the identified resident lost over ten pounds in three weeks and frequently found snacks still wrapped in cellophane in the resident's room.

The complainant stated other residents said staff was not helping the resident in the dining room.

FINDINGS #7:

Dietary Progress Notes, care plan, weight records and food intake records were reviewed for the identified resident regarding weight loss. The resident's care plan provided multiple interventions related to food preferences and routines. The food intake records showed the resident at 75% to 100% of meals, and snacks were accepted more often than not. Dietary progress notes documented discussions with the resident and DPOA regarding diet recommendations, preferences, average food intake and weight management concerns. Weight records revealed the resident lost 2.9 pounds in three weeks.

The Registered Dietician and Dietary Manager were interviewed regarding weight management for the identified resident, and said they spoke with the DPOA and resident often; the resident and DPOA never voiced concerns with weight. They were not aware of any significant weight loss for the resident.

Although the survey team was unable to determine deficient practice for the identified resident, the facility was cited at F325 for failure to meet the nutritional needs for other residents.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #8:

The complainant stated admission papers were not received until July 21, 2014, and the facility never went over the paperwork.

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FINDINGS #8:

Progress notes for the identified resident were reviewed and revealed multiple attempts were made to get the admission agreement signed by the DPOA.

The Administrator, Administrator in Training and the DNS were interviewed regarding the admission paperwork for the identified resident. They said the DPOA wanted copies of the admission paperwork to review and that they usually go over the admission paperwork with residents or residents' representatives. They said multiple attempts were made to get the admission paperwork signed but it was refused.

Based on records reviewed and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

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

LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor
Long Term Care

LKK/dmj