



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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3232 Elder Street
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Boise, ID 83720-0009
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CERTIFIED MAIL: 7012 1010 0002 0836 2052

November 21, 2013

Adam J. Smith, Administrator
Grangeville Health & Rehabilitation Center
410 East North Second Street
Grangeville, ID 83530-2258

Provider #: 135080

Dear Mr. Smith:

On **November 7, 2013**, a Recertification and State Licensure survey was conducted at Grangeville Health & Rehabilitation Center by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in

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the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 4, 2013**. Failure to submit an acceptable PoC by **December 4, 2013**, may result in the imposition of civil monetary penalties by **December 24, 2013**.

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

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

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

- The administrator must sign and date the first page of both the federal survey report, Form

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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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **December 12, 2013 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 12, 2013**. A change in the seriousness of the deficiencies on **December 12, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 12, 2013** includes the following:

Denial of payment for new admissions effective **February 7, 2014**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 7, 2014**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS

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Regional Office or the State Medicaid Agency beginning on **November 7, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through 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 4, 2013**. If your request for informal dispute resolution is received after **December 4, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj
Enclosures

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

PRINTED: 11/20/2013
FORM APPROVE
OMB NO. 0938-035

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2013
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NAME OF PROVIDER OR SUPPLIER GRANGEVILLE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 410 EAST NORTH 2ND STREET GRANGEVILLE, ID 83530
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Arnold Rosling, RN, BSN, QMRP Becky Thomas, RN</p> <p>The survey team entered the facility on Monday, 11/4/13 and exited on Thursday, 11/7/13.</p> <p>Survey Definitions: ADL = Activities of Daily Living AIT = Administrator in Training BIMS = Brief Interview for Mental Status cm = Centimeters CAA= Care Area Assessment CNA = Certified Nurse Aide DON = Director of Nursing GDR = Gradual Dose Reduction IDT = Interdisciplinary Team LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment NA = Nurse Aide NOC = Night shift POA = Power of Attorney PRN = As Needed ROM = Range of Motion</p>	F 000	<p>Please except this plan of correction as</p> <p>Our written credible allegation of</p> <p>Compliance.</p> <p>This plan of correction is submitted as required under Federal and State Regulations and statutes applicable to Long Term Care Facilities. This plan of correction does not constitute an admission of liability, and such liability to hereby specifically denied. The submission of this plan does not constitute agreement by the facility that surveyors conclusions are accurate that the findings constitute a deficiency, or that the severity of the deficiencies cited is correctly applied.</p>	
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p>	F 241	<p>RECEIVED</p> <p>DEC 18 2013</p> <p>FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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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OMB NO. 0938-0391

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F 241	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and observation, it was determined the facility failed to ensure residents were treated with dignity and respect during their dining experience when staff ignored residents while talking amongst themselves, staff failed to notice a resident with a large nasal discharge, clothing protectors were given to residents without their permission and were not offered a cloth napkin, and napkins were not readily accessible for staff to offer them as an alternate to clothing protectors. This was true for 1 of 10 sampled residents (# 3), 8 random residents (#s 12-19), and all other residents observed during meals. This practice created the potential to negatively affect the residents' self-worth and self-esteem. Findings included:</p> <p>1. On 11/5/13 from 7:52-7:54 AM during the breakfast observation, N.A.'s #1-3 and C.N.A.'s #4 & 5 were observed sitting at a table in the main dining room with Resident's #13-19. The five staff members were heard discussing an upcoming meeting they were to attend. During the conversation, the staff did not engage any of the residents and ignored the residents who needed assistance with their meals.</p> <p>On 11/7/13 at 9:10 AM N.A. #1 was interviewed regarding the observation. She said the five staff were talking about an upcoming staff meeting. When asked if the C.N.A. class she attended had covered the dining experience chapters, she said it had and it included to talk about topics the residents were interested in. When asked if the topic of the upcoming meeting was brought up by</p>	F 241	<p>F241</p> <p>Resident Specific:</p> <p>Residents number 13 through 19 will have appropriate conversations at the meal table.</p> <p>Resident number 12 will have appropriate personal cares at all times. Will be assisted appropriately by CNA's as needed.</p> <p>Other Residents:</p> <p>Please see systemic changes. All residents will have appropriate conversations during meals. All residents will be assisted with personal cares by nursing staff as needed. All residents will be offered cloth napkins at each meal, and may use clothing protectors as resident chooses</p>	
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F 241	<p>Continued From page 2 a resident she stated, "No."</p> <p>On 11/7/13 at 9:33 AM N.A. #2 was interviewed regarding the observation. She confirmed the five staff were talking about an upcoming staff meeting.</p> <p>On 11/7/13 at 9:37 AM RN #6, who conducted the C.N.A. course, was interviewed regarding the observation. She said the dining experience chapter of the course had been taught. When asked about the observation regarding the staff discussing the upcoming meeting, she stated, "They shouldn't be doing that at all...they knew better." She also stated she would review this issue in the class, "they will be told again."</p> <p>2. On 11/5/13 at 7:45-7:50 AM during the breakfast observation, C.N.A. #7 assisted Resident #12 with his meal set up. The resident had a large amount of discharge coming from his nose at the time, however the C.N.A. did not pay attention to the resident's condition and walked away.</p> <p>At 7:50 AM, C.N.A. #7 was stopped by the surveyor to notice the resident's nose, where upon the C.N.A. retrieved a tissue and wiped the resident's nose.</p> <p>On 11/5/13 at 5:50 PM, the Administrator and the DON were informed of the observation.</p> <p>3. On 11/5/13 at 5:10 PM, during the dinner observation, the Activity Director was in the main dining room and asked residents if they wanted a clothing protector or a napkin. Four of the residents declined the clothing protectors.</p>	F 241	<p>Systemic Changes:</p> <p>Staff have been verbally in serviced on Maintaining residents dining experience with dignity and respect , cloth napkins will be offered at each meal, residents may use clothing protectors as resident chooses. Appropriate resident friendly conversation during meals. Will assist residents with personal cares as needed.</p> <p>Monitors:</p> <p>DON or designee will observe to meals weekly times six months to ensure residents are being treated with dignity and respect that cloth napkin are being offered at each meal and residents may use clothing protectors as they choose. To ensure resident appropriate conversations during meal. That all residents will have appropriate personal cares by staff.</p> <p>DON or Designee will report findings at the Q.A meetings and will make changes to the above plan of correction as needed.</p>		

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F 241	Continued From page 3 At 5:20 PM, four aides came into the main dining room and began passing out clothing protectors to the residents without asking if they preferred them or not, including the four residents who declined them earlier. On 11/7/13 at 11:05 AM RN #6, who conducted the C.N.A. course, was interviewed regarding the observation. She stated of her N.A.s, "They've all be instructed to what they [residents] prefer." 4. On 11/5/13 at 7:30 AM and 5:20 PM, during the breakfast and dinner observations, staff were observed with clothing protectors in their arms and asked residents if they wanted clothing protectors or a napkin. On 11/6/13 at 11:50 AM, during the lunch observation, staff were observed with clothing protectors in their arms and asked residents if they wanted clothing protectors or a napkin. Note: During each observation, the staff did not carry cloth napkins with them and had to retrieve them from a cabinet drawer in the dining room when residents requested them. The laundry cart where staff retrieved the clothing protectors also did not contain napkins. On 11/7/13 at 12:55 PM the Administrator, DON, and AIT were informed of the dignity issues. No further information was provided by the facility.	F 241	Date of compliance: 12/06/2013		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activifies designed to meet, in accordance with the comprehensive assessment, the interests and	F 248			

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F 248	<p>Continued From page 4</p> <p>the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide an ongoing program of activities to include: - Activities based on assessments for 3 residents who triggered for activities, - A calendar of activities with variety built into the daily programs, and - Pre-meal activity to entertain/engage residents which would prevent boredom.</p> <p>This was true for 4 of 10 (#s 2, 3, 8 & 9) sampled residents and 8 (#s 12, 14, 18, 20, 21, 22, 23 and 24) random residents. This created a potential for psychological harm when residents were provided minimal activities which potentially could create an atmosphere of boredom and foster an increase in negative behaviors. Findings include:</p> <p>1. Three residents (#s 3, 8, & 9) were sampled that had triggered activities on the MDS assessments. The facility failed to develop and implement an activity program for these residents. The findings were:</p> <p>a. Resident #3 was admitted to the facility, on 5/29/13, with diagnoses of dementia with lewy bodies, depressive disorder and glaucoma.</p> <p>The admission MDS assessment, dated 6/4/13, documented the resident was severely cognitively impaired, required limited assistance with ADLs and the CAA triggered for activities due to little</p>	F 248	<p>Resident Specific:</p> <p>Residents number 2,3,8,9 have been assessed for their activity needs and care plans have been developed accordingly to meet their individual needs both physically and cognitively.</p> <p>Activities director or designee will ensure an activity occurs prior to all meals including breakfast lunch and dinner that meets all resident's needs, both physically and cognitively.</p> <p>Other Residents:</p> <p>See systemic Changes: All other residents will have their care plans developed to meet their specific needs both physically and cognitively.</p> <p>Activities will work and collaborate with occupational therapist in the development of ongoing activities designed to match residents interests according to residents ability both physically and cognitively.</p>	

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F 248	<p>Continued From page 5</p> <p>interest or pleasure in doing things. The CAA, dated 6/7/13, documented the resident, "Triggered due to mood interview indicating little interest or pleasure in doing things. She does not present to be in any distress. She reports that she has struggled some with little interest in doing things and depression related to her current health. She is unable to tell this Swer [social worker] the frequency of these..."</p> <p>The Initial Activity Assessment, dated 6/7/13, documented the resident's activity interests of: games, exercise, walking/wheeling outside, music, reading, writing, spiritual/religious, trips, talking/conversing, social events and radio.</p> <p>The resident's care plan for Activities, with a start date of 5/29/13, documented approaches, dated 6/7/13, of:</p> <ul style="list-style-type: none"> - Allow resident to follow the news through newspapers, TV, or staff report. - Allow resident to verbalize feelings. - Assist to go outside when weather is permitting. - Encourage individual and small group activities. - FYI: Due to the resident's tremors she can be very hard to understand [sic] what she says, have patience and listen closely. - Introduce to other residents with similar interests to promote socialization and new friendships. - Offer and invite to religious/spiritual events but respect resident's right to decline. - Provide self motivating material at resident's request. - Remind resident of upcoming activities and events. - Resident will have a calendar of scheduled monthly activities in room." <p>Review of the resident's Program Participation</p> 	F 248	<p>Activities Director and Grangeville Health and Rehabilitation Center have subscribed to web page (notjustbingo.com) to assist with activity ideas to meet residents needs. Will involve residents, and resident responsible party when developing care plan.</p> <p>Three new activities will be added to the activities calendar each month. Will discuss at resident council each month to gather information on likes and dislikes of each new activities, and to gather ideas from residents.</p> <p>Activities director or designee will ensure an activity occurs prior to all meals including breakfast lunch and dinner that meets all resident's needs, both physically and cognitively.</p> <p>Systemic Changes:</p> <p>Activities Director has been verbally in serviced to review all residents care plans to ensure activities meet resident needs both physically and cognitively. And to make changes accordingly.</p>		

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F 248	<p>Continued From page 6</p> <p>Record for October 2013 documented the resident participated in the following activities on the date listed: Music = 10/16, Reading/writing = 10/4, 10/18, and 10/25, Movies = 10/10, 10/15, 10/17, 10/29, and 10/31, Intergenerational = 10/30, Resident Socializing = 10/30 and 10/31, Party = 10/31, Special event = 10/30 and 10/31, Visits 1 - 1 = 10/7 and 10/28, Sports = 10/25, Arts/crafts = 10/18, Auditory Stimulation = 10/16, Cooking = 10/4, Nails = 10/8 and 10/28, and Religious Activity = 10/24 and 10/31.</p> <p>Review of the resident's Program Participation Record for September 2013 documented the resident participated in the following activities: Music = 9/24 and 9/26, Reading/writing = 9/3, 9/4, 9/6, 9/11, 9/12, 9/17, 9/19, and 9/20, Movies = 9/5, 9/10 (declined), 9/19, Resident socializing = 9/26, Family visits = 9/12, Special Event = 9/26, Sports = 9/6 and 9/20, Auditory stimulation = 9/24, Multi-sensory stimulation = 9/26, Pet visits = 9/24, and Religious Activity = 9/5, 9/12 and 9/26 (declined).</p> <p>The resident's Program Participation Record for August 2013 was reviewed. In summary the resident only attended 20 activities for the month.</p> <p>The resident was observed during the survey to</p>	F 248	<p>Monitors:</p> <p>Administrator will review monthly calendars to ensure three new activities are added each month times six months.</p> <p>Administrator will observe at least three resident's weekly times six months to monitor their involvement in activities and to ensure the activity meets resident needs both physically and cognitively.</p> <p>Administrator will meet with residents and families at care plan conference to discuss activities and if they meet resident's needs.</p> <p>Activities consultant to review activities plan/calendar q 2 months times four visits to ensure a variety of activities are implemented and that activities meet resident specific needs.</p> <p>Administrator will report findings at the Q.A meeting and will make change to the above plan of correction as needed.</p>		

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F 248	<p>Continued From page 7</p> <p>not participate in activities. The resident went to her room and laid down after meals. The observations were almost the same each observation: the privacy curtain was pulled around the resident's bed, no music was playing, the resident's roommate had the TV on when she was in the room, but the curtain was pulled so the resident, if she was awake, could not see it. Some of the observation dates and times were as follows:</p> <p>11/5/13 from 8:55 a.m. to 11:25 a.m. in bed resting.</p> <p>11/5/13 from 1:00 p.m. being transferred to bed, at 1:10 p.m. resting until after 4:30 p.m.</p> <p>11/6/13 from 9:00 a.m. to after 11:00 a.m. in bed resting.</p> <p>11/6/13 from 1:30 p.m. to after 3:35 p.m. in bed resting.</p> <p>The resident's activities were not based on her assessed interests, and the resident was put to bed after meals.</p> <p>The Activities Director (AD) was interviewed on 11/7/13 at 8:30 a.m. She said the resident does attend some activities. She indicated the staff put all the residents to bed after meals and trying to get the residents to activities had been a challenge. She indicated the resident did attend Bible study but, review of the three participation records, revealed participation was declining with the activity.</p> <p>b. Resident #8 was admitted to the facility on 4/6/12 with diagnoses of diabetes mellitus type II, Dementia unspecified without behavior disturbance and senility without psychosis.</p> <p>The annual MDS assessment, dated 4/4/13,</p>	F 248	<p>Activities director or designee will ensure an activity occurs prior to all meals including breakfast lunch and dinner three times weekly for six months.</p> <p>Date Of Compliance: 12/06/2013</p>		

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F 248	<p>Continued From page 8</p> <p>documented the resident had short and long term memory problems, required extensive assistance with ADLs, and triggered for activities.</p> <p>The Initial Activity Assessment, dated 4/9/12, documented the resident's activity interests of: walking/wheeling outside, music, talking/conversing and social events. The assessment was completed with the assistance of the resident's family member.</p> <p>The resident's care plan for Activities, with an initial start date of 4/6/12 documented approaches, dated 6/14/13, of:</p> <ul style="list-style-type: none"> - Invite and encourage to attend activities of interest i.e.; music, outdoors, social events, etc. - Invite and encourage to attend all Catholic functions within the facility, but respect right to decline. - Provide with calendar of scheduled monthly activities. - Resident may have a diet holiday, but watch sweets r/t [related to] being Diabetic. - Resident is of Catholic Faith, it is important to her to receive communion each Sunday. - Seat close to activity staff to help promote maximum participation. <p>The resident's Program Participation Records for August 2013, September 2013, and October 2013 documented "family visits" and "movement" almost daily. The resident's daughter visits daily, takes her for walks and feeds her lunch. The resident's activity participation for the other activities showed three month totals of:</p> <p>Movies = 4, Music = 2, Reading/writing = 4, Visits 1 - 1 = 2,</p>	F 248		
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F 248	<p>Continued From page 9</p> <p>Social events = 2 Walks = 3, Auditory Stimulation = 1 Multi-sensory stimulation = 1 Pets = 1, and Religious Activity = 13.</p> <p>The resident was observed during phase two of the survey. The resident on 11/6/13 was observed from 1:30 p.m. to after 3:35 p.m. in bed resting. The resident's privacy curtain was pulled around her bed. There was no radio or TV on. The resident appeared to be sleeping.</p> <p>The resident did not get activities based on her assessed interests, the resident was put to bed after meals. The AD was interviewed on 11/7/13 at 8:30 a.m. She indicated the resident does attend some activities and the resident's daughter visits almost daily around lunch time. The Activity director further said that she assists restorative by doing ROM. She said that the resident likes to sit out front and look out the window. She has been doing more visiting since her teeth have been fixed. When asked about her being in bed asleep the activity director said, "That's where she gets put." "I've asked them [aides] to not lay her down" but she [AD] said she "turns around and then she's laid down." "I'm told often they [residents] need to be laid down" by aides.</p> <p>c. Resident #9 was admitted to the facility on 9/19/13 with diagnoses of renal failure, diabetes mellitus uncomplicated and senile dementia.</p> <p>The admission MDS assessment, dated 9/25/13, documented the resident was severely cognitively impaired, required extensive assistance with ADLs and triggered for activities due to little</p>	F 248		

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F 248	<p>Continued From page 10</p> <p>interest or pleasure in doing things. The activity CAA, dated 9/25/13, documented the resident, "reports that he has been struggling with little interest or pleasure in doing things, feeling down, feeling tired, sleeping etc... however is unable to report to this Swer the origin of these concerns. When asked, 'Can you tell me more about that,' he reports, 'No, I can't, really.' He does report that his pain is limiting some of his activities...."</p> <p>The Initial Activity Assessment, dated 9/27/13, documented the resident's activity interests of: exercise, walking/wheeling outside, music, reading, spiritual/religious, trips, shopping, sports, watching TV, gardening/plants, talking conversing, social events, radio, hobbies. The resident had no interest in movies. [See example #2 which shows the Activity Calendars have movies scheduled three days a week.]</p> <p>The resident's care plan for Activities, with a start date of 9/19/13, documented: "The following areas are very important or somewhat important in the patient's daily routine: reading, visiting with pets or other animals, keeping up with the news, participating with group activities, doing favorite activities, spending time outdoors, and participating in religious activities. The approaches, dated 8/2/13, were: "- Encourage and assist as needed to activities of choice. - Provide a schedule of facility directed activities. - Provide verbal socialization during direct contact. - Resident wants to be invited to all scheduled activities. Respect resident's right to decline."</p> <p>The resident's Program Participation Records from September 19, 2013 through October 31,</p>	F 248		
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F 248	<p>Continued From page 11</p> <p>2013 were reviewed. The number of times the resident participated in the following activities were:</p> <ul style="list-style-type: none"> Music = 3 Reading/writing = 1 Movies = 2 Resident socializing = 3 Family visits = 2 Party = 2 Visits 1 - 1 = 2 Auditory stimulation = 1 Multi sensory stimulation = 2 Pets = 1 Cooking = 1 <p>The resident was observed during phase two of the survey. The resident on 11/6/13 was observed at 1:30 p.m. sitting across from the nurses station with his arms crossed doing nothing. From 2:00 p.m. to 3:35 p.m. the resident was in bed resting without any music or TV on in his room.</p> <p>On 11/7/13 at 8:30 a.m. the AD was interviewed. When asked about Resident #9 she stated, "They have him in therapy all day long." "He's currently down in the kitchen with therapy cooking." The director admitted the care plan did not address the activity and indicated the care plan needed to be updated.</p> <p>2. The Activity Calendars were reviewed for August 2013, September 2013, October 2013 and November 2013. The calendars lacked variety, and enough scheduled activities throughout the day to maintain resident interests. The August 2013 calendar had more things for the residents to do throughout the day than the following three months. The August activities were:</p>	F 248		
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F 248	<p>Continued From page 12</p> <p>Bible study (every Thursday), Get Fit (every Thursday), Movie and a snack (every Tuesday and Thursday), Bingo (every Monday, Wednesday(except third Wednesday) and Friday), Soft music and TMC Movie (every Saturday), Communion and church Services (every Sunday), Nail Time (every Monday), Be Creative (Every Friday), and Fun with Marilyn (Every Friday).</p> <p>The September 2013 Calendar for activities were: Bible study (every Thursday), Movie and a snack (every Tuesday and Thursday), Out for walks (every Tuesday) Reading (every Wednesday) Lets play a game (every Thursday), Bingo (every Monday, Wednesday (except second Wednesday) and Friday), Soft music and TMC Movie (every Saturday), Communion and church Services (every Sunday), Nail Time (every Monday), Be Creative (Every Friday), and Fun with Marilyn (Every Friday).</p> <p>The October 2013 Calendar for activities were: Bible study (every Thursday), Movie and a snack (every Tuesday and Thursday), Group Exercise (every Tuesday) Reading and reading with Theresa (every Wednesday) [Note: two reading activities on the same day] Bingo (every Monday, Wednesday (except second Wednesday) and Friday), Soft music and TMC Movie (every Saturday), Communion and church Services (every Sunday),</p>	F 248			

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F 248	<p>Continued From page 13</p> <p>Nail Time (every Monday and Tuesday), Be Creative (Every Friday), and Fun with Marilyn (every Friday).</p> <p>The November 2013 calendar for activities were: Bible study (every Thursday), Movie and a snack (every Tuesday and Thursday), Reading (every Wednesday) Bingo (every Monday, Wednesday (except second Monday and Wednesday) and Friday), Soft music and TMC Movie (every Saturday), Communion and church Services (every Sunday), Nail Time (every Monday), Be Creative (Every Friday), and Fun with Marilyn (every Friday).</p> <p>The AD was interviewed on 11/7/13 at 8:30 a.m. When asked about the Activity Calendar's repetition and the lack of variety she stated, "I'm not doing enough for them? Because I have been in classes for the past two months I have not been able [to do more]." She indicated she was taking CNA classes Monday through Fridays. She further said that she had been told she did not need any additional training or help. She said she was new at the AD job. [Note: review of her credentials revealed she completed the AD Training Program on October 5, 2012]</p> <p>3. During the survey the last scheduled activity on the calendar for 11/5/13 and 11/6/13 were finished by 4:00 p.m. For both evening meals at least 10 residents were seated in the dining room waiting at least an hour for dinner to arrive. Dinner was scheduled for 5:30 p.m. The dining room observation revealed the residents did not have any type of activity to keep them awake or prevent boredom while waiting for the meal to</p>	F 248		
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F 248	<p>Continued From page 14</p> <p>arrive. Some of the pre-meal observations were:</p> <p>11/5/13 4:00 - 4:15 p.m. -AD was reading to Resident #5 in the common area while sitting on the couch. No other activity was scheduled and no other activity was going on in the facility.</p> <p>11/5/13 4:38 p.m. - 5:28 p.m. main dining area observations:</p> <p>-4:38 p.m. Twelve residents were in the dining room. The AD was passing out coffee and cocoa to the residents that were sitting there. The TV was turned on to a cooking program. The volume was low enough it could not be heard. None of the residents appeared to be watching the program.</p> <p>- 4:42 p.m. An LN came in and gave a resident medications.</p> <p>- 4:45 p.m. Ten residents (#s 2, 12, 14, 18, 20, 21, 22, 23, 24 and 25) were present in the dining room. The observations were: 1 resident reading a book, 1 resident reading a newspaper and two residents socializing. The rest of the residents were in various stages of falling asleep.</p> <p>- 4:46 p.m. The AD took a resident out of the room and the CDM (Certified Dietary Manager) replaced her at serving up coffee and cocoa.</p> <p>- 4:50 p.m. The AD returned to the group with the resident with whom she had left.</p> <p>- 4:55 p.m. The ADr was seated next to Resident #5 and watched her read a book. She did not interact with any of the other residents in the room.</p> <p>- 4:58 p.m. A staff member turned the TV off and proceeded to pass fluids to residents coming into the room. The residents were not engaged in any activity, there was no TV or music on. Resident #5 was taken out of the dining room to be watched by staff at the nurse's station.</p>	F 248		
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F 248	<p>Continued From page 15</p> <ul style="list-style-type: none"> - 5:05 p.m. There were 20 residents in the dining room and still nothing going on for activities. - 5:08 p.m. The AD was back passing fluids to residents. She was the only staff person in the room. No activities were going on. - 5:10 p.m. The AD left the room and brought back a cart with clothing protectors. She started going around the room delivering them to residents who wanted them. - 5:20 p.m. Four aides came into the dining room and started preparing residents for supper. - 5:28 p.m. The first supper tray was served. <p>11/6/13 11:50 a.m. - 12:00 p.m. Main Dining Room - 23 residents were sitting at tables waiting for lunch. No TV, no radio and no activity was going on. The AD was in the room but only to assist residents with clothing protectors and napkins. The AD did not provide any kind of entertainment or meaningful interaction with residents during this observation. In the Assisted Dining Room, the TV was on and staff were interacting with the residents.</p> <p>11/6/13 4:10 p.m. - The AD was in the common area just standing there for a minute, not interacting with residents, then walked away. There were 3 residents in the area; one of those residents was sleeping in a chair.</p> <p>11/6/13 from 4:30 p.m. to 5:14 p.m. The main dining room observations were:</p> <ul style="list-style-type: none"> - 4:30 p.m. There were eight residents in the dining room. One Aide was passing out coffee and cocoa. The TV was on the Hallmark channel and the volume was down and barely audible. None of the residents appeared to be watching TV. Two residents were socializing, two residents were reading, and two residents were sleeping. 	F 248			

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F 248	<p>Continued From page 16</p> <p>The AD was out by the nurse's station with Resident #5.</p> <p>- 4:30 - 4:37 p.m. The AD was sitting on the couch in the common area next to Resident #5 who was reading while sitting in her wheelchair. Another resident was sleeping on the couch and another one was looking around. No activity was going on. The AD then talked with a family member about a personal hobby of quilting, this lasted for a few minutes. After the conversation the AD was still sitting there, then got up and left the area.</p> <p>- 4:35 - 4:55 p.m. In the main dining room the TV was observed to be on the Hallmark channel with a movie playing; the volume was turned way down and hard to hear. At 4:55 p.m. there were 16 residents in the dining room. Two may have been watching the TV, two were reading, four residents were socializing, Resident #5 had an RN with her. The rest of the residents were not engaged in any activity.</p> <p>- 5:05 p.m. Seventeen residents were in the dining area, the TV was still on with the movie playing, the volume low and hard to hear. Four residents were socializing, two residents were sleeping, 2 residents were looking out into space, none of the residents appeared interested in the TV. An LN was passing water and fluids to the residents.</p> <p>- 5:10 p.m. Nineteen residents in the dining room. Two residents left to go to the bathroom. The TV had the same movie on; only one resident appeared to be looking at it. Several residents appeared to be sleeping, two were talking, several were watching a nurse pass medications to Resident #8 and several residents were watching the surveyor take notes.</p> <p>- 5:12 - 5:14 p.m. No change in what the residents were doing. At 5:14 p.m. the AD</p>	F 248		

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F 248	Continued From page 17 brought in the cart with the clothing protectors and started to distribute them to residents. On 11/7/13 at 8:30 a.m. the AD was interviewed about the observations. She said that she was in CNA classes and was assisting staff and residents with cares during these observations. Resident #5 was not on a one to one but staff stayed near her because of her history of falls. The AD felt a responsibility for staying close to Resident #5. No other information was provided.	F 248			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280			

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F 280	<p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure Resident #6's care plan was updated to accurately reflect her status related to use of a wandergard. This was true for 1 of 10 (# 6) sampled residents. This created a potential for psychological harm if facility staff had placed a wandergard on her and created restrictions on her ability to move about freely. Findings include:</p> <p>Resident #6 was admitted to the facility 3/18/13 with diagnoses of chronic obstructive pulmonary disease (COPD), ischemic heart disease, depressive disorder and anxiety state.</p> <p>The quarterly MDS, dated 9/19/13, documented the resident was cognitively intact with a BIMS of 14 and was able to move her wheelchair independently within and outside the unit.</p> <p>The resident's comprehensive care plan included a problem, dated 3/18/13 and edited on 10/3/13 which documented, "Category: ADL Functional/Rehabilitation Potential. Self-care deficit: r/t [related to] COPD and chronic pain." The problem listed an intervention, dated 8/1/2013, which documented, "Wandergaurd [sic] bracelet to leg - check for placement QS [each shift]."</p> <p>The MDS coordinator was interviewed on 11/7/13 at 10:00 a.m. She stated the Wanderguard had been discontinued on 8/4/13. She provided the documentation to show it had been discontinued.</p>	F 280	<p>Resident Specific:</p> <p>Resident number six has had her care plan updated to reflect deletion of wonder guard.</p> <p>Other Residents:</p> <p>All other residents care plans have been audited to ensure proper documentation of wander guard use.</p> <p>Systemic Changes:</p> <p>MDS Coordinator has been verbally in serviced on adding or deleting care plan interventions. To ensure these interventions are appropriate to meet resident needs.</p> <p>Monitors:</p> <p>DON and MDS coordinator will review three care plans weekly for six months to ensure all appropriate interventions have been added or deleted appropriately to meet resident needs.</p> <p>DON and MDS coordinator will report findings at the Q.A meeting and will make change to the above plan of correction as needed.</p>	

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F 280	Continued From page 19 The Administrator and DON were informed on 10/7/13 at 12:55 p.m. No further information was provided.	F 280	Date of Compliance: 12/06/2013	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to supervise residents in the dining room while they were eating. This was observed for 1 of 10 sampled (# 6) residents. The facility's failure to respond immediately when Resident #6 started choking on her dinner, placed the resident at risk for airway obstruction Findings include: Resident #6 was admitted to the facility on 3/18/13 with diagnoses of chronic obstructive pulmonary disease, depression and anxiety state. The 9/19/13 quarterly MDS assessment documented the resident was cognitively intact with a BIMS of 14, and required set up assistance and supervision of one staff for eating. Resident #6 was observed, on 11/5/13 at 5:20 p.m., during the evening meals to be seated at the end of a table located on the far left hand side	F 323	F323 Resident Specific: Resident number six was evaluated by Medical Director on date of incident noted by State surveyor and was placed on alert. Referral has been obtained to have resident evaluated by speech therapist. This was done to evaluate the patient for possible interventions to decrease the risk of choking. Other Residents: Please see systemic changes. All other residents will be observed by the charge nurse during meals to monitor for assistance.	

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F 323	Continued From page 20 of the dining room. The resident was seated in a way that she could only be seen from the back. On 11/5/13 at 5:28 p.m. an aide delivered Resident #6's food tray and asked if she needed anything else then left. At 5:30 p.m. the resident started to choke on her vegetable soup. The resident was observed to become cyanotic and did not have any airway exchange for 30 to 40 seconds. Resident #6 was able to partially clear her airway and started to resume eating. As a result she started to choke again and turned cyanotic. She appeared to be have trouble clearing her airway so she could eat. The resident continued choking until 5:35 p.m. when a CNA walked by the resident, observed her choking, and summoned LN #9, who was busy passing trays on the far side of the room. The nurse assisted the resident by giving her a drink, then removed her from the room into the hallway so the resident could catch her breath and clear her airway. LN #9 was involved passing trays to residents and was not supervising the residents who needed supervision and were in the process of eating their meal. The Administrator and DON were informed on 11/5/13 at 6:00 p.m. of the dining room observations. The nursing staff were observed to be watching and helping residents that need assistance at meal time after the facility was informed of the incident.	F 323	Licensed nurse will observe and make self-available during meals to ensure resident safety and to meet resident needs. Charge nurse will not pass trays during meals and will be constantly observing dining room for any resident need or safety concern. Systemic Changes: All Licensed nurses have been verbally in serviced on importance of being available during meals to address any concerns involving residents and to meet their needs immediately. Monitors: DON or designee will observe two meals weekly times six months to ensure licensed nurse is monitoring dining room and meeting all resident needs and to ensure resident safety. DON or designee will report findings at the Q.A meeting and will make change to the above plan of correction as needed. Date of Compliance:	
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329	12/06/2013	

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F 329	<p>Continued From page 21</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</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 staff interview, it was determined the facility failed to consider the risks identified by the Food and Drug Administration (FDA) and to ensure residents were free from unnecessary drugs. This was true for 3 of 5 sampled residents (#s 1, 5 and 8). The implementation of medication drugs without adequate indication of use or full consideration of the serious side effects, placed residents at risk for adverse reactions and health decline. Findings included:</p>	F 329	<p>Resident Specific:</p> <p>Resident's numbers one, five and eight have had indication for medications reviewed; residents and or responsible parties have been informed of Black Box Warnings in association with medications.</p> <p>Resident number eight has been on alert charting for two weeks to review resident behaviors related to dementia with delusions. Physician has been updated regarding behaviors and a gradual dose reduction has been requested.</p> <p>Other Residents:</p> <p>See systemic changes. Have reviewed all residents who receive antipsychotic medications to ensure residents or responsible party are aware of risk verses benefits and adverse side effects as well as black Box Warnings.</p> <p>All residents with current orders for antipsychotic medications have been reviewed for indications of use.</p>	
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F 329	<p>Continued From page 22</p> <p>1. Resident #5 was originally admitted to the facility on 10/18/12 and readmitted on 1/11/13 with multiple diagnoses which included dementia, hypertension, undiagnosed cardiac murmur and hypothyroidism.</p> <p>The latest Quarterly MDS, dated 10/4/13, documented in Section E, the resident experienced delusions 1 to 3 days per week.</p> <p>The resident's Physician Order Report for the month of October 2013 included an order for Risperdal (antipsychotic), with a start date of 7/29/13, to be taken twice per day for the diagnosis of agitation related to dementia.</p> <p>The resident's record did not include documentation the resident and/or family was informed of the "black box" warning, which would indicate a need to closely evaluate and monitor the potential benefits and risks associated with Risperdal.</p> <p>According to Wolters Kluwer/Lippincott Williams & Wilkins Nursing 2013 Drug Handbook, 33rd Edition, page 1194, under Nursing Considerations for Risperdal, the Black Box Warning states, "Fatal cardiovascular or infectious adverse events may occur in elderly patients with dementia. Drug isn't safe or effective in these patients."</p> <p>On 11/6/13 at 2:30 PM, the surveyor asked for documentation the risks and benefits had been explained to the resident's family when adding Risperdal to the resident's medication regimen. The DON stated, "We don't have knowledge of needing the black box warning explained to residents or their families. We just have side</p>	F 329	<p>Systemic Changes:</p> <p>Pharmacy will review resident's physician orders for unnecessary medications every month.</p> <p>All licensed staff have been verbally in serviced on proper documentation prior to initiation of any antipsychotic medication.</p> <p>Antipsychotic medication consents will list all adverse side effects as well as any Black Box Warnings.</p> <p>Prior to administration of Medications, will review with resident or responsible party all adverse side effects as well as Black Box Warnings.</p> <p>Will ensure all appropriate Side Effects and Behavior Monitors are in place and appropriate.</p>	

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F 329	<p>Continued From page 23 effects."</p> <p>2. Resident #8 was admitted to the facility 4/6/12 with diagnoses of diabetes mellitus type II, dementia unspecified without behavior disturbance and senility without psychosis.</p> <p>The 7/3/13 quarterly MDS assessment documented the resident: * had short and long term memory problems, * did not exhibit delusional behaviors, * did not have any physical, verbal or other behavioral symptoms, and * was not taking any psychoactive medications.</p> <p>The 10/1/13 quarterly MDS assessment documented the resident: * did not have any physical or verbal behavioral symptoms directed toward others or other behavioral symptoms not directed toward others, * did not exhibit delusional behaviors, and * was taking a psychotropic medication seven days a week.</p> <p>The physician's recapitulation orders for October 2013 documented on 8/13/13 the resident was started on Seroquel 25 milligrams (mg) at bedtime for "Dementia with delusions."</p> <p>Resident #8's care plan documented a problem dated 4/06/12 and edited last on 10/14/13, of, "Category: Behavioral Symptoms. Occasional noncompliance due to dx [diagnosis] of Dementia with Delusions."</p> <p>The interventions were dated 7/3/13 and documented: "- Allow enough time so that you can move at resident's pace, utilize task segmentation (see ADL CP).</p>	F 329	<p>Staff have been verbally in serviced on all residents with potential need for antipsychotic medication use are to put residents on alert charting for seven days where behaviors will be clearly and specifically identified and documented prior to the beginning of medication use. Then the IDT will meet to review potential causes which may contribute to residents target behaviors to rule out potential need for antipsychotic use.</p> <p>Monitors:</p> <p>DON or Designee will ensure all consents with side effects or Black Box Warnings have been reviewed with families will all new orders for six months.</p> <p>DON or Designee will review each new antipsychotic medication order to ensure medication indications properly documentation and monitors are in place prior to initial dosing of medication for six months.</p> <p>IDT will review antipsychotic medications quarterly with residents</p>	

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F 329	<p>Continued From page 24</p> <ul style="list-style-type: none"> - Allow resident to maintain control as much as possible, allow him/her to make choices where able. - Anticipate and meet needs such as need for toilet, food, fluid, pain medication, reposition, rest, etc. - Approach resident in friendly calm manner. - Assess for pain, discomfort, illness or infection as possible cause of agitation. - Delay, postpone task, reapproach or alternate staff prn [as needed] and if helpful. - Encourage resident to ventilate feelings per her pace as she does tend to get irritated with staff. - Engage in friendly conversation to gain trust especially during times of calmness. - FYI: Resident moans as a self-soothing task. [Daughter] is aware. Please assess resident for needs during time of moaning. - Give choices in daily care i.e., ready for bath now or later? - Listen for reasons for non-compliance - Assess the effectiveness of prescribed medication, review with IDT at least quarterly and complete GDR attempts per schedule. - Behavior monitor to track indicated symptoms, assess effectiveness of interventions." <p>Upon review of the medical record for behavior monitoring, it was found that there were no behavior monitors in the record prior to August 13, 2013, when the Seroquel was started.</p> <p>The August 2013 behavior monitors were for, "Behavior: Refusal ADL assistance, Inconsolable, Hollering." The documentation was: "- 8/21/13 a.m. - Resident was moaning out, one on one was done but still unchanged. - 8/24/13 noc - Res[ident] refusing cares, hollering.</p>	F 329	<p>and or responsible party as applicable for six months.</p> <p>DON or Designee will report findings at the Q.A meeting and will make change to the above plan of correction as needed.</p> <p>DON or designee will review all residents with current antipsychotic medications and or residents with potential new orders for medications for indication of use.</p> <p>Date Of Compliance: 12/06/2013</p>	

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F 329	<p>Continued From page 25</p> <p>- 8/25/13 noc - Refusing ADL's, hollering. - 8/30/13 a.m. - Res refusing oral care."</p> <p>The September 2013 behavior monitors for, "Behavior: Refusal ADL assistance, Inconsolable, hollering" documented: "- 9/1/13 noc - Res refusing cares, hollering when being repositioned. - 9/2/13 noc - Refusing cares. - 9/22/13 a.m. - Inconsolable, hollering, moaning. - 9/30/13 a.m. - Refusing ADL assist."</p> <p>The October 2013 behavior monitors for, "Behavior: Refusal ADL assistance, Inconsolable, hollering" documented: "- 10/10/13 a.m. - Inconsolable, hollering."</p> <p>The nursing progress notes documented the following resident behaviors: "- 5/20/13 - a.m.- Routine assessment: ...Appetite usually poor, freq[ue]ntly refuses meals... Res[id]ent behaviors consist of resisting cares. Refuses to eat, Ref to take med[ic]ations, cries out when cares or movement provided. Res on routine pain med, these issues appear to be behavioral. Redirection provided and calm reassurance..." "- 6/26/13 -1300 [1:00 p.m.] - Routine assessment:Res is resistive to cares freq[ue]ntly. [no change] in functional status...[no] behaviors reported, just cont[in]ued non compliance/resistance to cares...." "- 7/7/13 - 1300 -Encouraged fluid intake [up] w/c [wheelchair]. Cooperative. [Lung Sounds] congestion in anterior lobes bilateral..." "- 7/8/13 - 1330 -Non productive cough. Cooperative with cares [will continue to monitor]." "- 7/9/13 - 10:18 a.m. - Res cheerful, cooperative....sitting up in wheelchair."</p>	F 329		

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F 329	<p>Continued From page 26</p> <p>"- 8/13/13 - 4:08 p.m. - See order for Seroquel 25 mg [each hour of sleep] for dementia with delusions. Resident hollers out frequently and MD feels maybe it could be r/t [related to] delusions. We will try this to see if it helps her sleep at night and helps her ability to function with ADL's t/o [throughout] the day."</p> <p>"- 8/26/13 - 5:49 p.m. - Routine assessment: ...Resident frequently refuses meals...Resident has long history of moaning and crying out whenever approached by staff for cares. Does not want to be changed, or turned, or fed. Staff has addressed her pain, and her mental status... Resident is currently taking Seroquel for Dementia with delusions since Resident is unable to speak effectively the MD feels like she must then be having issues we can not see and she can... Resident has shown some increased activity with medication and even tried to stand and walk which has not done in a while. (Will continue to monitor) for further improvement in overall mental status and hopefully with medication and dental issues resolved Resident's appetite will improve..." [Note: The resident had two teeth break off in the weeks previous to this note and the resident was scheduled 8/28/13 to have seven teeth extracted.]</p> <p>"- 9/13/13 - 9:53 a.m. - Psychotropic medication review. Seroquel 25 mg 1 [orally every hour of sleep], Dementia with Delusions. No [adverse side effects] since initiation of the new medication. Resident has had her teeth pulled and since then, has done well with this. She has had two episodes of refusing ADLs per behavior monitor in September and 4 days in August.. The resident presents to be doing well..."</p> <p>"- 9/26/13 - 10:00 a.m. - Routine assessment: ...Resident is total assist for all ADL's and is frequently resistive to cares and will attempt to</p>	F 329		
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F 329	<p>Continued From page 27</p> <p>not let staff perform needed cares. No change in functional status, but Resident is more alert and active since recent oral surgery....Appetite has picked up since oral surgery and Resident's weight is improving... Resident has some resistive behaviors during cares but no aggression at this time has been reported...Resident had a fall without injury on 9/23/13. Resident is more awake and was attempting to transfer self from bed..."</p> <p>"- 10/21/13 - 7:42 a.m. - According to standing order obtained urine sample to rule out UTI [urinary tract infection] related to behaviors. Resident has been aggressive, yelling, refusing medications. Urine dip was positive for leukocytes and protein..."</p> <p>"- 10/21/12 - 1:56 p.m. - Increased crying out and look of anxiety/fear. May be related to pain..."</p> <p>[Note: the resident was started on Fentanyl 25 mcg patch]</p> <p>The Medication Seroquel has an FDA warning of: "WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS and SUICIDAL THOUGHTS AND BEHAVIORS." The FDA warning further documented: "Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. SEROQUEL is not approved for elderly patients with dementia-related psychosis." (Information obtained from: "This Medication Guide has been approved by the U.S. Food and Drug administration." Seroquel is a registered trademark of the AstraZeneca group of companies, copywrite AstraZeneca 2013. Rev 7/13)</p> <p>On 11/6/13 at 3:15 p.m. the social worker and</p>	F 329		
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F 329	<p>Continued From page 28</p> <p>MDS coordinator were interviewed regarding a lack of documentation of delusional behaviors. Additionally, there was no documentation addressing the FDA warning being discussed with the resident's power of attorney. They confirmed there was some documentation lacking. Also, they indicated there was not a physician's progress note when he started the medication and they would get a copy for review.</p> <p>On 11/7/13 the facility provided a physician's progress note. The note was dated 7/5/13, it was dictated and typed on 11/6/13, 4 months later. The physician documented: "[Resident name] has had some behavioral problems with increased hollering, anxiety. She has been refusing to eat. Some of this has been because of recurrent yeast infection in the mouth. Some of it has been from possible psychosis that has just gotten her frightened....Her daughter is going to take her to the dentist sometime next month, and we need to have her calmer to get a good exam from the dentist. Also, I think if we have something that will keep her calm, she will eat a little better, and therefore, we can control her blood sugars better... PHYSICAL EXAMINATION GENERAL: She is fearful when I approach her and starts to moan and yell before I even touch her..."</p> <p>Resident #8 was started on Seroquel on 8/23/13; however, there was no documentation the resident had delusional behaviors. The facility failed to review other issues such as pain and dental problems. There was no documentation in the record to show the resident's family was informed of the risks associated with taking Seroquel.</p> <p>The Administrator and DON were informed on</p>	F 329			

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OMB NO. 0938-0391

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F 329	<p>Continued From page 29 11/7/13 at 12:55 p.m. No additional information provided.</p> <p>3. Resident #1 was admitted to the facility on 3/16/11 and readmitted on 6/27/13 with multiple diagnoses including, failure to thrive, peripheral vascular disease, hypertension, and dementia with agitation.</p> <p>Resident #1's November 2013 MAR documented, with a start date of 6/27/13, "Seroquel (quetiapine) tablet; 50 mg...Oral QHS-At Bedtime" with a diagnosis of dementia with agitation. The MAR documented the resident had received the medication as ordered.</p> <p>The Resident's medical record contained a document titled Consent to Use Psychotherapeutic Medications and was signed by the Resident's POA and contained common side effects listed for Seroquel, however, the document did not contain a warning of increased risk of death in the elderly.</p> <p>According to Wolters Kluwer/Lippincott Williams & Wilkins Nursing 2014 Drug Handbook, 34th Edition, page 1177, under Nursing Considerations for Quetiapine, the Black Box Warning documented, "Drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk for death from CV [cardio vascular] disease or infection."</p> <p>On 11/6/13 at 3:00 PM the DON was interviewed regarding the consent form. When asked if the POA was informed of the risk of death with Resident #1's medication, she stated, "We didn't</p>	F 329		
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F 329	Continued From page 30 do it." On 11/6/13 at 5:10 PM, the Administrator and the DON were informed of the risks of medication issues. On 11/7/13 at 12:55 PM, the Administrator, the DON, and the AIT were informed of the clinical indication issue. No further information was provided.	F 329		
F 371 SS=F	483.35(f) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the countertop in the food preparation area was serviceable and had a cleanable surface. This had the potential to affect all residents in the facility including 10 of 10 (#s 1 - 10) sampled residents. There was a potential for harm to residents because the food preparation surface could not effectively be cleaned of food borne bacteria which could result in residents getting a food borne illness. Findings include: On 11/6/13 at 1:15 p.m. the counter on the left	F 371	Resident Specific: Residents one through ten, please see systemic changes. Other Residents: Please see systemic changes. Systemic Changes: The counter top has been scheduled to be replaced on February 1 st , 2014 Dietary Staff have been in serviced in regards to notifying management of any surfaces that need repair or replaced and to not utilize referenced surface until repaired/replaced. Large cutting boards have been placed over counter tops to ensure cleanable sanitary surface until counter tops have been replaced.	

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F 371	<p>Continued From page 31</p> <p>side of the food preparation sink was observed to have an area of 16 inches wide by 4 feet long which was worn down to a degree that the wood base for the counter was exposed. In addition to the wood showing there appeared to be deep knife gouges in the wood.</p> <p>On the right hand side of the sink was an area that was 10 inches wide by 2 and a half feet long where the surface was worn down and this area also had deep knife gouges in it.</p> <p>Additionally there was a worn down area with the wood base showing on the right hand side of the steam table that was 30 inches wide by 24 inches long. This area was directly behind the serving window.</p> <p>On 11/6/13 at 1:15 p.m. the RD was shown the worn down areas and stated she was aware of the area needing repair.</p> <p>The Administrator and DON were informed of the worn surfaces on 11/6/13 at 5:00 p.m. A work order was provided for repairs to be done in the future.</p>	F 371	<p>Monitors:</p> <p>The Dietary manager will inspect the kitchen counter tops monthly times six months to ensure that surfaces are not in need of repair.</p> <p>The dietary manager or designee will perform audits 3 times a week until the counter top is repaired to ensure that the cutting boards that provide a cleanable sanitary surface are being utilized.</p> <p>Dietary manager will report findings to the Q.A meeting and will make change to the above plan of correction as needed.</p> <p>Date of compliance: 12/06/2013</p>	
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p>	F 431		

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F 431	<p>Continued From page 32</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of physician orders, it was determined the facility failed to ensure medication labels matched the physician orders. This affected 1 of 13 residents (#19) sampled during the medication pass observation. This failed practice created the potential for harm should residents be undermedicated resulting in increased pain and anxiety. Findings included:</p> <p>Resident #19 was admitted to the facility on 8/19/13 with multiple diagnoses including chronic</p>	F 431	<p>Resident Specific:</p> <p>Resident number nineteen had her medication labels reviewed with the physician orders and the medication sheet to ensure they were all accurate.</p> <p>Other Residents:</p> <p>See systemic changes. All other residents have had their medication labels reviewed with the physician orders and the medication sheet to ensure accuracy.</p> <p>Monitors:</p> <p>DON or designee will review all new physicians orders weekly times six months to ensure all physician orders match the labels and medication sheet.</p> <p>DON or Designee will report findings at the Q.A meeting and will make change to the above Plan of Correction as needed.</p> <p>Date of compliance: 12/06/2013</p>	
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F 431	<p>Continued From page 33 pain, hypertension, and emphysema.</p> <p>On 11/6/13 at 3:55 PM, during the Medication Administration Observation, LN #8 was observed to give Resident #19 a Morphine 15 mg (milligram) tablet. The label documented "Morphine Sulfate 15 mg take one tab PO (oral) TID (three times daily) PRN (as needed) [for] pain." LN #8 did not have the resident rate her pain before she gave the PRN medication. LN #8 stated, "it used to be PRN but was changed to a TID schedule."</p> <p>A review of the resident's medical record included a telephone order, dated 10/29/13, which documented in part: *DC (discontinue) Morphine IR (immediate release) PRN (as needed). *Morphine IR 15 mg one tab PO TID 3 hours after each dose of Morphine ER (extended release) with times of 0800 (8:00 AM), 1600 (4:00 PM) and 0000 (midnight).</p> <p>The Medication Flowsheet for the month of November, 2013, documented an order for Morphine 15 mg PO TID, for the diagnosis of pain with a start date of 10/29/13.</p> <p>Note: Residents who receive pain medication on a need basis, and not on a schedule as ordered by the physician, have an increased risk of being undermedicated.</p> <p>On 11/6/13 at 4:15 PM, the DON was notified of the observed mislabeled medication. The DON stated, "The routine medication card for the Morphine IR was in the medication slot but LN #8 thought it would be okay to use the PRN card." The DON stated she educated LN #8 on proper</p>	F 431		

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F 431	Continued From page 34 procedure, pulled the PRN card and would destroy the Morphine IR with another nurse, per policy.	F 431		
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Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER GRANGEVILLE HEALTH & REHABILITATION C	STREET ADDRESS, CITY, STATE, ZIP CODE 410 EAST NORTH 2ND STREET GRANGEVILLE, ID 83530
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the State licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Arnold Rosling, RN, BSN, QMRP Becky Thomas, RN</p>	C 000	<p>RECEIVED</p> <p>DEC - 4 2013</p> <p>FACILITY STANDARDS</p>	
C 125	<p>02.100,03,c,ix Treated with Respect/Dignity</p> <p>ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;</p> <p>This Rule is not met as evidenced by: Refer to F241 regarding dignity issues during dining observations.</p>	C 125	<p>Please refer to F-241</p>	
C 147	<p>02.100,05,g Prohibited Uses of Chemical Restraints</p> <p>g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician.</p> <p>This Rule is not met as evidenced by:</p>	C 147	<p>Please refer to F-329</p>	

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12-1-13
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C 147	Continued From page 1 Please refer to F-329 as it relates to antipsychotic medications.	C 147		
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F371 as it relates to preparing food under sanitary conditions.	C 325	Please refer to F-371	
C 674	02.151,01 ACTIVITIES PROGRAM 151. ACTIVITIES PROGRAM. 01. Organized Program. There shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be designed to include a variety of processes and services which are designed to stimulate patients/residents to greater self-sufficiency, resumption of normal activities and maintenance of an optimal level of psychosocial functioning. It shall include recreation, therapeutic, leisure and religious activities. This Rule is not met as evidenced by: Refer to F 248 as it relates to Activities.	C 674	Please refer to F-248	

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C 782	Continued From page 2	C 782		
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it relates to care plan revision.	C 782	Please refer to F-280	
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as it relates to preventing resident injury.	C 790	Please refer to F-323	
C 832	02.201,02,f Labeling of Medications/Containers f. All medications shall be labeled with the original prescription legend including the name and address of the pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.) This Rule is not met as evidenced by: Please refer to F-431 as it relates to medication labels.	C 832	Please refer to F-431	