



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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

December 4, 2014

Bobette Steffler, Administrator  
McCall Rehabilitation & Care Center  
418 Floyde Street  
Mc Call, ID 83638-4508

Provider #: 135082

Dear Ms. Steffler:

On **November 21, 2014**, a Recertification and State Licensure survey was conducted at McCall Rehabilitation & Care Center 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 15, 2014**.

Failure to submit an acceptable PoC by **December 15, 2014**, may result in the imposition of civil monetary penalties by **January 6, 2015**.

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 **May 21, 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 &**

Bobette Steffler, Administrator  
December 4, 2014  
Page 3 of 3

**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.I.D.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Option 2; 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:

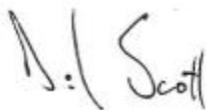
- BFS Letters (06/30/11)

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

This request must be received by **December 15, 2014**. If your request for informal dispute resolution is received after **December 15, 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, Option 2.

Sincerely,



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

DS/dmj  
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>135082</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE:  <b>11/21/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MCCALL REHABILITATION &amp; CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>418 FLOYDE STREET MC CALL, ID</b>
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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<b>F 278</b>	<p><b>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</b></p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure 1 of 6 (#2) sampled residents who were reviewed for MDS had an accurate assessment as it related to weight on admission to the facility. Findings include:</p> <p>Resident #2 was admitted to the facility on 8/15/14 with diagnoses that included loss of weight, dementia, and lipoid metabolic disorder.</p> <p>The resident's vitals chart documented the resident's weight on 8/16/14 was 86.6 pounds.</p> <p>The resident's admission Nutrition Evaluation form documented the resident's weight on 8/20/14 was 86.5 pounds.</p> <p>The resident's Admission MDS, dated 8/21/14, documented the resident's weight as 105 pounds.</p> <p>On 11/19/14 at 10:30 a.m., the Dietitian stated the resident's admission weight was about 86 pounds and the resident had never weighed 105 pounds since her time of admission to the facility.</p> <p>On 11/20/14 at 10:30 a.m. the DON stated the Admission MDS was incorrect.</p> <p>On 11/20/14 at 6:40 p.m. the Administrator and the DON were informed of the above concern. The</p>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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<b>F 278</b>	Continued From Page 1 Administrator stated the facility would do an addendum to correct the MDS.
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/21/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MCCALL REHABILITATION &amp; CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>418 FLOYDE STREET MC CALL, ID 83638</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the annual federal recertification survey of your facility.  The surveyors conducting the survey were: Sherri Case, BSW, LSW, QIPD, Team Coordinator Susan Gollobit, RN Kirsti Stephenson, RN  The survey team entered the facility on November 17, 2014 and exited on November 21, 2014  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 MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed SSD = Social Service Designee	F 000			
F 151 SS=E	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL  The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.  The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.	F 151		12/25/14	

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

TITLE

(X6) DATE

Electronically Signed

12/15/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/21/2014</b>
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F 151	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, it was determined the facility failed to ensure that 5 of 5 residents in the group interview and any resident who may have desired to exercise their right to vote in public elections, were offered the opportunity to cast a ballot. This failed practice had the potential to cause more than minimal psychological harm when resident were not offered the opportunity to exercise their right to vote in the most recent mid-term congressional and local elections. The 5 residents in the group interview all stated they had not been offered the opportunity to vote in the 11/4/14 elections: Findings included:</p> <p>On 11/18/14 at 1:30 PM, two surveyors conducted a group interview with residents of the facility. When the five residents were asked if they had been provided the opportunity as a citizen while in the facility to vote in the 11/4/14 elections, each of the five residents stated they had not been offered the opportunity to vote on 11/4/14. One of the residents present stated he had always voted in the past and the most recent election had been the first time he had not voted in the elections.</p> <p>On 11/17/14 at 12:25 PM, the SSD (Social Worker Designee) was asked if she had provided the opportunity for residents to vote in the election on 11/4/14. The SSD stated some of the residents in the facility had voted absentee ballot. When asked how the residents had cast the absentee ballots, she stated, "They came from various sources ... family members brought them in, some were mailed directly to the residents</p>	F 151	<p>Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority. Accordingly, the facility has drafted this Plan of Correction in accordance with Federal and State Laws which mandate the submission of a Plan of Correction as a condition for participation in the Medicare and Medicaid program. This Plan of Correction shall constitute this facility's credible allegation compliance with this section.</p> <p>The facility does ensure the resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: The Administrator or designee interviewed the five residents identified in the survey process in the group interview and informed them of their right to vote, cast a ballot, during local and/or state and/or national elections by 12/19/14. Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following: The Administrator or designee sent a letter to all residents or resident</p>		

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F 151	Continued From page 2 here." The SSD was asked about residents who did not have the resources to obtain the absentee ballot and whether she provided them instructions on obtaining an absentee ballot. The SSD stated, "No... if they would have shown an interest we would have but we did not offer it" to the residents.  On 11/21/14 at 11:00 AM, the Administrator and the DON were informed of the findings. no additional information was provided.	F 151	representative of their right to vote, cast a ballot during local and/or state and/or national elections as a citizen of the United States during local and/or state and/or national elections by 12/19/14. Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure that the deficient practice does not recur the Administrator inserviced the social service designee on 12/10/14 regarding F-151 on the importance of Residents right to vote as a citizen of the United States, that they were offered the opportunity to vote or cast a ballot during local and/or state and/or national elections. By 12/19/14 a letter was added to the admission packet informing the resident they have the right to vote, cast a ballot, during local and/or state and/or national elections as a citizen of the United States. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through: The Administrator or designee will interview at least three (3) residents to ensure they are informed of their voting right, cast a ballot, during local and/or state and/or national elections as a citizen of the United States. Monitoring will start on 12/22/14. This will be done weekly x 4 weeks, then every 2 weeks x 4 weeks, then monthly x 3 months. The facility Administrator or designee will		

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F 151	Continued From page 3	F 151	present to the QA&A Committee during the quarterly QA&A Committee meeting her/his findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the quarterly QA&A Committee Meeting.		
F 154 SS=D	<p>483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, &amp; TREATMENTS</p> <p>The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</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 antipsychotic medications. This was true for 3 of 7 residents (#s1, 7, &amp; 9) sampled for medication use. The deficient practice had the potential to cause harm when the residents were not provided with the opportunity to make informed decisions about the risks and benefits of the use of the medications. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 2/1/14 with diagnoses which included dementia, without behaviors, and LBKA (left below the knee</p>	F 154	<p>The facility does ensure that the resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to his or her medical condition.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: The Director of Nursing or designee informed resident #1, #7, &amp; #9 or their representative of the FDA Black Box warning for the use of antipsychotic medications by 12/19/14. Identification of other residents having the</p>	1/1/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/21/2014</b>
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F 154	<p>Continued From page 4 amputation).</p> <p>*8/21/14 - An Informed Consent for Psychoactive Medications was implemented and documented the resident was started on the antipsychotic medication "Haldol" [no dose or frequency was documented] for "Endstage dementia (with agitation)." A second form was implemented and documented the medication was "Haldol 2 mg (milligrams) (every) 6 (hours) (as needed). Both of the consents were signed by the resident's family member.</p> <p>NOTE: The Black Box warning was not documented on the form. The family member was not informed of possible death related to the use of Haldol.</p> <p>The Nursing 2014 Drug Handbook documented: *Page 686: Haldol - Black Box warning; Elderly patients with dementia-related psychosis treated with atypical or conventional antipsychotics are at increased risk for death. Antipsychotics aren't approved for the treatment of dementia-related psychosis.</p> <p>On 11/18/14 at 6:00PM, the resident's family member, who had signed the consent, was asked if the facility had explained the black box warning to her which included possible death. She stated, "No, they didn't."</p> <p>On 11/19/14 at 4:15 PM the DON was asked if the consent form for the Haldol had the black box warning on it. The DON reviewed the Form and the sticker provided on the form which documented The name of the medication, the side effect and nursing alerts. The DON stated,</p>	F 154	<p>same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following: The deficiency is an isolated deficiency as reflected in the statement of deficiencies form CMS-2567. However, to address other residents who potentially may be affected by this deficiency, the Director of Nursing or designee completed an audit of all resident's medications and informed the resident or resident representative of the FDA Black Box warning(s) for those medication(s) that have FDA Black Box Warning(s) by 12/30/14.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure that the deficient practice does not recur by 12/30/14 the Director of Nursing or designee inserviced all Licensed Nurses regarding F154 on the importance of informing the resident or resident representative on medications with FDA Black Box Warning(s).</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through: The Director of Nursing or designee will review sampling of at least (three) 3 Residents' medications to ensure that the resident or the resident representative were informed of the FDA Black Box Warning(s) on those medications that</p>		

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F 154	<p>Continued From page 5</p> <p>"We don't have the black box warning on the form."</p> <p>2. Resident # 7 was admitted to the facility on 5/3/11 with diagnoses which included late effects of cerebrovascular disease and unspecified episodic mood disorder.</p> <p>The resident's Quarterly MDS assessment, dated 9/24/14, documented the resident had a diagnosis of Non-Alzheimer's Dementia.</p> <p>The resident's physician orders, dated 11/1/14 - 11/30/14, documented: *Haloperidol 5 mg tablet. One tablet orally at hour of sleep. *Zyprexa 20 mg tablet. One tablet orally in the evening.</p> <p>*5/3/11 - An "updated" Informed Consent for Psychoactive Medications documented the resident was on the antipsychotic medication "Haldol" [no dose or frequency was documented] for "mood swings." A second form, "updated" 5/3/11, documented the resident was on the antipsychotic medication Zyprexa [no dose or frequency was documented] for "Hallucination/Delusions R/T (related to) dx (diagnosis) dementia (with) agitation." Both of the consents were signed by the resident's family member, and did not include the black box warning of possible death with the use of either of the medications.</p> <p>On 11/20/14 at 3:45 PM, the DON was asked if the resident's Informed Consent for Psychoactive Medication forms documented the black box warning of possible death related to the use of</p>	F 154	<p>have FDA Black Box Warning(s).</p> <p>Monitoring will start on 12/31/14. This will be done weekly x 4 weeks, then every 2 weeks x 4 weeks, then monthly x 3 months.</p> <p>The facility Director of Nursing or designee will present to the QA&amp;A Committee during the quarterly QA&amp;A Committee meeting her/his findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the quarterly QA&amp;A Committee Meeting.</p>		

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F 154	Continued From page 6 Zyprexa and/or Haldol in residents with dementia. The DON stated it was not on the form.  On 11/21/14 at 11:00 AM, the Administrator and DON were informed of the findings. No additional information was provided.  3. Resident #9 was admitted to the facility on 3/21/13 with diagnoses which included dementia with behavior disturbance and systolic heart failure.  The resident's 11/1/14 Physician's Orders (recapitulation) included an order for Zyprexa (antipsychotic) 2.5 mg at bedtime for dementia with psychotic features, with a start date of 10/7/13.  The 2015 Nursing Drug Handbook documented: Zyprexa, page 1040: "Black Box Warning: Drug may increase risk of CV [cardiovascular] or infection-related death in elderly patients with dementia. Olanzapine [Zyprexa] isn't approved to treat patients with dementia-related psychosis."  Resident #9's record did not document the resident had been informed of the Black Box warning for the use of this medication.  On 11/21/14 at 10:45 a.m., the Administrator and DON were informed of the concern. The facility provided no further information.	F 154			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit	F 226		12/25/14	

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NAME OF PROVIDER OR SUPPLIER  <b>MCCALL REHABILITATION &amp; CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>418 FLOYDE STREET MC CALL, ID 83638</b>		
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F 226	<p>Continued From page 7</p> <p>mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of staff personnel files and staff interviews, it was determined the facility failed to obtain a criminal background check for 1 of 5 employees reviewed for background checks. This practice created the potential to place residents at risk for and subject to abuse, neglect, and/or misappropriation of property. Findings included:</p> <p>Idaho Administrative Code (IDAPA) 16.02.03.009 Criminal History and Background Check documented: 05. New Criminal History and Background Check - "An individual must have a criminal history and background check when : (3-26-08) a. Accepting employment with a new employer; and (3-26-08) b. His last criminal history and background check was completed more than three (3) years prior to his date of hire."</p> <p>On 11/21/14 at 8:15 a.m., five employee personnel files were reviewed for the state's criminal history background check verification. The Notice of Clearance Letter for Staff A, who was hired on 10/22/14, documented the clearance was effective as of 9/21/07. The Administrator was present during the review and stated Employee A had worked for the facility and quit for about three weeks. Since the employee had only left for a short time the facility had not initiated a new criminal background check and</p>	F 226	<p>The facility does ensure that all allegations of abuse or neglect are investigated, and that residents are protected from further abuse when abuse is alleged.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: A new Criminal History and Background Check was completed on the Employee #A on 12/11/14.</p> <p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following: This deficiency is an isolated deficiency as reflected in the Statement of deficiencies - form CMS 2567. However, to address residents in the facility which may have the potential to be affected by this deficiency, the Staff development Coordinator or designee completed an audit for Criminal Background Checks of all employees hired in the last twelve months by 12/19/14.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not</p>		

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F 226	Continued From page 8 Employee A was rehired on 10/2/14.	F 226	<p>recur includes the following: To ensure that the deficient practice does not recur the Staff Development Coordinator or designee inserviced the Hiring Coordinator on 12/10/14 regarding F226 with emphasis on Idaho Administrative Code (IDAPA) 16.02.03.009 on requirements of when an individual must have a Criminal History and Background Check.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through: The Staff Development Coordinator or designee will review all new hires to ensure a Criminal Background Check is completed.</p> <p>Monitoring will start on 12/22/14. This will be done weekly x 4 weeks, then every 2 weeks x 4 weeks, then monthly x 3 months. The facility Staff Development Coordinator or designee will present to the QA&amp;A Committee during the quarterly QA&amp;A Committee meeting her/his findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the quarterly QA&amp;A Committee Meeting.</p>		
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and</p>	F 246		1/1/15	

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F 246	<p>Continued From page 9</p> <p>preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview it was determined the facility failed to ensure 2 of 5 (#1 and #3) sampled residents were provided access to their call lights. The deficient practice had the potential to cause more than minimal harm when residents did not have access to their call lights to request staff assistance as needed. Findings included:</p> <p>1. Resident #3 was admitted to the facility on 7/21/14 with diagnoses that included dementia, without behavior; joint pain-L (left) leg, and abnormality of gait.</p> <p>A Quarterly MDS (Minimum Data Set) dated 10/22/14, documented a score of 6 on BIMS (Brief Interview for Mental Status), indicating severe cognitive impairment.</p> <p>On 11/18/14 at 9:15 AM, 10:20 AM, 11:30 AM, and 11/19/14 at 11:00 AM, the resident was observed in his/her room on her bed with the call light on the floor. The call light was situated behind the recliner and between the recliner and bed.</p> <p>On 11/20/14 at 9:25 AM, the resident was observed in his/her room with the call light and nasal cannula on the floor. Both items were situated behind the recliner and between the</p>	F 246	<p>The facility does ensure that a resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other resident would be endangered.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: - Resident #3, with the consent of the resident and/or resident representative, the room was rearranged by the facility to assist with call light placement on 12/12/14. - Resident #3, on 11/20/14 (at the time of occurrence), the C.N.A. replaced the oxygen tubing. - Resident #3.on 12/12/14 the facility rearranged the room to improve accessibility of the oxygen tubing. - Resident #1, the facility added an additional call light to center call light plus for use when not in bed on 12/15/14.</p> <p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:</p>		

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F 246	<p>Continued From page 10</p> <p>recliner and bed. The resident was seated on the side of his/her bed. When CNA (Certified Nurse Assistant) #3 was asked about the call light and nasal cannula, he/she picked up the call light, draped it over the night stand next to the bed, and said, "I thought I clipped this call light to the pillow." CNA #3 then picked up the nasal cannula and handed it to the resident. The resident promptly put the nasal cannula in his/her nose. When CNA #3 was asked if the cannula was considered clean since it had been on the floor, he/she stated, "Probably not, I can get [him/her] a new one." CNA #3 then left the room and returned with a new nasal cannula.</p> <p>Resident #3 was observed not have access to his/her call light on more than one occasion. The deficient practice had the potential to cause more than minimal harm to Resident #3 who could not request staff assistance as needed.</p> <p>On 11/21/14 at 10:45 AM, the Administrator and DON were notified of the findings. No additional information was provided.</p> <p>2. Resident #1 was admitted to the facility on 2/1/14 with diagnoses which included dementia without behaviors and LBKA (left below the knee amputation).</p> <p>The resident's Quarterly MDS assessment, dated 8/6/14, documented the resident's cognition was moderately impaired.</p> <p>The resident's care plan had a focus problem for memory deficit exhibited by short and long term loss and diagnosis of dementia. The care plan documented the resident may not remember to</p>	F 246	<p>This deficiency is an isolated deficiency as reflected in the State of deficiencies -form CMS 2567.</p> <p>However, to address other residents who potentially may be affected by this deficiency, the Administrator or designee did a visual observation to ensure;</p> <ul style="list-style-type: none"> <li>- Placement accessibility of call lights in all residents' rooms by 12/19/14.</li> <li>- Oxygen tubing is accessible to residents who use oxygen and is stored properly when not in use by 12/19/14.</li> </ul> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur; The Administrator inserviced all Nursing staff by 12/19/14 regarding F246 with regards:</p> <ul style="list-style-type: none"> <li>- On ensuring that residents have access to their call lights to request staff assistance as needed.</li> <li>- On ensuring that oxygen tubing is accessible to residents for residents who use oxygen and that the oxygen tubing is stored properly when not in use.</li> </ul> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <ul style="list-style-type: none"> <li>- The Administrator or designee will do a visual observation on at least three (3) rooms to ensure that residents have access to their call lights to request staff assistance as needed.</li> </ul>		

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F 246	Continued From page 11 use the call light to ask for assistance and may call out for help. Interventions included staff reminders to the resident to use the call light, and ensuring her call light was within reach and line of sight.  On 11/18/14 at 8:55 AM, the resident was observed in her wheelchair (w/c) at the foot of her bed facing towards the end of her bed watching television. The resident's call light was positioned on the bedside stand next to the head of her bed. The call light was approximately five feet behind her, not in view of the resident or within the resident's reach. The resident was asked how she would be able to summon staff for help. The resident looked around the area she was seated in and stated, "Oh I don't know. I guess I would yell." At 9:00 AM, CNA #2 and CNA #3 entered Resident #1's room to assist her to bed. The CNAs were asked if the resident would have been able to reach the call light. Both agreed she would not have been able to reach the call light. CNA #2 stated, "It was the error of whoever brought her down here."  On 11/21/14 at 11:00 AM the Administrator and DON were notified of the findings. No additional information was provided.	F 246	- The Administrator or designee will do a visual observation on at least three (3) different residents on oxygen in their rooms to ensure that oxygen tubing is accessible to residents and is stored properly when not in use.  Monitoring will start on 12/22/14. This will be done weekly x 4 weeks, then every 2 weeks x 4 weeks, then monthly x 3 months. The facility Administrator or designee will present to the QA&A Committee during the quarterly QA&A Committee meeting her/his findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the quarterly QA&A Committee Meeting.		
F 280 SS=E	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	F 280		1/1/15	

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F 280	<p>Continued From page 12</p> <p>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 observation, staff interview and record review, it was determined the facility failed to ensure care plans were updated for 2 (#s 2, and 6) of 9 residents reviewed for care plans. The deficient practice had the potential to cause more than minimal harm when residents' care plans were not updated with accurate information affecting their care in the facility. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 8/15/14 with diagnoses that included loss of weight, dementia, and lipoid metabolic disorder.</p> <p>The resident's 11/1/14 physician orders documented the resident was to receive a regular diet with no added sodium.</p> <p>The resident's 8/21/14 Nutrition Evaluation included in the Dietitian Assessment that due to "...very low body weight" were to send snacks 3</p>	F 280	<p>The facility does ensure that the comprehensive care plan is reviewed and revised to reflect current resident needs.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> <li>- Resident #2 on 12/9/14 the nutritional care plan was updated to include snacks TID.</li> <li>- Resident #2 on 12/8/14 elopement assessment was completed and wanderguard was discontinued and the risk for elopement care plan was updated to include the non-restrictive interventions.</li> <li>- Resident #3 room was rearranged by the facility, with resident and resident representative permission, allowing walker to be more assessable on 12/12/14. Resident assessed by OT for</li> </ul>		

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F 280	<p>Continued From page 13 times a day.</p> <p>A 9/30/14 Care Plan Update documented, "Offer snacks frequently..."</p> <p>On 11/20/14 at 10:30 a.m. the DON stated the resident received at least 3 snacks a day but it was not reflected in the Care Plan.</p> <p>Additionally, the resident's 8/24/14 Care Plan for impaired safety awareness for elopement only had an intervention to use a Wanderguard bracelet, it did not include any non-restrictive interventions.</p> <p>On 11/19/14 at 10:45 a.m. the Social Service Designee (SSD) was asked if the sole intervention for the elopement was the use of the Wanderguard bracelet. The SSD stated the Care Plan should have included non restrictive interventions, such as walks outside.</p> <p>On 11/19/14 at 10:30 a.m. the DON stated the resident was at risk for elopements when he/she was admitted to the facility, however that was no longer a concern and the Wanderguard should be removed from the Care Plan.</p> <p>Resident #3 was admitted to the facility on 7/21/14 with diagnoses of dementia without behavior, joint pain, and abnormality of gait. Fall Risk Assessments - dated 7/23/14, 9/20/14, 10/16/14, and 10/22/14 - all indicated Resident #3 was at high risk for falls. A Social Service Progress Note (SSPN), dated 7/31/14, documented 15/15 on BIMS indicating cognition intact.</p>	F 280	<p>the use of a commode chair near bed to address urgency on 12/11/14. Care Plan modified with assessments by 12/19/14.</p> <p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following: To address other residents that may have the potential to be affected by this deficiency; by 12/30/14 the facility's Administrator or designee will audit: All resident's Care Plans</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur; A root cause analysis was done by the Administrator and DON by 12/29/14, hence starting 12/30/14 a systemic measure that would be put in place will be that resident(s) with recommendations with changes in the care plan intervention will be reviewed during the scheduled IDT Stand Up Meeting to ensure that new interventions are transcribed in the care plan intervention section. The facility's Administrator or designee by 12/30/14 will inservice the IDT regarding F-280 on care plans with emphasis on the importance of ensuring that recommended changes in the care plan interventions are transcribed in the care plan. Starting on 12/30/14 resident(s) with recommendation(s) with changes in the care plan intervention will be reviewed during the scheduled IDT Stand Up</p>		

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F 280	<p>Continued From page 14</p> <p>A Quarterly MDS assessment, dated 10/22/14, documented 6 on BIMS, indicating a severe impairment.</p> <p>The resident's Care Plan (CP), dated 7/30/14, documented bladder incontinence and dementia. Interventions were documented as, "Encourage resident to seek assistance with toileting as needed." The 7/30/14 Care Plan also documented a potential for falls. Interventions included, "Cue resident to use proper footwear when ambulating, encourage resident to call for assistance, resident has shuffling gait, takes very small steps - allow time to walk."</p> <p>An Accident and Incident Report recorded the resident experienced a fall on 10/16/14 at 8:20 PM. The report documented the resident fell while on his/her toilet, cause of the fall was listed as "non-compliance, unassisted ambulation, and responding to bladder urgency." The report further documented the resident was not wearing socks, shoes, or slippers, the resident's walker was located next to her bed at the time of the incident, and the resident had last voided about 6:30 PM, approximately 30 minutes after the dinner meal. The report documented the resident was placed immediately on alert charting and had his/her care plan updated.</p> <p>The report summarized that Resident #3 had urinary frequency and incontinence, but was usually independent with toileting, and had been incontinent on the bed and floor by the bed prior to his/her attempt to ambulate to the toilet. Corrective actions included, "Encourage resident to toilet more frequently to avoid urgency." The report concluded that contributing factors included bare feet, not using gait assist device, and that the resident was more than 15 feet from the gait assist device when he/she attempted the</p>	F 280	<p>Meeting to ensure that interventions are transcribed in the care plan.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through; the facility's Administrator or designee will review; - At least three (3) resident's care plans to ensure that recommended changes in interventions are transcribed in the care plan.</p> <p>Monitoring will start on 12/31/14. This will be done weekly x 4 weeks, then every 2 weeks x 4 weeks, then monthly x 3 months.</p> <p>The facility Administrator or designee will present to the QA&amp;A Committee during the quarterly QA&amp;A Committee meeting her/his findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the quarterly QA&amp;A Committee Meeting.</p>		

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

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F 280	<p>Continued From page 15</p> <p>self-transfer. The report did not document a root cause for the fall.</p> <p>Note: The resident's Care Plan was not updated to toilet more frequently or for staff to encourage the resident to take larger steps.</p> <p>A second Accident and Incident Report documented the resident experienced a second fall on 11/7/14 at 10:55 PM. The report documented the "resident fell while attempting to use the toilet without staff assistance." The report further documented the resident was not using his/her walker, was not wearing socks, shoes, or slippers, and had last voided one hour previous to the incident (approximately 10:00 PM). The report documented the resident was placed immediately on alert charting, had his/her CP updated, and new physician orders.</p> <p>The report summarized that the resident frequently expressed he/she experienced knee pain, denied slipping although urine was observed on the floor, and took short shuffle steps.</p> <p>Corrective actions included, "Encourage resident to have staff flush toilet to prevent leaning over."</p> <p>The report concluded that contributing factors included bare feet, not using gait assist device, received anticoagulant, cardiovascular, and narcotic medications within 8 hours prior to the fall. The report documented a root cause for the fall: footwear, not using assistive device and, urine on floor next to toilet.</p> <p>Initial interventions to prevent future falls: encourage resident to use walker, wear gripper socks or shoes, place continence supplies in a bag attached to the handrail for resident convenience, and call staff to assist at night time hour.</p> <p>Note: The resident's CP was not updated to</p>	F 280			

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F 280	<p>Continued From page 16</p> <p>include staff flushing the toilet or to include the wearing of gripper socks.</p> <p>The surveyor observed the resident wearing socks and shoes when ambulating outside of her room. The surveyor also observed the resident in bare feet or wearing non-gripper socks. The following observations were made:</p> <ul style="list-style-type: none"> <li>· On 11/17/14 at 3:30 PM, the resident was observed in bed with bare feet, Physical Therapy (PT) was removing hot pack from the resident's right knee.</li> <li>· On 11/18/14 at 9:15 AM, the resident was observed getting into her bed. The resident was not wearing gripper socks.</li> <li>· On 11/18/14 at 10:20 AM, the resident was in bed, laying on his/her right side, facing window. Socks were noted to be on the floor.</li> <li>· On 11/18/14 at 4:20 PM, the resident was in bed reading with an ice pack on the right knee. The resident was not wearing gripper socks.</li> <li>· On 11/19/14 at 11:00 AM, the resident was seated on the side of his/her bed reading. The resident was not wearing gripper socks. The resident transferred, without stand-by assist (SBA) from the bed to his/her recliner using the bed and the arm of the chair. He/she did not put full weight on the right leg. The resident then attempted to transfer from the recliner chair back to the bed with complaints of right leg pain. He/she was able to stand from the seated position on the third attempt, and did not put full weight on the right leg.</li> <li>· On 11/19/14 at 12:00 PM, the resident was observed seated at table in dining room, shoes on both feet.</li> <li>· On 11/19/14 at 4:40 PM, the resident was seated on the side of his/her bed. The resident was observed in bare feet and reported he/she</li> </ul>	F 280			

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

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FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/21/2014</b>
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F 280	Continued From page 17 wasn't feeling well and would have dinner in his/her room. The resident reported he/she needed to use the toilet. The resident stood and started to walk toward the toilet. When reminded he/she needed to wear shoes and use the walker, the resident the put on his/her shoes on and used the walker to ambulate to the toilet. · On 11/20/14 at 9:25 AM, the resident was observed seated in his/her recliner chair, wearing shoes but no socks. The resident was observed taking his/her shoes off and transferred to the bed using the chair arm and the bed for support without putting his/her full weight onto the right leg. NOTE: Staff was not observed to encourage the resident to toilet during this survey. A Nurse's Note, recording a condition change and dated 9/30/14 at 4:30 PM, documented the resident walked to the bathroom without his/her walker or shoes, wearing bulky slippery socks, and fell. The resident was found lying on the floor next to the bathroom door, yelling, and demanding to be helped up. Note: An Accident and Incident Report for this fall was not provided by the facility. Resident #3 experienced 3 unwitnessed, non-injury falls between 9/30/14 and 11/17/14. The facility identified "footwear, toileting and non-compliance with ambulation" as root causes, but failed to update the CP to ensure proper footwear interventions were implemented correctly and consistently to prevent future falls and possible injury to the resident.	F 280			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		12/25/14	

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F 314	<p>Continued From page 18</p> <p>who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interview, and record review it was determined the facility failed to ensure 2 of 4 (#1, #9) residents reviewed for pressure sores did not develop pressure sores, or that the facility had interventions implemented to prevent pressure sores. Resident #1 was admitted to the facility without a pressure sore, but was harmed when the facility failed to implement interventions to ensure the resident did not develop pressures sores. On 3/5/14, the resident developed an unstageable, black SDTI (suspected deep tissue injury) to her right heel, which had reportedly healed. On 11/19/14, during the survey, the resident was observed with a recurrent, unstageable, purple area of concern to the right heel. Additionally, Resident #9 was care planned to have protective boots to prevent the development of pressure, however the protective boots were not provided to the resident. Findings include:</p> <p>Quick Reference to Wound Care Palliative, Home, and Clinical Practices 4th Edition; Copyright 2013, Edited by Pamela Brown. Page 88 and 89 documented: "Pressure Ulcer Stages Revised by NPUAP (National Pressure Ulcer</p>	F 314	<p>The facility does ensure that resident who enter the facility without a pressure sore, do not develop pressure sores unless the individual's clinical condition demonstrate that they were unavoidable.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: With regards to Resident #1: - Wound on the right heel was healed on 9/10/14. - Right heel that according to surveyor that was observed during the survey "recurrent, unstageable, purple area of concern on the right heel", of Resident #1 was evaluated by the MD on 11/21/14 and on 12/12/14 that according to the MD progress note documented "No evidence of deep tissue injury. Normal temperature and blood flow... Previous scar tissue" and "heel intact, no worsening breakdown", respectively. - Air mattress setting on bed was adjust on 11/21/14. A training provided by the Director of Nursing to the License Nurses with regards to the different mode settings</p>		

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F 314	<p>Continued From page 19</p> <p>Advisory Panel) 2007 SDTI and Unstageable Pressure sores: SDTI: A purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and / or shear may indicate deep tissue injury... Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by... and/ or eschar (tan, brown, or black) in the wound bed."</p> <p>1. Resident #1 was admitted to the facility on 2/1/14 with diagnoses which included dementia and left below the knee amputation (LBKA).</p> <p>The resident's nursing admission assessment dated 2/1/14, documented "redness noted to coccyx area. ...redness noted to inner (and) outer (left) knee from prosthesis. (Right) foot (with) charcot deformity."</p> <p>NOTE: The assessment did not document the resident had skin concerns to the right heel.</p> <p>The resident's Norton Plus Pressure Ulcer scale form, used to predict risk of development of a pressure ulcer, dated 2/2/14, scored the resident high risk.</p> <p>The resident's admission MDS dated 2/6/14, documented the resident's cognition was severely impaired; bed mobility was extensive assistance of two people; at risk to develop a pressure sore; no pressure sore on admit and had a pressure reducing device to bed and chair.</p> <p>The resident's care plan dated 2/9/14, documented the resident had a potential for skin break down related to poor intake, hydration and decreased mobility. The interventions included</p>	F 314	<p>of her air mattress by 12/19/14.</p> <ul style="list-style-type: none"> <li>- The skin care plan intervention section was updated to include Licensed Nurses to check for the air mattress pressure relief mode setting every shift on 12/1/14.</li> <li>- Resident no longer uses her electric wheelchair.</li> <li>- Resident no longer uses AFO foot brace, instead she is on Prevalon protective boots and care plan updated on 12/11/14 to reflect the use of Prevalon protective boots.</li> <li>- Skin care plan updated on 12/11/14 to include the time frame on when to elevate the legs and float the heels for protection and time frame on when to turn and reposition her.</li> <li>-Daughter was educated on the risk versus benefits of following the programmed air mattress pressure relief setting mode and of the use of the Prevalon protective boots by 12/19/14.</li> </ul> <p>With regards to Resident #9:</p> <ul style="list-style-type: none"> <li>- MD updated the order on 11/25/14 to discontinue green boots at all times (from 1/8/13). May use shoes for transfers. Green-Heel float boots with thick socks and tubi grips when up. May float heels with out boots in recliner. Use heel float boots in bed. her skin care plan was updated to reflect this order from her MD.</li> </ul> <p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following:</p>		

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F 314	<p>Continued From page 20</p> <p>elevate right leg at times to prevent edema and skin prevention [hand written at the side of the intervention]; assist with turning and repositioning for comfort as needed as resident tolerates; report redness to LN; and pressure reducing device to bed and wheelchair. On 2/22/14 a new intervention was added to the care plan for the resident to wear an AFO/shoe to right foot ...</p> <p>NOTE: The care plan documented the right leg was to be elevated at times, with no guidelines as to when to elevate the leg and float the heels for protection of the heel and to turn and position as needed (no time frame provided). The care plan did not direct staff to monitor the AFO brace for position of the foot when the resident was up in her wheel chair, tightness, or pressure areas.</p> <p>An I &amp; A (Incident and Accident) report dated 3/5/14, 7:00 AM, documented a change in the resident's condition written by the LN, "Black blister noted to back of [right] heel 3 cm (centimeter) round.... Will start some new approaches to her care. Has had her boot for a couple years." A CNA documented, "(Resident's name) was laying in bed.... Right leg had nothing on no pillow [sic] foot was just laying on bed." A second CNA documented, "... No we did not turn her side to side and yes she did move her foot when we would prop her foot upon a pillow and when we went in again for our rounds she had moved her leg off the pillow." The DON invesigation summary documented, on 3/4/14, the resident had been assisted from bed and her AFO brace was on the right foot. The resident was observed by the activity director with her right heel resting on the end of the foot rest and the activity director was unable to tell how long</p>	F 314	<p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, Residents that are assessed at high risk for skin breakdown may have the potential to be affected by this deficiency therefore:</p> <ul style="list-style-type: none"> <li>- By 12/19/14 a visual observation will be done by the facility's wound team or their designee, with the Director of Nursing or designee, and Administrator or designee to endure that current Resident who use an Air Mattress with pressure relief setting modes are programmed appropriately.</li> <li>- By 12/19/14 a visual observation will be done by the facility's wound team or their designee, with the Director of Nursing or designee, and Administrator or designee to ensure that current Residents who have an MD order for AFO foot brace or Prevalon protective or heel float boots had those devices placed according to that resident's particular order and that the LN initialed in the treatment sheet to ensure placement.</li> <li>- By 12/19/14 a visual observation will be done by the facility's wound team or their designee, with the Director of Nursing or designee, and Administrator or designee reviewed the treatment sheets to ensure license nurses provided treatment as ordered on resident with pressure sores and initialed the treatment sheet as completed.</li> <li>- By 12/19/14 a visual observation will be done by the facility's wound team or their</li> </ul>		

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F 314	<p>Continued From page 21</p> <p>the foot had been resting on the device or whether the resident had hit her heel when she positioned it on the foot rest. The DON documented the resident moved her right foot up and down in the bed and her right leg had been off the pillow during rounds, and documented, "... If there was an injury from earlier, the rubbing would have added to the blister / deep tissue injury site." The use of the electric wheel chair with the foot rest was new to the resident since admission to the facility.</p> <p>NOTE: The facility was aware the resident did not keep her foot floated on the pillows and did not implement new measures to ensure the heel was floated and protected from pressure or friction from rubbing on the bed until after the black blister was identified on the right heel. Prevalon boots were implemented, however the facility failed to identify or assess the new wheelchair for potential skin concerns.</p> <p>The resident's Wound/ Skin report (WSR), Nurse's notes (NN), Physician Progress notes (PPN) and Change of Condition form (CCF) documented:</p> <p>*WSR 3/5/14 at 7:15 AM: The right heel had a 3 cm, round, black blister, a Stage II SDTI (suspected deep tissue injury.)</p> <p>NOTE: According to the NPUAP [National Pressure Ulcer Prevention Panel] a black blister is considered "unstageable." The LN documented the black blister as a Stage II pressure ulcer.</p> <p>*NN 3/5/14 0730-11:00 AM: "(No) edema noted</p>	F 314	<p>designee, with the Director of Nursing or designee, and Administrator or designee to ensure that Residents who use and electric wheel chair have been assessed for potential pressure areas on the electric wheel chair.</p> <p>- By 12/19/14 residents who use preventive measures such as: Air Mattress with pressure relief setting mode and/or AFO foot brace or Prevalon protective or heel float boots who have family members who are active participants in providing the resident care in the facility will be identified.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur, all License Nurses will be inserviced by the Director of Nursing by 12/19/14 with regard to F-314:</p> <p>- The importance of following the programmed Air Mattress pressure relief mode.</p> <p>- On the importance of implementing and documenting in the treatment sheet with regards to the use of AFO foot brace or Prevalon protective or heel float boots, as ordered by MD.</p> <p>- On the importance of providing and initialing in the treatment sheet with regards to the pressure ulcer treatment, as ordered by MD.</p> <p>- Residents identified who have family</p>		

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F 314	<p>Continued From page 22 to R (right) foot.... Air Mattress (and) bed changed out...."</p> <p>*CCF 3/5/14: "...noted afternoon Pitting edema in R (right) foot (and) ankle today. (And) (no) feeling in Rt. foot."</p> <p>The resident's November 2014 physician orders documented: Air mattress to bed for skin breakdown prevention and Prevalon boots to right foot every shift for skin breakdown. Start date: 3/5/14.</p> <p>NOTE: The resident was at high risk for skin breakdown. The air mattress and Prevalon boots were not ordered until after the resident's right heel developed a black blister.</p> <p>The resident's care plan was updated on 3/5/14, with a focus problem for impaired skin integrity related to the black blister on the right heel. New interventions implemented included air mattress; Prevalon boot while in bed; treatment as prescribed; turn every 2 hours, and float right heel while in bed. The AFO/ shoe to right foot was placed "on hold."</p> <p>*PPN 3/7/14: The resident was seen in the office to establish care for eleven medical conditions, #10 was "R (right) heel wound: She has charcot's foot deformity and usually wears a brace. This is a tight brace and may be a culprit for her wound...." The physician progress note documented, "R heel - necrotic tissue," and the plan was to "get traction boot padded."</p> <p>NOTE: The physician documented the wound to the right heel was necrotic tissue. The traction</p>	F 314	<p>members who are active participants in providing the resident care in the facility will be provided with education on the importance of following preventive measures such as the use of air mattress with pressure relief setting mode and/or AFO foot brace or Prevalon protective or heel float boots.</p> <ul style="list-style-type: none"> <li>- Residents who use an electric wheelchair are assessed for potential pressure areas on the electric wheelchair.</li> </ul> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through the Director of nursing and Administrator or designee;</p> <ul style="list-style-type: none"> <li>- Visual observation on all residents who use an air mattress with pressure relief setting modes to ensure programmed setting is set appropriately.</li> <li>- Visual observation on residents who have a MD order for AFO foot brace or Prevalon protective or heel float boots had those devices placed according to that resident's particular order and that the LN initialed in the treatment sheet to ensure placement.</li> <li>- Review the treatment sheets to ensure LN provide treatment as ordered on resident with pressure sores and initialed the treatment sheet as completed.</li> <li>- Review of resident who use an electric wheelchair to ensure assessment for potential pressure areas on the electric wheelchair.</li> <li>- Review all residents identified who uses</li> </ul>	

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F 314	<p>Continued From page 23</p> <p>boot was tight and may have contributed to the wound and the boot needed to be padded. The facility had not documented an assessment of the AFO to ensure the brace properly fit the resident from the time of admission to the facility.</p> <p>*NN 3/8/14: "...skin prep to necrotic blister on heel. Skin remains intact - other edges remain firm and pink...."</p> <p>*CCF 3/11/14: "...Most of the fluid in blisters feels like it is gone. ...[Right] inside ankle has 0.1 cm x 0.3 cm dk (dark) pink area. Skin prep applied to both sites."</p> <p>*WSR 3/11/14: Stage II, irregular; size: 3 cm L (length) x 2.5 cm W (wide), depth: unknown; wound bed: black.</p> <p>*NN 3/12/14: "...Rub area to inner ankle still dark pink. A transfer boot (not) used today."</p> <p>The resident's care plan was updated on 3/12/14 to include the problem of impaired skin integrity related to edema and high risk skin. The interventions included padding to the electric wheel chair foot rest.</p> <p>*WSR's 3/20, 3/25, 4/2, 4/9, 4/16, 4/30, 5/7, 5/14 and 5/21/14 had similar documentation that the wound had decreased in length and width, depth was still unknown and the wound bed was described from black to purple to a scab.</p> <p>*CPU 3/25/14: Skin integrity on the right medial ankle continued to be a care issue with the right heel. Healing the right medial ankle continued to be the goal.</p>	F 314	<p>air mattress pressure relief with setting mode and/or Prevalon or protective/float boots that have family members who are active participant in providing the resident care in the facility will be provided with education on the importance of following such preventive measures.</p> <p>Monitoring will start on 12/22/14. This will be done weekly x 4 weeks, then every 2 weeks x 4 weeks, then monthly x 3 months.</p> <p>The facility Director of Nursing or designee will present to the QA&amp;A Committee during the quarterly QA&amp;A Committee meeting her/his findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the quarterly QA&amp;A Committee Meeting.</p>		

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F 314	<p>Continued From page 24</p> <p>*CPU 3/26/14: Implemented an intervention for frequent turning.</p> <p>The resident's TAR (Treatment Administration Record), dated 3/1/14 through 3/31/14, documented:</p> <p>* Prevalon boots on while in bed from 3/5/14. The boots were not documented as being on the resident on 3/17, 3/29 and 3/30/14 on evening shift and on 3/25 on night shift.</p> <p>*Skin prep to right heel blister area: The treatment was to be provided on day shift. Treatment was not documented as provided on 3/26, 3/27, and 3/28.</p> <p>*WSR 5/28/14: The wound had "deteriorated" and was 1.4 cm by 0.4 cm by 0.2 cm, and the wound bed was described as "scab". Comments: "Heel becomes worse [with] each UTI [urinary tract infection]- then starts healing."</p> <p>*WSR 6/3/14: The wound was 1.0 cm x 0.8 cm; Depth: unknown; Wound bed: Scab; "Improved."</p> <p>*WSR dated 6/11, 6/18, 6/24, 7/2, 7/9 and 7/16 documented the wound in length, width, and depth; the wound bed; and that the wound had "improved."</p> <p>*WSR 7/23: The wound had "deteriorated." Size: 0.12 cm L x 1 cm W; Depth: unknown; wound bed: scab; "Becomes enlarged [with] UTI's. Will monitor."</p> <p>The resident's July 2014 TAR documented skin prep was provided to the resident's right heel area to "toughen" the skin in that area. The</p>	F 314			

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F 314	<p>Continued From page 25</p> <p>treatment was not documented as provided on 7/5, 7/6, 7/23, 7/24, 7/25, 7/26, 7/27, 7/29 and 7/31.</p> <p>NOTE: The treatment was not documented as provided on 7/23/14 when the LN had documented the wound had deteriorated.</p> <p>*WSR 7/30: The wound had "improved." Size: 0.3 cm L x 0.9 cm W. Depth: Unknown; Wound Bed: scab.</p> <p>NOTE: The length of the wound had doubled in size from 7/23 to 7/30/14 and the LN documented the wound had "improved." The TAR documented the resident received treatment to the wound once only from 7/23 through 7/31, with the treatment documented as performed on 7/30, the day of the WSR.</p> <p>*WSR 8/13: The wound was documented as "improved." Two areas of breakdown were documented as follows: Size: 0.2 cm L x 0.3 cm W, and 0.2 cm L x 0.1 cm W; Depth: sup[erficial]; Wound bed: Pink. Comments: "0.2 cm in center healed."</p> <p>NOTE: This was the only documentation of two open areas on the resident's heel and the facility had documented the wound had improved with two superficial open areas; previous documentation was for one wound.</p> <p>The WSR documented assessments on 8/19, 8/27, and 9/3 with fluctuating length and width from decreased to increased in size, and depth from superficial to greater than 0.1 cm.</p>	F 314			

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F 314	<p>Continued From page 26</p> <p>The WSR documented on 9/10 and 9/17 the wound was healed.</p> <p>The resident's November 2014 TAR documented; *Prevalon boots to right foot every shift for skin breakdown. On evening shift, the boots were not documented as being on the resident on 11/3, and 11/15/14. *Right heel apply A and D ointment every shift to prevent opening. Start date: 11/19/14.</p> <p>On 11/18/14 at 9:00 AM, CNA #2 and CNA #3 were observed providing cares for the resident and assist her to bed. The CNAs were asked if the resident's heel had an open area at this time. CNA #3 stated, "I don't think so." CNA #2 stated the boots were for protection. The resident was positioned on her right side with the blue Prevalon boot on. The right foot was not floated.</p> <p>On 11/18/14 at 10:20 AM, the resident was observed in the same position.</p> <p>On 11/18/14 at 6:00 PM, the resident was observed in bed on her back and her family member was at the bedside. The resident's right foot had a beige sock on, and the Prevalon boot was not on the foot. The right heel was directly on the bed. The family member was asked if she had taken off the Prevalon boot and she stated, "No, I took off her shoe. I don't like her to have the boot on in bed. I think they have it on her during the day." The family member stated she had put her mother to bed.</p> <p>On 11/19/14 at 10:40 AM, the resident was observed in bed propped on the right side with a pillow behind the left side of her back. The blue</p>	F 314			

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F 314	Continued From page 27 boot was on the right foot, the heel was not floated.  On 11/19/14 at 11:15 AM, the resident was observed in bed with LN #1, CNA #2 and CNA #3 in the room. LN #1 was asked if the resident had been admitted with the black blister, and she stated, "No, it was acquired here." The blue boot was removed from the right foot and LN #1 observed the heel. The LN identified an area to the back of the heel and stated, "It is not open which is a good thing." She was asked if the area blanched and she stated, "Not very good but it does blanch." The LN was asked what color it was and she stated, "It is a purple area." The LN was asked how big the area was in March and she stated, "It covered the heel. It was purple-black in the beginning. It was huge." When asked when the Prevalon boots were implemented, LN #1 stated, "When it started" in March. The LN left the room to retrieve a tape measure to measure the area. The CNA's were asked if the bed was inflated and was it an air bed. CNA #3 stated it was a new bed they had received about a month prior. The two CNAs looked for a setting on the bed and CNA #2 opened the cover on the foot of the footboard of the bed. There was a control panel with options for "firmer, softer, pressure relief, comfort, 1. heel relief, 2. heel relief, 3. heel relief." None of the controls were on or lit up. The CNA pressed the pressure relief option and the bed made an instant puff of air sound, which then inflated the bed with air. The CNA's were asked if they checked the bed to ensure pressure relief was on. CNA #3 stated she would not know how to check it and CNA #2 stated she would not have thought to check if the air mattress option was	F 314			

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F 314	<p>Continued From page 28</p> <p>on. Outside the panel on the bed a green light came on which had "pressure relief" beside the light. The LN, who had returned to the resident's room, verified the bed did not have air protection when it was not on pressure relief mode. The LN was asked if anyone was responsible to check if the bed was in pressure relief mode, and she stated she was not aware of anyone being responsible to check the bed. She stated, "Probably the nurse or CNA should check it at least once every day." The LN was then asked if the resident had a pressure sore to her feet before coming to the facility, and she stated, "That is how she lost her other leg." The LN was asked if the resident should be considered high risk with preventive measures implemented upon arrival to the facility. The LN stated, "She was high risk over all, the [family member] has a way of doing things." The LN was asked if the family member had been educated on preventive measures when the resident arrived and was it documented, to which she stated, "I am sure there should be," [documentation].</p> <p>On 11/19/14 at 3:00 PM, the resident was observed in bed with a blue protective boot on and the right heel floated off a pillow. CNA #4 stated the resident's family member often put the resident to bed at night and as the evening CNA she would go in to check the resident around 6:30 PM and the protective boot would not be on. CNA #4 stated, "So we put the boot on and tell the [family member] it needs to be on for pressure relief." The CNA was asked if she checked the bed to verify the bed was on pressure relief mode and she stated, "I have never checked the light or the switch to verify the bed was on. I just push on the bed and feel if it</p>	F 314			

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F 314	<p>Continued From page 29</p> <p>goes down and comes back up." The bed was observed to have the green light on for pressure relief and heel relief.</p> <p>On 11/19/14 at 4:15 PM, the DON was asked to describe what the facility implemented when the resident arrived to prevent pressure sores as she was documented as high risk and had lost her left leg due to a pressure sore. The DON was also asked whether the facility had assessed the brace for proper fit and protection prior to the development of a black blister in March. The DON stated the resident's brace was flexible over the heel and the heel rested on the "hard spot" of the heel, and that up to that point the resident did not have redness to the heel. It was a very narrow time line. The DON verified the resident's new bed was received approximately one month earlier, but said she wasn't sure whether staff had been in-serviced on its operation.</p> <p>*CCF 11/19/14: "(Right) heel was a 0.3 cm x 1.0 cm dk (dark) purple area. A and D applied - Area around blanches poorly. Unstageable. .... (unknown depth). [Family member] talked to about bed. Will be in to learn about pressure relief on bed. Explained need for Provolon [sic] boot (and) use."</p> <p>*CPU 11/19/14: Problem focus are skin integrity impaired, related to (right) heel unstageable purple area. Goal: (Right) heel will return to pink color (without) opening. Interventions included ensuring air mattress was inflated; show [family member] how to use the bed; ensure Prevalon boots are on; monitor every week and treatment as prescribed.</p>	F 314			

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F 314	<p>Continued From page 30</p> <p>On 11/20/14 at 3:45 PM, the DON verified the brace had not been assessed by Physical Therapy or facility staff prior to the black blister appearing in March. The DON was asked if the intervention on the care plan that stated to elevate the right leg was the same as float the heels and she stated, "It was assumed and did not specifically say float the heels." When staff documented the resident did not keep her feet on the pillows, the DON was asked whether the facility considered using the Prevalon boot or other interventions prior to the heel skin breakdown. The DON stated, "We did not tie it to pressure in the bed; we felt like it was an injury, not pressure from the bed." When asked to describe the bed in place prior to the resident's receipt of the new bed, the DON stated, "...a regular air mattress." When asked whether there was documentation that staff had been trainin on the bed and the different modes possible with it, the DON stated, "No, we never did an inservice."</p> <p>On 11/21/14, at 11:00 AM, the Administrator and DON were informed that Resident #1 who was admitted to the facility as high risk to develop a pressure sore, had been harmed when she developed an unstageable black blister in March 2014. The resident's right AFO foot brace had not been assessed by the facility for proper fit, or potential pressure areas. The resident was provided a new electric wheelchair, which had not been assessed for potential pressure areas, and the resident had been observed with her foot not floated on a pillow. The resident developed a new purple, unstageable area of concern to the right heel, which was discovered during survey on 11/19/14. At the time of discovery the resident's new air bed did not have the pressure</p>	F 314			

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F 314	<p>Continued From page 31</p> <p>relief function turned on and the staff had not been in-serviced on the bed's various operational modes.</p> <p>On 11/24/14, the facility provided the following additional information: The resident was seen by her physician on 11/21/14. The progress note resulting from the physician's visit documented an evaluation of the resident's right foot with an area of concern on the posterior aspect of the heel. The MD Progress Note documented, "No evidence of deep tissue injury. Normal temperature and blood flow.... Previous scar tissue. Continue padding of heel." This information did not change the findings.</p> <p>The resident's heel was observed by the LN on 11/19/14, two days prior to when the resident was seen by the physician. The LN, who the facility designated to provide wound/skin assessments, assessed that wound was "unstageable," blanched poorly, was purple, and the resident was in a bed that was not in its pressure-relieving mode when the area of concern was discovered.</p> <p>2. Resident #9 was admitted to the facility on 6/2/06 with diagnoses which included Alzheimer's Disease and a heel pressure ulcer.</p> <p>The resident's 11/1/14 Physician Orders (recapitulation) included an order to, "Keep heels dry and heel boots on, except with cares."</p> <p>The resident's 12/14/13 Care Plan for skin integrity included an intervention, dated 9/9/14,</p>	F 314			

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F 314	Continued From page 32 for "foam boots when in bed. Heel float boots when up as needed."  On 11/19/14 at 3:15 p.m., the resident was observed sitting in a recliner with a pillow under her legs to elevate her heels off the recliner. A pair of heel boots were observed laying on her bed.  On 11/20/14 at 11:55 a.m. the DON looked at the physician orders and stated the resident should have had the boots on.	F 314			
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 interviews, and record reviews, it was determined the facility failed to implement interventions to keep a resident safe from experiencing falls after identifying a fall risk and contributing factors such as lack of footwear. This was true for 1 of 1 resident (#3) observed for history of falls. Resident #3 was admitted to the facility on 7/21/14 with diagnoses of dementia, without behavior; joint pain; and abnormality of gait. Fall Risk Assessments - dated 7/23/14, 9/20/14, 10/16/14, and 10/22/14 - all indicated Resident	F 323	The facility does 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.  Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: - Resident #3 room was rearranged by the facility, with resident and/or resident representative permission, allowing	1/1/15	

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F 323	<p>Continued From page 33</p> <p>#3 was at high risk for falls.</p> <p>A Quarterly MDS assessment, dated 10/22/14, documented 6 on BIMS, indicating severe cognitive impairment.</p> <p>The resident's Care Plan (CP) dated 7/30/14, documented bladder incontinence and dementia. Interventions were documented as, "Encourage resident to seek assistance with toileting as needed." The 7/30/14 CP also documented a potential for falls. Interventions included, "Cue resident to use proper footwear when ambulating, encourage resident to call for assistance, resident has shuffling gait, takes very small steps - allow time to walk."</p> <p>An Accident and Incident Report recorded the resident experienced a fall on 10/16/14 at 8:20 PM. The report documented the resident fell while on his/her toilet, and attributed the cause of the fall to "non-compliance, unassisted ambulation, and responding to bladder urgency." The report further documented the resident was not wearing socks, shoes, or slippers, the resident's walker was located next to her bed at the time of the incident, and the resident had last voided about 6:30 PM, approximately 30 minutes after the dinner meal. The report documented the resident was placed immediately on alert charting and had his/her CP updated.</p> <p>Corrective actions included, "Encourage resident to toilet more frequently to avoid urgency." The report concluded that contributing factors included bare feet, not using gait assist device, and that the resident was more than 15 feet from the toilet when he/she attempted the self-transfer. The report did not document a root cause for the fall.</p> <p>Note: The resident's CP was not updated to toilet more frequently.</p>	F 323	<p>walker to be more assessable on 12/12/14. Resident assessed by OT for the use of a commode chair near bed to address urgency on 12/11/14. Care plan modified with assessments by 12/19/14.</p> <p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following: This deficiency is an isolated deficiency as reflected in the Statement of deficiencies - form CMS 2567. To address other residents that may have the potential to be affected by this deficiency, by 12/30/14 the facility's Clinical Case Manager, Director of Nursing, Therapy Program Manager or designees (The Enviro Team) will do a visual observation on all residents' rooms in the facility to review setup and assistive devices ensuring that the appropriate interventions are implemented and care plans were updated.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure that the deficient practice does not recur; A root cause analysis was done by Administrator and DON by 12/30/14, hence the facility developed the "Enviro Team" that will review starting 12/30/14 each resident room setup and assistive devices on admit and with significant changes in the resident to ensure that the</p>		

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F 323	<p>Continued From page 34</p> <p>A second Accident and Incident Report documented the resident experienced a second fall on 11/7/14 at 10:55 PM. The report documented the "resident fell while attempting to use the toilet without staff assistance." The report further documented the resident was not using his/her walker, was not wearing socks, shoes, or slippers, and had last voided one hour previous to the incident (approximately 10:00 PM). The report documented the resident was placed immediately on alert charting, had his/her CP updated, and new physician orders. The report summarized that the resident frequently expressed he/she experienced knee pain, denied slipping although urine was observed on the floor, and took short shuffle steps. Corrective actions included, "Encourage resident to have staff flush toilet to prevent leaning over." The report concluded that contributing factors included bare feet, not using gait assist device, received anticoagulant, cardiovascular, and narcotic medications within 8 hours prior to the fall. The report documented a root cause for the fall: footwear, not using assistive device and, urine on floor next to toilet. Initial interventions to prevent future falls: encourage resident to use walker, wear gripper socks or shoes, place continence supplies in a bag attached to the handrail for resident convenience, and call staff to assist at night time hour. Note: The resident's CP was not updated to include staff flushing the toilet. The surveyor observed the resident wearing socks and shoes when ambulating outside of her room. The surveyor also observed the resident in bare feet or wearing non-gripper socks. The</p>	F 323	<p>intervention are in place and are reflective in the care plan.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through the facility's Administrator or designee, who will do a visual observation on three (3) different resident rooms to review room setup and assistive devices to ensure fall preventative interventions are in place and reflective on the care plan.</p> <p>Monitoring will start on 12/31/14. This will be done weekly x 4 weeks, then every 2 weeks x 4 weeks, then monthly x 3 months. The facility Administrator or designee will present to the QA&amp;A Committee during the quarterly QA&amp;A Committee meeting her/his findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the quarterly QA&amp;A Committee Meeting.</p>		

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F 323	Continued From page 35 following observations were made: <ul style="list-style-type: none"> <li>· On 11/17/14 at 3:30 PM, the resident was observed in bed with bare feet, Physical Therapy (PT) was removing hot pack from the resident's right knee.</li> <li>· On 11/18/14 at 9:15 AM, the resident was observed getting into her bed. The resident was not wearing gripper socks.</li> <li>· On 11/18/14 at 10:20 AM, the resident was in bed, laying on his/her right side, facing window. Socks were noted to be on the floor.</li> <li>· On 11/18/14 at 4:20 PM, the resident was in bed reading with an ice pack on the right knee. The resident was not wearing gripper socks.</li> <li>· On 11/19/14 at 11:00 AM, the resident was seated on the side of his/her bed reading. The resident was not wearing gripper socks. The resident transferred, without stand-by assist (SBA) from the bed to his/her recliner using the bed and the arm of the chair. He/she did not put full weight on the right leg. The resident then attempted to transfer from the recliner back to the bed with complaints of right leg pain. He/she was able to stand from the seated position on the third attempt, and did not put full weight on the right leg.</li> <li>· On 11/19/14 at 12:00 PM, the resident was observed seated at table in dining room, shoes on both feet.</li> <li>· On 11/19/14 at 4:40 PM, the resident was seated on the side of his/her bed. The resident was observed in bare feet and reported he/she wasn't feeling well and would have dinner in his/her room. The resident reported he/she needed to use the toilet. The resident stood and started to walk toward the toilet. When reminded he/she needed to wear shoes and use the walker, the resident the put on his/her shoes on</li> </ul>	F 323			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/21/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MCCALL REHABILITATION &amp; CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>418 FLOYDE STREET MC CALL, ID 83638</b>		
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F 323	Continued From page 36 and used the walker to ambulate to the toilet. · On 11/20/14 at 9:25 AM, the resident was observed seated in his/her recliner, wearing shoes but no socks. The resident was observed taking his/her shoes off and transferred to the bed using the chair arm and the bed for support without putting his/her full weight onto the right leg. NOTE: Staff was not observed to encourage the resident to toilet during this survey. A Nurse's Note, recording a condition change and dated 9/30/14 at 4:30 PM, documented the resident walked to the bathroom without his/her walker or shoes, wearing bulky slippery socks, and fell. The resident was found lying on the floor next to the bathroom door, yelling, and demanding to be helped up. Note: An Accident and Incident Report for this fall was not provided by the facility. Resident #3 experienced 3 unwitnessed, non-injury falls between 9/30/14 and 11/17/14. The facility identified "footwear, toileting and non-compliance with ambulation" as root causes, but failed to ensure the documented interventions were implemented correctly and consistently to prevent future falls and possible injury to the resident. On 11/21/2014 at 10:45 AM, the Administrator and DON were notified of the findings. No additional information was provided.	F 323			
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329		1/1/15	

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F 329	<p>Continued From page 37</p> <p>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 ensure residents were free from unnecessary medications. The facility failed to monitor behaviors for which 3 of 9 sample residents (#s 4, 5, 6,) received psychopharmacological medication, and did not have documentation to justify continued use. Additionally, for residents with diagnoses of dementia (#s 1,3 9), the facility failed to ensure clinical indication for the use of an antipsychotic medication was in place. This practice placed residents at risk for unanticipated declines or newly emerging or worsening symptoms. Findings included:</p>	F 329	<p>The facility does ensure that each resident's drug regimen is free from unnecessary drugs.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident #9 (which should be #8 on Resident Identifiers for Survey Report) - Clarification of behaviors will be included on BM and Care Plan by 12/19/14. - The Care Plan (CP) for "Psychotropic drug use to manage behaviors" was modified for clarification as this specific CP refers to the resident being on</p>		

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F 329	<p>Continued From page 38</p> <p>1. Resident #9 was admitted to the facility on 3/21/13 with diagnoses which included dementia with behavior disturbance and systolic heart failure.</p> <p>The resident's 11/1/14 Physician's Orders (recapitulation) included an order for Zyprexa (antipsychotic) 2.5 mg at bedtime for dementia with psychotic features, with a start date of 10/7/13.</p> <p>The 1/12/14 Care Plan (CP) for "Psychotropic Drug use to manage behaviors" documented in the intervention section behaviors of verbal aggression towards others and uncontrolled crying. The intervention section had no other information.</p> <p>The resident's CP for "Altered thought process inappropriate yelling..." included a goal to decrease inappropriate yelling to less than weekly and "less episodes of aggression..." Interventions included:</p> <ul style="list-style-type: none"> <li>-Encourage activities</li> <li>-Redirect</li> <li>-Reassure when tearful</li> <li>-Close observation when agitated</li> <li>-Reward positive behavior with complements</li> <li>-Identify if behavior for unmet need</li> <li>-Remain calm, state boundaries in firm but gentle manner</li> <li>-1 to 1 with social service as needed</li> <li>-Allow to verbalize feelings and validate those feelings</li> <li>-Decrease agitation by i.e. offering beverage of choice</li> </ul>	F 329	<p>behavior monitoring of Verbal Aggression of others and Uncontrolled Crying. That is why the intervention section had no other information except the behaviors to be monitored. The CP problem was relabeled as "Resident is on behavior monitoring for Psychotropic Drug use". The CP goal was changed to reflect "Behavior will be monitored through next review". The CP intervention will continue to be the behavior which will be monitored.</p> <ul style="list-style-type: none"> <li>- The CP for "Altered thought process inappropriate yelling..." was modified to include specific criteria of how the inappropriate yelling would present, defined verbal aggression, triggers for initiating and behavior, what the resident was trying to communicate and when the 1 to 1 with SS would be implemented.</li> <li>- The October Behavior Monitor sheet that the surveyor identified during the survey as 12 days with 2 behaviors on Shift 1 are not actual behaviors. They are the nurse initial that resembles the number 2. The November Behavior Monitoring sheet that the surveyor identified during the survey as 7 days on Shift 1 are also the nurse's initial. That is why the intervention and outcomes were blank. The resident had no episodes.</li> </ul> <p>Resident #4 - Clarification of behaviors will be included on BM and CP by 12/19/14.</p> <ul style="list-style-type: none"> <li>- The Care Plan (CP) for "Psychotropic drug use to manage behaviors" was modified for clarification as this specific</li> </ul>		

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F 329	<p>Continued From page 39</p> <p>The CP did not include specific criteria how inappropriate yelling would present (swearing, could be heard outside of room, more than 2 minutes etc.) or verbal aggression ( name calling, derogatory comments, etc.) and the CP did not include what initiated the behavior (environment, toileting, bathing, getting out of bed etc.). There was no documentation of what the resident was trying to communicate with the behavior (fear, pain, hallucinations etc.) Additionally the CP did not specify when the intervention of 1- to - 1 social services would be implemented ( after 1 incident, after all other interventions etc.).</p> <p>Behavior Monitor sheets (BM) documented the behavior and had an area for each day of the month to document the number of incidents, interventions, and the results of the intervention.</p> <p>The October BM sheet documented on shift 1 there were 12 days with 2 behaviors each of verbal aggression and uncontrolled crying. The BM was blank where the type of intervention and result of the interventions were to be documented. For shift 2 there were 5 days with 2 behaviors of verbal aggression and 0 days of depression. The BM documented interventions of 1- on-1 and fluids were offered on 2 of the 5 days for behaviors of verbal aggression. The form documented the results were "improved."</p> <p>Note: The 2 days the interventions were documented as implemented the results were documented as " improved" and there were 0 incidents of uncontrolled crying documented.</p>	F 329	<p>CP refers to the resident being on behavior monitoring of Depression aeb crying out and Screaming out. That is why the intervention section had no other information except the behaviors to be monitored. The CP problem was relabeled as "Resident is on behavior monitoring for Psychotropic Drug use". The CP goal was changed to reflect "Behavior will be monitored through next review". The CP intervention will continue to be the behavior which will be monitored.</p> <ul style="list-style-type: none"> <li>- The Behavior monitor was modified to distinguish between crying out and screaming out.</li> <li>- The potential for Depression CP was modified to define how anxiousness is exhibited.</li> <li>- The "Psyc" CP was modified to give examples of "dark stories" and how it affected the resident and to define "spending time with friends".</li> </ul> <p>Resident #5 Clarification of behaviors will be included on BM and CP by 12/19.</p> <p>-The Care Plan (CP) for "Psychotropic drug use to manage behaviors" was modified for clarification as this specific CP refers to the resident being on behavior monitoring of SX of Depression aeb short tempered and easily angered. That is why the intervention section had no other information except the behaviors to be monitored. The CP problem was relabeled as "Resident is on behavior monitoring for Psychotropic Drug use".</p>		

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F 329	<p>Continued From page 40</p> <p>The November BM sheet documented on shift 1 there were 7 days with 2 behaviors each of verbal aggression and uncontrolled crying. The form was blank where interventions or the results of the interventions were to be documented. For shift 2 there were 0 incidents documented where the number of incidents were to be documented.</p> <p>On 11/20/14 at 5:00 p.m. the DON stated the CP did not include criteria for the behaviors.</p> <p>Note: Without specific criteria or the effectiveness of the non-pharmacological interventions it would not be possible to determine the antipsychotic medication was clinically indicated.</p> <p>On 11/20/14 at 5:50 p.m. the Administrator stated Resident #9 was physically aggressive toward other residents as well as staff. When asked if the facility had assessed what the resident was trying to communicate when the behaviors were displayed, the Administrator stated she could not. When asked to define "uncontrolled crying" the Administrator stated "continuous" and "could be heard down the hall." The Administrator stated the CP needed to be revised to include criteria for the behaviors.</p> <p>2. Resident #4 was admitted to the facility on 5/12/14 with diagnoses which included pain, anxiety and vascular dementia.</p> <p>The resident's 11/1/14 Physician's Orders (recapitulation) included an order for Cymbalta (antidepressant) 30 mg twice a day for depression and Ativan (anxiolytic) 0.5 mg as needed for anxiety.</p>	F 329	<p>The CP goal was changed to reflect "Behavior will be monitored through next review". The CP intervention will continue to be the behavior which will be monitored.</p> <p>-The SP for Depression was modified to include information defining "short tempered" and easily angered".</p> <p>Resident #1 PRN Haldol was discontinued on 11/21/14.</p> <p>Resident #3</p> <p>- The Licensed Nurses were identified who did not complete the BM documentation, therefore the Director of Nursing or designee provided instruction with regards to F 329 on the importance of completion of the BM sheet observation and intervention outcomes by 12/19/14.</p> <p>-On 12/9/14 a request for GDR was submitted to the physician and response was received on 12/12/14.</p> <p>Resident #6 - No documentation regarding resident in 2567.</p> <p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following: This deficiency has the potential to impact any residents receiving a Psychotropic Medication, therefor by 12/19/14, the Director of Nursing or designee reviewed Behavior Monitoring of each resident on a Psychotropic Medication to ensure that:</p>		

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F 329	<p>Continued From page 41</p> <p>The resident's 10/16/14 CP for "Psychotropic Drug use to manage behaviors" identified behaviors of crying out and screaming out. There were no interventions documented in the CP.</p> <p>The BM for 11/1/14-11/17/14 documented 10 days on shift 1 of behaviors of crying out and 8 days of screaming out. The BM documented interventions of toileting or changing position was attempted and effective 3 days (did not specify which one of the interventions was effective) and ineffective 2 days. The BM included three days when documented interventions of toileting and offering food were ineffective and 2 days documented an unidentified intervention (BM did not include code for the intervention) as ineffective. For shift 2 the BM documented 7 days of crying out and 1 day of screaming out. The interventions of toileting and changing positions were documented as effective.</p> <p>Note: The BM did not include how to distinguish between crying out and screaming out.</p> <p>The resident's 11/4/14 "Potential for depression" CP documented a goal of decreased episodes of tearfulness and anxiousness. The CP did not identify how the anxiousness was exhibited. The intervention section directed staff to allow the resident to express concerns, and encourage him/her to participate in activities and decision making.</p> <p>There was no documentation in the resident's record for episodes of tearfulness and/or anxiousness.</p>	F 329	<ul style="list-style-type: none"> <li>- CP for "Psychotropic drug use to manage behaviors" were modified for clarification.</li> <li>- CP were modified to define behaviors.</li> <li>- The Behavior Monitoring sheets observation and intervention outcomes are completed when resident is identified to have episode of behavior.</li> <li>- GDR were requested as indicated for Psychotropic medications.</li> </ul> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following: Through root cause analysis the Director of Nursing and Administrator determined that previous citations in F-329 were related to other systems, thus focus will be on the below areas as it relates to unnecessary medication. To ensure that the deficient practice does not recur an inservice training was completed by 12/15/14 by Director of Nursing regarding F329 to all LN regarding;</p> <ul style="list-style-type: none"> <li>- CP for Behavior Monitoring of Psychotropic Drug use is identified for the purpose of BM.</li> <li>- CP for Behavior Monitoring manifestations is clearly defined.</li> <li>- Importance of completing the Behavior Monitoring sheet observation and intervention outcomes section when resident is identified to have episode of behavior.</li> <li>- GDR are requested as indicated for Psychotropic medications.</li> </ul>		

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F 329	<p>Continued From page 42</p> <p>The resident's 11/4/14 "Psc" CP documented a history of delusions of her husband stealing her belongings and having affairs with other women. The CP also documented the resident would tell "dark stories about [her] past." The CP did not include any information as to what a "dark story" was or how it affected the resident. Interventions were to encourage the resident to participate in activities, spend time with friends, and for staff to state "that you (they) will take care of it" when the resident had delusions. The CP did not include what spending time with friends met (other residents, or friends outside of the facility or how staff would "take care of it").</p> <p>The resident's record did not have any documentation of delusional episodes or or telling "dark stories" about the past.</p> <p>On 11/20/14 at 11:55 a.m. the DON stated the resident appeared to be confused, tearful and thoughtful when he/she cried out. The DON stated screaming out was loud and the resident sometimes appeared fearful.</p> <p>On 11/20/14 at 4:15 p.m. the SSD stated the only provisions for anxiety on the resident's CP were the same as those for depression. The SSD stated the resident's anxiety would present through the use of "off based language" and the resident would close her eyes and rapidly open and close her mouth.</p> <p>3. Resident #5 was admitted to the facility on 12/16/11 with diagnoses which included peripheral vascular disease and diabetes mellitus.</p>	F 329	<p>Systemic measures that will be put in place, the Administrator developed a checklist by 12/30/14 for the monthly Behavior Team Meeting that the Pharmacist, Director of Nursing, and Social Services (or designees) will utilize to ensure types of BM, completion of BM sheets, care plans of behaviors, and potential or GDR are reviewed during the scheduled Behavior Team Meeting.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through: The Director of Nursing or designee will review sampling of at least 3 residents on psychotropic medications to ensure that:</p> <ul style="list-style-type: none"> <li>- The Care Plan (CP) for "Psychotropic drug use to manage behaviors" clearly reflects what behavior is being monitored</li> <li>- CP behavior monitor manifestations are clearly defined.</li> <li>-The Behavior Monitoring sheet observation and intervention outcomes are completed when resident is identified to have episode of behavior.</li> <li>- GDR were requested as indicated for Psychotropic medications.</li> </ul> <p>Monitoring will start on 12/31/14. This will be done weekly x 4 weeks, then every 2 weeks x 4 weeks, then monthly x 3 months.</p> <p>The facility Director of Nursing or designee will submit to the Administrator or designee and the QA&amp;A Committee</p>		

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F 329	<p>Continued From page 43</p> <p>The resident's 11/1/14 Physician's Orders (recapitulation) included an order for Prozac (antidepressant) 20 mg at bedtime for depression.</p> <p>The resident's 9/30/14 CP for "Psychotropic Drug" use to manage behaviors identified behaviors in the intervention section of " short tempered and easily angers." The CP had no other information.</p> <p>The resident's 9/30/14 CP for "has tendency towards depression as manifested by short temper and being easily angered" included in the intervention section:</p> <ul style="list-style-type: none"> <li>-Allow to express concerns</li> <li>- Quickly address when resident asks for something</li> <li>-Encourage activities</li> <li>-Meds as ordered</li> <li>-Reward positive behavior with compliments</li> <li>-Identify if behavior for unmet need</li> <li>-Offer opportunity for reminiscing</li> <li>-1 to 1 as needed</li> </ul> <p>The CP did not have information defining "short temper" or being "easily angered" such as verbal aggression or physical aggression.</p> <p>The resident's 11/1/14-11/18/14 documented there had been 0 incidents of the resident being short tempered and/or easily angered.</p> <p>On 11/20/14 at 10:45 a.m. the DON stated the resident had a history of being violent and the CP should include behaviors of kicking and hitting. The DON stated the resident's behaviors had</p>	F 329	<p>during the quarterly QA&amp;A Committee meeting her/his findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the quarterly QA&amp;A Committee Meeting.</p>		

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F 329	<p>Continued From page 44 improved and the Prozac had been reduced on 11/19/14 from 20 mg to 10 mg.</p> <p>On 11/21/14 at 10:45 a.m. the Administrator and DON were informed of the above concerns. The facility provided no further information.</p> <p>4. Resident #1 was admitted to the facility on 2/1/14 with diagnoses which included dementia without behaviors and LBKA (left below the knee amputation).</p> <p>The resident's Quarterly MDS assessment, dated 8/6/14, documented the resident's cognition was moderately impaired; no physical, verbal or other behaviors directed towards other; no hallucinations or delusions; no rejection of cares or wandering; and had not received an antipsychotic medication. The resident did, however, have a diagnosis of depression and was administered an antidepressant.</p> <p>The resident's care plan, dated August 2014, documented a behavior monitor, psychotropic drug use to manage behaviors, hallucinations, and depression as evidenced by self negative talk. The focus was updated 9/26/14, with an intervention for medication per orders.</p> <p>The DON provided an in-service sign-in sheet, dated 8/1/14, which documented: "There have been reports from her [family member] that [resident name] is very anxious in the evening and says she is scared. For the next 4 days from 16:00 [4:00PM] to 20:00 [8:00 PM], Please do (every) 15 minutes checks on the 4 P's to access the level of anxiety. We will then report to (physician) for further treatment as needed.</p>	F 329			

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F 329	<p>Continued From page 45</p> <p>When she is awake, ask the 4P questions- Positioning, Personal (potty) needs, Pain (or anxiety for this test) and placement. Especially ask "Is there anything else I can do for you?" The forms documented no behaviors on 8/1, 8/2 and 8/3. On 8/4 at 4:00 PM, the form documented the resident was "anxious (complaint of) not feeling well" and was watching television, up to the dining room and talking with other female residents. No behaviors were documented for 8/5/14.</p> <p>The resident's Nurse Notes (NN), Medication Administration Record (MAR), Change of Condition form (CCF), Physician orders (PO), Care Plan update (CPU), Social Service Progress Notes (SSPN) and Pharmacist Consultant Report (PCR) documented:</p> <p>*NN 8/6/14 night shift: "(Up) to BSC [bedside commode] after yelling for help.... appear anxious related to placement on BSC [bedside commode]. ...1-1 (with) resident- talking her through each step of changing incontinent pad (and) assisting back to bed-... -10 min(utes) later res(ident) was sleeping (without) (signs or symptoms) of restlessness."</p> <p>*NN 8/7/14: "Review of Supervision loop - x 5 days- 2 statements of anxiety voiced - easily redirected by staff (and) res(ident) calmed - when awaked [sic] for toileting - [no] assessed need for anti-anxiety med(ication) (at) this time."</p> <p>* NN 8/13/14: Quarterly assessment: "No episodes of delusions this (Quarter) but resident can become confused (and) may not remember where her room is at. Sleeps well at night (and)</p>	F 329			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/21/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MCCALL REHABILITATION &amp; CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>418 FLOYDE STREET MC CALL, ID 83638</b>		
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F 329	<p>Continued From page 46 takes naps...."</p> <p>*NN documented on 8/13, 8/14, 8/15, 8/16, 8/17, 8/19, and 8/20/14 the resident had no behaviors.</p> <p>*Nursing 2014 Drug Handbook. Lippincott, Williams &amp; Wilkins, Page 686. Documented: "Haldol- Black Box Warning: Elderly patients with dementia-related psychosis treated with atypical or conventional antipsychotics are at risk for death. Antipsychotics aren't approved for the treatment of dementia-related psychosis."</p> <p>*8/21/14 - An Informed Consent for Psychoactive Medications was implemented and documented the resident was started on the antipsychotic medication "Haldol" [no dose or frequency documented] for "Endstage dementia (with agitation." A second form was implemented and documented the medication was "Haldol 2 mg (milligrams) (every) 6 (hours) (as needed). Both consents were signed by the resident's family member.</p> <p>NOTE: The Black Box warning was not documented on the form. The daughter was not informed of possible death related to the use of Haldol. See F 154.</p> <p>*CPU 8/21/14: Documented thought process was impaired related to endstage dementia with agitation. The interventions included medication as prescribed, monitor for signs and symptoms of fear/ agitation and family member may request Haldol.</p> <p>*NN 8/22/14 at 6:00 PM: The note documented the physician was in the facility, reviewed the</p>	F 329			

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F 329	<p>Continued From page 47</p> <p>resident's medication with her family members, and had ordered "Haldol 2 mg (by mouth) (every) 6 (hours) (as needed). No agitation noted so far this pm (evening) shift."</p> <p>*NN 8/23/14 at 8:10 PM: "Long lost [family member] in to visit. [Another family member] in also (and) stated resident cried during the visit. [Family member] in at supper (and) stated resident asked to go home (with) her. When told she lives here resident said 'Just let me die.' Haldol 2 mg given (and) no further tearfulness or negative statements noted."</p> <p>*NN 8/25/14 at 6:15 PM: "Noted to be shivering, delirious (and complaint of) being cold. Tylenol given, Haldol given per [family member] request..."</p> <p>*NN 8/26/14 at 9:30 PM: "... res(ident) fearful (at)1700 [5:00PM] med(icated) (with) Haldol (with) good effects..."</p> <p>NOTE: Non-pharmacological interventions were not documented as provided prior to the administration of the antipsychotic.</p> <p>*CCF 8/27/14 at 9:30 PM: "Res(ident) [family member] is requesting that Haldol (and) Oxycodone be scheduled to ensure [resident] has no pain or behaviors!"</p> <p>*NN 8/29/14: "[Family member] in (and) is requesting Haldol (two times a day) (and) Oxycodone [Narcotic pain medication] on a more routine basis. Scheduled Oxy (and) Haldol given (at) 17:15 PM [5:15 PM]...."</p>	F 329			

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F 329	<p>Continued From page 48</p> <p>*NN 8/30/14 PM: "Haldol given at 17:10 [5:10 PM] per [family member's] request (and) stating she is more quiet than usual..."</p> <p>NOTE: The record did not document behaviors for the use of the Haldol or non-pharmacological interventions prior to the administration of Haldol. The family member had voiced concern that the resident was quieter than usual.</p> <p>*SSPN August 2014: Monthly Behavior Monitor: "(Resident) had 0 episodes of negative talk, 0 episodes of tearfulness, and 0 episodes of angry outbursts. Medications were adjusted and an increase of Haldol was prescribed prn..."</p> <p>*MAR 8/1/14 - 8/31/14: Documented the resident received Haldol 2 mg on 8/23, 8/25, 8/26, 8/27, 8/28, 8/29, 8/30, and 8/31.</p> <p>*CCF 9/1/14 at 4:30 PM: "Resident found sitting on the floor between bed (and) window. States she was trying to get the attention of her son who was outside...."</p> <p>*CCF 9/25/14 at 11:25 AM: "[Family member] was in to see (resident name). Request that Haldol dose decreased in half d/t (due to) makes her sleep too much ... is on ... Haldol 2 mg PRN (every 6 (hours.)..."</p> <p>*CCF 9/26/14 at 9:20 AM: "[Family member] in today. Visited (with her today about the Haldol causing (increased) sleepiness when given. ... is no longer having hallucinations. Is having some anxiety (at) bedtime (with) where she will sleep (and) who will be here (with) her. [Family member] discussed whether antianxiety</p>	F 329			

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F 329	<p>Continued From page 49 [medication] would be more appropriate."</p> <p>*NN 9/26/14 at 6:00 PM: "... office phoned. Because of guidelines (related to) advanced age (and) dementia, antianxiety meds are not recommended..."</p> <p>*PO 9/30/14: "Haldol 1-2 mg po (by mouth) (every) 6 (hours) prn for agitation."</p> <p>*SSPN September 2014: Monthly Behavior Monitor: "(Resident name) had 0 episodes of negative talk. Through the month of September there were intermittent times of increased fear and hallucinations reported by the [family member]. During a 3 day observation no behaviors were indicated."</p> <p>*MAR 9/1/14- 9/30/14: Documented the resident received a prn dose of Haldol 2 mg on 9/24/14. The scheduled dose of Haldol 2 mg at bedtime was held 9/9 through 9/18 and 9/20 through 9/22.</p> <p>*PO recapitulation orders 10/1/14 - 10/31/14: Haloperidol 2 mg tablet. One tablet oral at bedtime for anxiety. Start date: 9/9/14. Haloperidol 2 mg tablet. One tablet orally prn every 6 hours for anxiety. Date started: 8/21/14.</p> <p>*CCF 10/2/14 at 1:15 PM: "[Family member] request to hold scheduled Haldol ... asked to make prn only. Have been holding routine Haldol ... makes her sleep. (Current dose Haldol 2 mg po BID [two times a day] &amp; prn). [Family member] would also like it reduced to 1 mg prn."</p> <p>*PCR 10/8/14: "(Physician name), (Resident name) has an order for Haldol 1-2 mg po (every)</p>	F 329			

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F 329	<p>Continued From page 50</p> <p>6 hr (hours) prn for agitation. She was on routine and prn Haldol but almost all of the routine doses were held because (resident name) became sedated and confused when she was given the Haldol. Also, because of the increased risk for side effects, Haldol and other antipsychotic medications are not recommended for the treatment of agitation in a geriatric patient. She was discussed at the psychotropic meeting today. She has not shown agitation however she does have some symptoms of anxiety. She is at risk for falls however. You could consider a trial of Buspar which is effective in the treatment of chronic anxiety and does not increase the patient's risk for sedation or falls. Please consider discontinuing her Haldol order and starting Buspar 5 mg bid for seven days..."</p> <p>Physicians Response: "I accept the recommendation..." Signed and dated 10/21/14. Handwritten at the bottom of the report: 10/24/14 "[Family memberr] declined med change at this time."</p> <p>NOTE: The pharmacist had documented the Haldol caused the resident to become sedated and confused and Haldol was not recommended for this resident. The physician agreed with the recommendation for the discontinuation of the Haldol. The daughter had declined the medication change and Haldol remained prn to be administered to the resident even though the facility had identified the medication caused the resident to be sedated, confused and was at risk for falls.</p> <p>*SSPN "Psychotropic meeting notes from October 8, 2014: "She is taking ... Haldol 2 mg po (every) 6 (hr) prn for dementia with agitation</p>	F 329			

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F 329	<p>Continued From page 51 (started 8-22-14, routine dose added then changed back to prn 10/6/14). The Haldol was started at her [family member's] request. She has dementia with some delusions but very little agitation..."</p> <p>*MAR 10/1/14 -10/31/14: Documented the resident received the scheduled Haldol at bedtime on 10/1/14, but had not received the prn Haldol throughout the rest of the month.</p> <p>*NN 11/5/14 at 11:40 AM: Quarterly assessment: "No episodes of delusions this quarter but resident does have times when she is quite anxious. Reported by [family member]. med changes offered by MD per Pharmacy recommendations but have been refused by [family member]..."</p> <p>*PO 11/1/14-11/30/14: Haloperidol 1-2 mg tablet. One tablet oral as needed every 6 hours for anxiety.</p> <p>*MAR 11/1/14 through 11/19/14: Did not document the resident received the prn Haldol.</p> <p>NOTE: The Haldol remained available as a prn order for staff to administer for agitation.</p> <p>On 11/17/14 at 4:15 PM, the DON was asked why the resident had been started on Haldol. The DON stated the family member had approached staff that the resident was scared. The DON stated, "We did a 3-4 day assessment to determine if the resident was scared. We did not feel that there was anything [drug] warranted at that time, but the [family member] is very proactive and called the doctor and requested</p>	F 329			

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F 329	<p>Continued From page 52</p> <p>something so her [resident] would not be scared." The DON was asked if the family member had specifically requested Haldol to be given. The DON stated the family member had not requested Haldol specifically, noting "I have no idea why the doctor chose Haldol." When the DON was asked if the doctor was aware the resident was not having behaviors, she stated, "We attempted to communicate that. What we saw of the behaviors was always easily redirected." The DON was asked whether staff had offered any non-pharmacological interventions when the family member asked for a medication to address her concerns regarding the resident. The DON responded by shaking her head up and down, and stated "It was probably a verbal thing and was not documented." The DON was asked if 9/1/14 was when the resident climbed out of bed and fell. The DON stated, "That's when we convinced [family member] we did not want the scheduled Haldol." The DON was asked to provide the documentation of non-pharmacological interventions provided prior to the administration of Haldol, behavior monitors, and indications of use for the Haldol.</p> <p>On 11/18/14 at 6:00 PM, the resident's family member was asked if she knew why the resident was taking Haldol. The family member stated, "She is suppose to be totally off of that. It made her hallucinate and very sleepy, groggy. It was hard to get her off of it too, but she should be off of it."</p> <p>On 11/21/4 at 11:00 AM, the Administrator and DON were informed of the findings. No additional information was provided.</p>	F 329			

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F 329	<p>Continued From page 53</p> <p>5. Resident #3 was admitted to the facility on 7/21/14 with diagnoses that included dementia, without behavior; joint pain-L (left) leg; and abnormality of gait.</p> <p>The resident's Admission Assessment dated 7/21/14, documented behavioral/emotional status as "none."</p> <p>The resident's initial Abnormal Involuntary Movement Scale (AIMS), dated 7/23/2014, and an additional evaluation dated 8/22/14, documented no abnormal involuntary movements.</p> <p>Fall Risk Assessments - dated 7/23/14, 9/20/14, 10/16/14, and 10/22/14 - all indicated Resident #3 was at high risk for falls.</p> <p>A Social Service Progress Note (SSPN) dated 7/31/2014, documented 15/15 on BIMS indicating cognition intact.</p> <p>An updated Care Plan (CP) dated 7/31/14, documented behaviors as "potential to act out both verbally and physically at times of agitation," and documented interventions as "explain to resident limitations of others for better understanding," and "talk with resident about previous coping skills that worked well when agitated."</p> <p>A Quarterly MDS (Minimum Data Set) dated 10/22/14, documented a score of 6 on BIMS (Brief Interview for Mental Status), indicating severe cognitive impairment.</p> <p>The resident was admitted to the facility with the</p>	F 329			

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F 329	<p>Continued From page 54</p> <p>following medications for treating behaviors: Citalopram (Celexa, anti-depressant), Chlorpromazine (Thorazine, used to treat mental disorders, severe behavior disorders), Trihexyphenidyl (used to treat the symptoms of Parkinson's disease and tremors caused by other medical problems or drugs), and Carbamazepine (Tegretol, used to treat seizures, nerve pain and/or bipolar disorder). An office visit report dated 6/11/2014 indicated the medications were current.</p> <p>The resident was in the facility for 120 days at the time of its annual recertification survey on 11/17/14. During this time, the facility documented on the Medication Administration Record (MAR) only 8 days (6.7%) in which the resident exhibited behaviors.</p> <p>License Nurse's Notes (LNN) in July 2014 reported the resident as "...pleasant and cooperative," and "resident pleasant." Monthly Behavior Monitor (MBM), dated July 2014, documented "Resident [#3] is taking psychotropic medication for anxiety aeb (as evidenced by) verbal and physical aggression and depression aeb negative statements. For the month of July, resident showed 0 (zero) behaviors. Will continue to monitor as this could be the honeymoon phase of [his/her] stay here."</p> <p>There were no behaviors documented for the month of August. MBM dated August 2014, documented "Resident [#3] is taking psychotropic medication for anxiety aeb verbal and physical aggression and depression aeb negative statements. For the month of August, MBM documented 0 (zero) behaviors. I will discuss with staff about behaviors that Resident [#3] is showing that may need to be monitored.</p>	F 329			

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F 329	<p>Continued From page 55</p> <p>Resident [#3] has only been here 2 months so as [he/she] continues to get more comfortable behaviors may increase."</p> <p>An in-service, dated 8/4/14, and attended by staff and POA documented "...may feel overwhelmed at times and close [his/her] eyes when feeling that way. When [he/she] is angry, the resident will normally excuse themselves [sic] to [his/her] room and may, at times, need cueing if [he/she] is obviously angry..."</p> <p>A Medication Regimen Review (MRR) for Resident #3, dated 8/13/14, documented "Clarify psych indications." Psychotropic meeting notes, dated 8/13/14, documented, "She is taking Celexa 20 mg daily for depression and chlorpromazine 25 mg bid (twice daily) for seizures. According to the family when the chlorpromazine was reduced in the past she became violent. We will ask for indication to be clarified. So far she is doing well with no side effects noted. No dose changes are recommended at this time."</p> <p>NOTE: Resident #3 was not documented as having a seizure disorder.</p> <p>A Consultation Report to the physician treating the resident, dated 9/11/14, documented, "Under federal guidelines an antipsychotic medication like Chlorpromazine cannot be used to treat dementia but it can be used to treat the behavioral and psychological symptoms of dementia (BPSD). Please consider clarifying the indication for the Chlorpromazine to BPSD." The physician responded, "The Chlorpromazine is indicated for treating BPSD."</p> <p>The MBM dated September 2014, documented the resident exhibited behaviors of "verbal aggression to others" and "depression" on 9/16/14 through 9/18/14, and 9/24/14. The</p>	F 329			

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F 329	<p>Continued From page 56</p> <p>intervention documented the resident would be redirected, provided with one-to-one supervision, and offered food when exhibiting behaviors. The LNN did not document the observations or intervention outcome.</p> <p>The MBM dated October 2014, documented the resident exhibited "depression e/b [evidenced by] negative statements," from 10/24/14 through 10/27/14. Interventions included changing the resident's position. The LNN did not document the observations or intervention outcome.</p> <p>Psychotropic Meeting Notes, dated 9/10/14, 10/8/14, and 11/12/14, documented, "[He/she] is taking Celexa 20 mg daily for depression and Chlorpromazine 25 mg bid (twice daily) for BPSD. According to the family when the chlopromazine was reduced in the past [he/she] became violent. We will ask for indication to be clarified. So far [he/she] is doing well with no side effects noted. No dose changes are recommended at this time."</p> <p>NOTE: The resident ' s documentation did not specify that indication for use was clarified. On 11/19/14, when asked why a GDR (Gradual Dose Reduction) had not been attempted on any of the " behavioral " medications the resident was administered since he/she was admitted, the DON responded, "We have not been successful in getting any information on the medications. [He/she] was on them when [he/she] was admitted. We think at some point [he/she] may have been at a state hospital and it is possible [he/she] has been on these meds for 20 years or so. The doctor is not going to change [his/her] meds." When asked what behaviors had been observed during the resident's stay at the facility, the DON responded, "Up until recently, [he/she] hasn't had any behaviors. There have been no</p>	F 329			

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F 329	<p>Continued From page 57</p> <p>specific interventions. [He/she] grabbed at a resident's arm while admitted to another facility. [He/she] can come across with a 'gruff' voice. As far as I know, we have not had behaviors." When asked what behaviors had been observed recently the DON responded, "I wasn't there [med pass], but from what I understand there was some verbal aggression toward [his/her] roommate this morning during med pass. Social Services stepped in."</p> <p>NOTE: During this med pass at 8:50 AM, the resident's roommate was observed sitting in his/her wheel chair in the doorway, blocking Resident #3 from leaving the room. The resident was standing next to his/her bed located on the opposite side of the room and used a loud voice to say, "Get out of the way so I can leave." No physical aggression was observed.</p> <p>On 11/19/14 at 4:10 PM, the Social Services Designee (SSD) was asked about GDR for " behavior " medications. The SSD stated, "It's hard with the resident to discern if the behavior is cognitive or imperative because [he/she] has been on Thorazine. I think [he/she] has been on it [Thorazine] for twenty years." Regarding monthly psychotropic meetings, the SSD stated, "The pharmacist leads the meeting. We have talked about dose reduction but haven't done much yet. We just talked about the Thorazine last week." When told about the lack of supporting documentation of behaviors, the SSD stated, "We have to document behaviors because [he/she] is on the [behavioral] drugs. Resident #3 was admitted to the facility on 7/21/2014 with orders for psychotropic medications. Since his/her admission, the facility did not attempt a GDR to determine if symptoms could be managed at a lower dose. Additionally,</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/21/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MCCALL REHABILITATION &amp; CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>418 FLOYDE STREET MC CALL, ID 83638</b>		
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F 329	Continued From page 58 indications for use were not supported as documented in MBM. On 11/21/2014 at 10:45 AM, the Administrator and DON were notified of the findings. No additional information was provided.	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, it was determined the facility failed to dispense medications as ordered. This was true for 3 of 3 (#4, #6, and #14) residents observed during medication pass. The failure created the potential for residents to receive less than optimum benefit from their medications. Findings include:  · On 11/19/14 at 8:08 AM, Resident #14 was dosed one Omeprazole 20 mg capsule following physician orders on the bubble pack, "Take one cap every day" · On 11/19/14 at 8:35 AM, Resident #6 was dosed one Omeprazole 20 mg capsule following physician orders on the bubble pack, "Give one cap by mouth every day take 30-60 min before eating" · On 11/19/14 at 8:50 AM, Resident #3 was dosed one Omeprazole 20 mg capsule following physician orders on the bubble pack, "Give one cap by mouth every morning (before breakfast)"  NOTE: According to the Nursing 2014 Drug	F 332	The facility does ensure that it is free of medication error rates of five percent or greater.  Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: - The facility Director of Nursing obtained clarification orders for Omeprazole for Residents #14, #6, #3 by 12/19/14. - The identified Licensed Nurse was provided with inservice education by 12/19/14 by the Director of Nursing or designee regarding F332 with emphasis on importance of dispensing Omeprazole medication before meal(s) as ordered by physician.  Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following: This deficiency is an isolated deficiency	1/1/15	

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F 332	<p>Continued From page 59 Handbook, 34th Edition, page 1026, administration of Omeprazole is to be accomplished at least 1 hour before meals.</p> <p>Residents #3, #6, and #14 received Omeprazole after the breakfast meal.</p> <p>On 11/21/14 at 10:45 AM, the Administrator and DON were notified of the findings. No additional information was provided.</p>	F 332	<p>as reflected in the Statement of deficiencies - form CMS 2567. All residents that take time sensitive medications have the potential to be affected, thus the Director of Nursing or designee will review by 12/30/14 medication orders for time sensitive medications and drug interactions.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure that the deficient practice does not recur; All licensed Nurses were provided with inservice education by 12/30/14 by the Director of Nursing or designee regarding F-332 with emphasis on importance of passing medications as ordered by the physician. In addition a systemic measure that will be put in place is the Director of Nursing or designee will complete a Medication Administration Skill Check on each Licensed Nurse by 12/30/14 and Medication Administration Skill Check will be part of the Licensed Nurse orientation.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through: The Director of Nursing or designee will complete a visual observation of medication given during at three (3) complete med passes to ensure that meds are given as ordered by the physician.</p>		

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F 332	Continued From page 60	F 332	The Pharmacist will review medication orders during monthly Pharmacy review.  Monitoring will start on 12/31/14. This will be done weekly x 4 weeks, then every 2 weeks x 4 weeks, then monthly x 3 months. The facility Administrator or designee will present to the QA&A Committee during the quarterly QA&A Committee meeting her/his findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the quarterly QA&A Committee Meeting.		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		1/1/15	

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F 441	<p>Continued From page 61 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff washed their hands between assisting 4 of 4 residents (#9, 11, 12, &amp; 13) with meals, and implement adequate infection control practice for 1 of 1 (#6) resident reviewed for use of oxygen. The deficient practice had the potential to cause more than minimal harm when 2 CNA's did not wash/sanitize their hands between assisting residents with eating, which could result in transmissions of infections and Resident #6's oxygen nasal cannula was observed to be on the floor. The CNA picked the cannula off the floor and gave it to the resident for continued use. Findings include:  On 11/18/14 from 5:37 PM until 5:42 PM, CNA #5 was observed assisting Resident #11 and Resident #12 with the dinner meal. During the</p>	F 441	<p>The facility does establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: - The facility adjusted placement of assistive dining tables in dining room and installed a wall mount hand sanitizer near tables on 12/5/14. - C.N.A. #3 was provided with inservice education by 12/19/14 by the Director of Nursing or designee regarding F441 with emphasis on importance of replacing oxygen tubing when it fell on the floor to</p>		

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F 441	<p>Continued From page 62</p> <p>five minute period, CNA #5 was observed to assist #12 with spoonfuls of food, then rolled her stool to resident #11 who she then provided spoonfuls of food and hand the resident the spoon to feed herself. After she assisted Resident #12, CNA #5 rolled her stool back to Resident #11 and assisted her. The CNA was observed to do this multiple times and she did not wash or sanitize her hands between resident contacts.</p> <p>On 11/18/14 at 5:55 PM, CNA #4 was observed to assist Resident #9 with the use of her spoon at the dinner meal. CNA #4 walked over to Resident #13 and assisted her to pick up her bowl of soup, placed it in her hand, provided a spoon, and assisted the resident in eating the soup. CNA #4 then walked out of the dining room without washing or sanitizing her hands between assisting the two residents with the meal.</p> <p>On 11/19/14 from 7:55 AM until 8:09 AM, CNA #2 was observed assisting Resident #11 and Resident #12. During the observation CNA #2 rolled her stool back and forth between the two residents. She assisted the residents with spoonfuls of food and drinks from their cups. CNA #2 was observed to sanitize her hands 2 times during the 14 minute time period.</p> <p>On 11/19/14 from 12:07 PM until 12:16 PM, CNA #2 was observed assisting Residents #4, #11, #12 with their lunch meal. During the observation, CNA #23 was observed roll on her stool from one resident to the next resident to assist the three residents with the use of their spoon and forks; she both provided food and handed the residents the utensil to provide their</p>	F 441	<p>ensure infection control.</p> <p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action(s) taken includes the following: To address other residents who may have the potential to be affected by the deficiency; - The Director of nursing or designee will do a visual observation for each meal service on one (1) day in the dining room by 12/19/14 to ensure that nursing staff washes or sanitize their hands between assisting residents with meals. - The Director of Nursing or designee will visually observe nursing staff providing care to at least four (4) residents with oxygen by 12/19/14 to ensure oxygen tubing is replaced if it falls on the floor.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure that the deficient practice does not recur; Through root cause analysis, the Administrator and Director of Nursing determined that the infection control issues identified were different in each situation. All Nursing staff will be inserviced by the Director of Nursing or designee by 12/19/14 regarding F441; - On the importance of staff to wash or sanitize their hands between assisting residents with meals.</p>		

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F 441	<p>Continued From page 63</p> <p>own food as they were able to manage. CNA #2 handed resident #12 a cup to drink from and then rolled on her stool to resident #11, handed her a spoon to eat with, and adjusted the resident's napkin. During the 9 minute observation, CNA #2 assisted the 3 residents, she did not wash or sanitize her hands.</p> <p>On 11/20/14 at 2:00 PM, the ICN (Infection Control Nurse) was asked if she would expect the staff to wash their hands between assisting more than one residents with meals. The ICN stated, "yes" she would. When the meal observations were explained to the ICN, she stated, "That is not okay. We told them [staff] as long as the resident did not touch the spoon it was okay."</p> <p>On 11/21/14 at 11:00 PM, the Administrator and the DON were informed of the findings. No additional information was provided.</p> <p>Resident #3 was admitted to the facility on 7/21/14 with diagnoses that included dementia without behavior; joint pain, and abnormality of gait.</p> <p>A Quarterly MDS (Minimum Data Set) assessment, dated 10/22/14, documented a score of 6 on BIMS (Brief Interview for Mental Status), indicating severe cognitive impairment.</p> <p>On 11/20/14 at 9:25 AM, the resident was observed in his/her room with the call light and nasal cannula on the floor. Both items were situated behind the recliner and between the recliner and bed. The resident was seated on the</p>	F 441	<p>- On the importance of replacing oxygen tubing when it falls on the floor to ensure infection control.</p> <p>In addition to inservicing, the Director of Nursing or designee will complete a Handwashing Skills Check on Nursing Staff by 12/30/14 and will start quarterly written testing that identifies infection control situations by 12/30/14. Starting 12/30/14 Handwashing Skills Check and written infection control testing will be part of the orientation for new nursing staff.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through;</p> <p>- The Director of Nursing or designee will do a visual observation for each meal service in the dining room on a given day to ensure that nursing staff washes or sanitizes their hands between assisting residents with meals.</p> <p>- The Director of Nursing or designee will do a random interview of three (3) different nursing staff of what action should be taken if oxygen tubing is observed on the floor to ensure infection control.</p> <p>Monitoring will start on 12/31/14. This will be done weekly x 4 weeks, then every 2 weeks x 4 weeks, then monthly x 3 months.</p> <p>The facility Director of Nursing or designee will present to the QA&amp;A Committee during the quarterly QA&amp;A Committee meeting her/his findings</p>		

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 441	<p>Continued From page 64</p> <p>side of his/her bed. When CNA (Certified Nurse Assistant) #3 was asked about the call light and nasal cannula, he/she picked up the call light, draped it over the night stand next to the bed, and said, "I thought I clipped this call light to the pillow." CNA #3 then picked up the nasal cannula and handed it to the resident. The resident promptly put the nasal cannula in his/her nose. When CNA #3 was asked if the cannula was considered clean since it had been on the floor, he/she stated, "Probably not, I can get [him/her] a new one." CNA #3 then left the room and returned with a new nasal cannula.</p> <p>On 11/21/14 at 10:45 AM, the Administrator and DON were notified of the findings. No additional information was provided.</p>	F 441	<p>and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the quarterly QA&amp;A Committee Meeting.</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001590</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/21/2014</b>
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Sherri Case, BSW, LSW, QIPD, Team Coordinator Susan Gollobit, RN Kirsti Stephenson, RN</p>	C 000		
C 121	<p>02.100,03,c,v Encouraged/Assisted to Exercise Rights</p> <p>v. Is encouraged and assisted, throughout his period of stay, to exercise his rights as a patient/resident and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; This Rule is not met as evidenced by: Please refer to F151 as it relates to voting.</p>	C 121	See POC F151.	12/25/14
C 191	<p>02.105,05 Applicable Idaho &amp; Federal Laws</p> <p>05. Applicable Idaho and Federal Laws. Applicable Idaho and federal laws shall be observed in relation to employment of any individual. This Rule is not met as evidenced by: Please refer to F226 as it relates to employee criminal background checks.</p>	C 191	See POC for F226.	12/25/14
C 393	02.120,04,b Staff Call System at Each Bed/Room	C 393		12/25/14

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  12/15/14
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Bureau of Facility Standards

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C 393	Continued From page 1  b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Please refer to F246 as it relates to call light accessibility.	C 393	See POC for F246.	
C 672	02.150,03,c Staff Knowledge of Infection Control  c. Exhibited knowledge by staff in controlling transmission of disease. This Rule is not met as evidenced by: Please refer to F441 as it relates to universal precautions and the prevention of the spread of disease.	C 672	See POC for F441.	12/25/14
C 782	02.200,03,a,iv Reviewed and Revised  iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F-280 as it relates to care plan revisions.	C 782	See POC for F280.	12/25/14

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C 789	Continued From page 2	C 789		
C 789	02.200,03,b,v Prevention of Decubitus  v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please refer to F314 as it relates to pressure ulcers.	C 789	See POC for F314.	12/25/14
C 790	02.200,03,b,vi Protection from Injury/Accidents  vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F323 as it relates to falls and supervision.	C 790	See POC for F323.	12/25/14
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. This Rule is not met as evidenced by: Please refer to F332 as it relates to medication errors.	C 811	See POC for F332.	12/25/14