



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7012 1010 0002 0836 2014

December 4, 2013

John H. Williams, Administrator
Oneida County Hospital & Long Term Care Facility
150 North 200 West, PO Box 126
Malad, ID 83252-0126

Provider #: 135062

Dear Mr. Williams:

On **November 22, 2013**, a Recertification and State Licensure survey was conducted at Oneida County Hospital & Long Term Care Facility by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 17, 2013**. Failure to submit an acceptable PoC by **December 17, 2013**, may result in the imposition of civil monetary penalties by **January 6, 2014**.

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

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

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

John H. Williams, Administrator

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

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

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

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 22, 2014**, if substantial compliance is not achieved by that time.

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

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

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

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

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

- BFS Letters (06/30/11)

John H. Williams, Administrator

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

This request must be received by **December 17, 2013**. If your request for informal dispute resolution is received after **December 17, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

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

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

LKK/dmj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2013
NAME OF PROVIDER OR SUPPLIER ONEIDA COUNTY HOSP & LTC FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 200 WEST MALAD, ID 83252	
(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 recertification survey of the facility. The survey team entered the facility on 11/18/13 and exited 11/22/13. The surveyors conducting the survey were: Arnold Rosling RN, BSN, QMRP Team Coordinator Nina Sanderson LSW Susah Gollobit RN Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide DNS/DON = Director Nursing Services/Director of Nursing LN = Licensed Nurse MDS = Minimum Data Set assessment RNA = Restorative Nurse Aide R/T = Related To W/C = Wheelchair	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	11/17/14 12/21/13 pa T/C/E mail Admin 11/14 MSJ
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to promote care in a manner that promoted dignity and respect for 2 of	F 241	F241 <u>Residents with Potential to be Affected:</u> All residents have the potential to be affected. <u>Corrective Measures:</u> Resident #1's family was contacted regarding clothing preferences. Resident #1's family indicated that resident preferred to be in gown-like attire throughout the day and while in bed. To promote dignity, center staff encouraged Resident #1's family to bring in house coats or similar attire for resident to wear rather than using hospital gowns. Resident's family brought in several house coats. Education was conducted in person with LN #2 on 11/20/13 regarding use of napkins when wiping a resident's face rather than using the resident's clothing protector. LN #2 agreed to immediately engage this practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE ADMINISTRATOR (X6) DATE 12/14/13

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

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

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F 241	<p>Continued From page 1</p> <p>9 residents sampled (#s1 & 9). The deficient practice had the potential for more than minimal psychological harm when:</p> <ul style="list-style-type: none"> * Resident #1 was dressed in the same clothing and/or hospital gown for multiple days, and * Staff used a clothing protector to wipe Resident #9's face. Findings include: <p>1. Resident #1 was admitted to the facility on 4/23/04 with diagnoses that included hypertension, depression, malnutrition mild degree, transcerebral ischemia and non-insulin dependent diabetes mellitus without complication.</p> <p>The resident's care plan documented:</p> <ul style="list-style-type: none"> *Focus "[Resident] has an ADL self-care performance deficit r/[related to] Wasting Disease/Depression" Date Initiated: 8/20/13 *Intervention -Dressing: "[Resident] is passive in her environment and does not see the need for ADL cares. [Resident] refuses to choose her own clothes. [Resident] needs assist to remove clothes from closet/drawers. [Resident] is total assist with dressing and undressing activity. [Resident] likes to wears[sic] socks in bed she states to keep her feet warm. [Resident] wears religious garments. [Resident] is facility laundry." Date Initiated: 8/30/13 *Focus "[Resident] is resistive to care R/T Dx [diagnosis] depression." Date Initiated: 8/20/13 Revision on: 9/25/13 *Interventions - "If possible, negotiate a time for ADL's so that [Resident] participates in the decision making process. Return at the agreed upon time." Date Initiated 8/28/13 Revision on 8/28/13 	F 241	<p><u>Measures to Prevent Reoccurrence:</u></p> <p>The care plan for Resident #1 was updated to address clothing preferences. Staff education initiated related to daily changing of all residents' clothing, following resident clothing preferences, and appropriate use of clothing protectors.</p> <p><u>Monitoring/Assurance:</u></p> <p>Administrator or designee will conduct rounds specific to resident attire and appropriate use of clothing protectors four times a week for four weeks then weekly for four weeks, then monthly for two months. Findings will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate.</p> <p><i>audits started 12/9/13 Per Email admin 1/6/14 ASR</i></p>	

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F 241	<p>Continued From page 2</p> <p>*Focus "[Resident] has impaired cognitive function/dementia or impaired thought processes, Dx post CVA [Cerebral Vascular Accident] wasting disease." Date Initiated 8/20/13 Revision on: 9/25/2013</p> <p>*Interventions - "Provide [Resident] with a homelike environment." Date Initiated: 9/20/13</p> <p>On 11/18/13 at 1:30 pm during the Tour of the Facility the resident was observed by the Surveyor to be wearing a white background flannel top with red and black Minnie Mouse on it.</p> <p>On 11/19/2013 at 7:41 am the Surveyor observed the resident to be awake and dressed in the white flannel top with red and black Minnie Mouse on it.</p> <p>On 11/19/2013 at 8:41 am the Surveyor observed the resident to be awake and dressed in the white flannel top with Minnie Mouse on it. The resident's breakfast tray had been removed from the room.</p> <p>On 11/19/2013 at 11:40 am, 2:29 pm, 3:05 pm, the Surveyor observed the resident dressed in the white flannel top with red and black Minnie Mouse on it.</p> <p>On 11/20/2013 at 8:04 am the Surveyor observed the resident to be dressed in the white flannel top with Minnie Mouse on it. CNA #3 was asked about the changing of the resident's clothes. CNA stated, "we change the shirt every other day and bath day." [Note: The resident was observed to wear the white flannel top with red and black Minnie Mouse on it for at least 42 1/2 hours.]</p> <p>On 11/20/2013 at 9:50 am the Surveyor observed</p>	F 241			

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F 241	<p>Continued From page 3</p> <p>the resident to be in a hospital gown. At 9:54 am CNA#5 came into the room to reposition the resident. The Surveyor asked the CNA about the gown the resident was in. The CNA stated, "I changed her pajama's after breakfast this morning because she had food on it" and further stated the resident will have a bath this evening, and that the resident was not a morning person.</p> <p>On 11/21/2013 at 8:10 am CNA#3 was asked by Surveyor about the resident receiving her bath the night before, and the hospital gown the resident wore throughout the day on 11/20/2013. The CNA stated, "I told them to put the hospital gown on her so they knew I was coming back to do her shower." CNA stated she had returned at 5:00 pm to do the shower.</p> <p>On 11/21/2013 at 8:40 am the Surveyor asked the DON about the use of the hospital gown. The DON stated, "When we are wanting to look at their skin we ask them to put her in the gown, it is easier to see her skin." The Surveyor asked about looking at the skin during the shower, the DON stated, "Honestly I don't know why they had her in a gown yesterday."</p> <p>On 11/21/2013 at 2:30 pm the Administrator and the DON were notified of the findings. No additional information was provided.</p> <p>2. Resident #9 was admitted to the facility on 11/16/2002, with diagnoses of malnutrition, depressive disorder and pernicious anemia.</p> <p>During breakfast on 11/20/13 at 8:30 a.m. Resident #9 was observed to be fed by LN #2. The nurse had put a terry cloth clothing protector on the resident and there were two paper napkins</p>	F 241		

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F 241	Continued From page 4 located on the table next to the resident's breakfast plate. The resident was resisting the LN and not swallowing his food. The LN tried to give the resident a spoonful of cereal and milk. The resident closed his mouth causing the contents to spill on the residents chin. Instead of using a napkin to wipe the resident's chin off, she picked up the bottom half of the terry cloth clothing protector and wiped his face.	F 241	<i>This Plan of Correction is the center's credible allegation of compliance.</i>		
F 246 SS=D	The Administrator and DON were informed of the observation on 11/21/13 at 2:30 p.m. No further information was provided. 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 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 residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and record review the facility failed to meet the needs of 1 of 9 residents sampled, and 1 of 1 random resident, for accommodation of needs (#'s 1 & 11). The deficient practice had the potential to cause more than minimal harm when resident's call lights were not within reach so they could access them as they needed to. Findings included: 1. Resident #1 was admitted to the facility on	F 246	<u>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</u> F246 <u>Residents with Potential to be Affected:</u> All residents have the potential to be affected. <u>Corrective Measures:</u> Call lights for Residents #1 and #11 placed within reach and both residents were assessed for to ensure their ability to activate call light. Staff education related to call light placement and assessing resident needs for adaptive call light equipment initiated immediately. <u>Measures to Prevent Reoccurrence:</u> A sweep of all resident rooms was conducted to assure call lights were within resident reach and residents were able to activate call light. General staff in-service scheduled for 12/18/13 in which education regarding call light placement and assessing residents	11/27/14 12/21/13 pu email /TC 2 admin 1/6/14 BR	

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F 246	<p>Continued From page 5 4/23/04 with diagnoses that included hypertension, depression, malnutrition mild degree, transcerebral ischemia and non-insulin dependent diabetes mellitus without complication.</p> <p>The Resident ' s Care Plan documented: *Focus: "[Resident] is at risk for injury from falls R/T[related to] decreased mobility, DX[diagnosis] of: wasting disease, malnutrition, sever[sic] bone pain." Date Initiated: 8/20/13 Revision: 9/25/13</p> <p>*Interventions: - "Be sure [Resident's] colored call light is within reach and encourage [Resident] to use it for assistance as needed. [Resident] needs prompt response to all requests for assistance. Room by desk." Date Initiated: 9/25/13 Revision on: 9/25/13</p> <p>- "May choose to eat in her room. Make sure call light is in reach and encourage use and waiting for assist." Date Initiated: 9/27/13</p> <p>*Focus: "[Resident] has chronic pain r/t DX of: severe bone pain, haed[sic] and neck symptoms, pain." Date Initiated: 9/20/13 Revision on: 9/25/13</p> <p>*Interventions: - "[Resident] is able to: call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increase or alleviates pain." Date Initiated: 9/25/13 Revision on: 9/25/13</p> <p>On 11/18/13 at 3:55 pm the surveyor observed Resident #1 awake in bed. The resident's call light was observed to be hooked to the right top corner of the pillow. When the surveyor asked the</p>	F 246	<p>related to need for adaptive call light equipment will be conducted..</p> <p><u>Monitoring/Assurance:</u></p> <p>DON or designee will audit resident rooms to assure that call lights are functioning properly and are placed within the resident's reach, that the resident is able to activate the call light, and that resident adaptive call light equipment is being used when appropriate. DON or designee will conduct these audits four times a week for four weeks then weekly for four weeks, then monthly for two months. Findings will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate.</p> <p><i>audits to begin 12/2/13 per admin email 11/6/14 ASR</i></p>	

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F 246	Continued From page 6 resident how she would be able to get a hold of the nurse, resident stated, "oh boy." On 11/19/13 at 11:40 am the resident was observed to be in bed awake. The call light was wrapped inside the blanket, not visible. The resident stated, "I have to go to the bathroom." When asked, if she could reach her call light, the resident began to touch around her chest that was not covered in blanket trying to find it. On 11/20/13 at 8:04 am the Surveyor observed CNA#3 to be leaving the resident's room. CNA#3 walked back in the room with the surveyor. The call light was observed to be hooked on the bed in the right upper corner of the bed, out of reach of the resident. After interviewing the CNA, the CNA began to leave the room again. The Surveyor asked the CNA if the resident was able to use the call light, the CNA stated, "Oh yes she does, thank you that reminds me." The CNA then went back in the room and moved the call light, hooking it to the right edge of the resident's clothing protector. The CNA asked the resident if she could reach the call light, the resident stated, "Yes."	F 246		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 252		

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F 252	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a comfortable, orderly, homelike interior, as evidenced by stored equipment in such a way as to block access to a comfortable chair and the nearby handrail. The facility also administered medications in the dining room without first obtaining permission from the residents. This was true for 3 of 10 sampled residents (#s 3, 4, and 9), and any resident wishing to access the chair at the end of the hall outside room 114. The deficient practice had the potential to cause more than minimal harm if residents became embarrassed or frustrated receiving medications in front of others or trying to access the chair. Findings included:</p> <p>1. The facility had a hallway which ended with a large glass window outside resident room 114. A comfortable chair was positioned under the window near the end of the handrail, and a potted plant had been placed in this location, creating an inviting place for residents to sit. On 11/18/13 at 1:15 PM, during the initial tour of the facility, 2 vital sign machines were observed across the hall from room 114. The vital signs machines were positioned in such a way as to block the handrail and the chair. The vital signs machines were observed in that location throughout the survey on the following occasions: -11/18/13 at 3:50 PM. -11/19/13 at 7:40 AM through 8:15 AM, 11:45 AM, one vital sign machine noted at 11:45 AM, then two machines again at 2:05 PM and 2:34 PM -11/20/13 at 8:55 AM. A Sit-to-Sstand machine</p>	F 252	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F252</p> <p><u>Residents with Potential to be Affected:</u></p> <p>All residents have the potential to be affected.</p> <p><u>Corrective Measures:</u></p> <p>All equipment identified to be stored in such a manner as to be blocking handrail access was removed from the hallway and stored in an appropriate alcove off the hallway.</p> <p>Immediate education conducted with LN #6 regarding administration of medications at mealtime and regarding receiving appropriate approval from residents before administering medications at a community table during mealtime. LN #6 agreed to immediately engage this practice.</p> <p><u>Measures to Prevent Reoccurrence:</u></p> <p>Staff education regarding acceptable medication pass etiquette conveyed to</p>	<p>11/27/14 12/21/13 Am</p>

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F 252	<p>Continued From page 8</p> <p>was noted along with the 2 vital signs machines at that time.</p> <p>On 11/20/13 at 8:55 AM, RN #1 was asked about the placement of the vital signs machines and the Sit-to-Stand machine. RN #1 stated the machines were used throughout the facility when needed, and as such were moved all around. RN #1 did acknowledge the placement of those machines as noted throughout the survey blocked access to the handrail and the chair.</p> <p>On 11/21/13 at 2:30 PM, the Administrator, DNS, and Social Worker were informed of the surveyor's findings. The facility offered no further information.</p> <p>2. During the breakfast observation on 11/19/13 at 7:45 a.m. an LN was observed passing medications in the dining room while residents were eating their meals. On 11/20/13 from 8:10 am to 8:40 am during the medication pass observation, LN#6 was observed to administer Residents #4 and #9 their morning medications. The residents were in the process of eating their breakfasts. The LN set up the medications in the hall and went to the residents in the dining room and delivered them. The LN did not ask prior to administration or set up if the resident's wanted their medications with their meal. None of the medications were required to be specifically administered with meals or food. LN#6 had difficulty giving Resident #9 his medications as he shut his mouth tight and would not let her administer them. The LN had to go back to the cart and mark the medications as refused.</p> <p>Resident #4's care plan, had an intervention, dated 8/21/13, that documented, "[Resident #4] may choose to take medications with meals."</p>	F 252	<p>all nurses on shift. General staff in-service scheduled for 12/18/13 in which both storage of center equipment and medication pass etiquette will be addressed.</p> <p><u>Monitoring/Assurance:</u></p> <p>Administrator or designee will audit center hallways during environmental rounds to assure that center equipment is being appropriately stored.</p> <p>DON or designee will audit mealtime medication pass to assure proper med pass etiquette is being observed with regards to gaining permission from residents before administering medications with meals in shared areas</p> <p>These audits will be conducted four times a week for four weeks then weekly for four weeks, then monthly for two months. Findings will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate.</p> <p><i>audits to begin 12/9/13 & 12/16/2013 per TC / email admin 1/6/14 ASL dy</i></p> <p><i>12/9/2013 for equipment in hallways 12/16/2013 for med pass dy</i></p>	

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F 252	Continued From page 9 The resident was not asked so she could make a choice. Resident #9's care plan did not have any intervention about administering medications with meals. The administrator and DON were informed on 11/21/13 at 2:30 p.m. No further information was provided.	F 252	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 280	F280 <u>Residents with Potential to be Affected:</u> All residents with interventions related to prevention of skin breakdown have the potential to be affected. <u>Corrective Measures:</u> Upon identification that a foot cradle was not present, the DON immediately placed a foot cradle on the bed in accordance with the resident's care plan. Staff education regarding appropriate use of care planned interventions initiated immediately as well. <u>Measures to Prevent Reoccurrence:</u> A review of all care planned wound prevention interventions conducted and the identified interventions were placed on the TAR to increase nurse awareness. General staff in-service scheduled for 12/18/13 in which identification of residents with care	11/17/14 12/21/13 AK

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F 280	<p>Continued From page 10</p> <p>interview, the facility failed to ensure care planned interventions were appropriate for the focus/problem areas identified in the plan. This was true for 1 of 9 (# 8) sampled residents. Not ensuring the interventions matched the focus area related to use of a foot cradle placed the resident was at risk for skin breakdown. Findings include:</p> <p>Resident #8 was admitted to the facility on 12/10/04 with diagnoses of general anxiety disorder, nutritional deficiency, chronic kidney disease and depressive disorder.</p> <p>The most recent Quarterly MDS assessment, dated 11/5/13, documented the resident was severely cognitively impaired and required extensive to total assistance with transfers, dressing, eating, personal hygiene and bathing.</p> <p>The resident's comprehensive care plan had a Focus area, dated 8/7/13, of, "[Resident's name] is on pain medication therapy [related to] [diagnoses] of: chronic pain syndrome, osteoporosis, osteoarthritis" and a Focus of, "[Resident's name] has a mood problem [related to] [diagnoses] of generalized anxiety, depressive disorder." Interventions for the Focus areas, dated 8/9/13, included, "Foot cradle to keep blankets/sheets off toes and decrease skin breakdown."</p> <p>On 11/21/13 at 8:15 a.m. the surveyor and DON went into Resident #8's room and observed the resident's bed. There was no foot cradle on the bed. The DON was interviewed and said the cradle should be there and she would fix the problem and get one installed.</p>	F 280	<p>planned interventions and placement of interventions will be addressed.</p> <p><u>Monitoring/Assurance:</u></p> <p>DON or designee will audit appropriate use of skin breakdown interventions by reviewing physician orders, resident care plans, and Tar's. As part of this audit the DON or designee will also visually assess residents with skin breakdown interventions to assure the interventions are in place and being used properly.</p> <p>These audits will be conducted four times a week for four weeks then weekly for four weeks, then monthly for two months. Findings will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate.</p> <p><i>audits to begin 11/25/13 per TC/email admin 1/6/14 ASR</i></p>	

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F 280 F 314 SS=G	<p>Continued From page 11</p> <p>The foot cradle use as an intervention for Pain and Mood was not an intervention used for these two issues. As a result the intervention was not done by the staff. The Administrator and DON were informed on 11/21/13 at 2:30 p.m. No further information was provided</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and review of the facility's Policy and Procedure for Skin Care, the facility failed to prevent the reoccurrence of a pressure ulcer for 1 of 1 resident sampled for pressure ulcers (#1). The deficient practice caused actual harm to the resident when the facility failed to consistently document on and ensure implementation of care planned interventions to prevent the reoccurrence of an unstageable pressure ulcer to the resident's left heel. Findings include:</p> <p>Resident #1 was admitted to the facility on 4/23/04 with diagnoses that included hypertension, depression, malnutrition mild degree, transcerebral ischemia and non-insulin</p>	F 280 F 314	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F314</p> <p><u>Residents with Potential to be Affected:</u></p> <p>All residents who are high-risk for skin breakdown have the potential to be affected.</p> <p><u>Corrective Measures:</u></p> <p>The physician and family of Resident #1 were notified of the resident's new episode of breakdown. Per IDT discussion, recommendations were received to place heel suspension boots on Resident#1 and boots were placed. Also, recommendations were received to place Resident #1 on a pressure reducing rotating mattress and this was done. A center sweep of all residents conducted to identify all other resident's with high risk for skin breakdown. Staff education regarding wound care and skin breakdown prevention was initiated immediately.</p>	<p>1/14/14 12/21/13 AK</p>

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F 314	<p>Continued From page 12 dependent diabetes mellitus without complication.</p> <p>The resident's Annual MDS, dated 6/18/13, recorded: *BIMS score- 7 severe cognitive impairment *Bed Mobility- Extensive 2 physical assist *Walk in Room- Limited assistance 2 person physical assist *Walk in Corridor- Limited assistance 2 person physical assist *Locomotion on Unit- Total dependence 2 person physical assist *Dressing- Total dependence 1 person physical assist *Toilet Use- Extensive assistance 2 persons physical assist *Personal Hygiene- Limited assistance 1 person physical assist *Risk of Pressure Ulcers- Yes *Unhealed Pressure Ulcer- Stage 1 or Higher- No</p> <p>The resident's Significant Change MDS, dated 8/19/13, recorded: * BIMS Score -99 Unable to interview *Bed Mobility- Extensive 2 physical assist *Walk in Room- Activity occurred only once or twice 2 person physical assist *Walk in Corridor- Activity did not occur *Locomotion on Unit- Activity occurred only once or twice 2 person physical assist *Dressing- Extensive assistance 2 person physical assist *Toilet Use- Total dependence 2 person physical assist *Personal Hygiene- Extensive assistance 1 person physical assist *Risk of Pressure Ulcer- Yes *Unhealed Pressure Ulcer- Stage 1 or Higher-</p> <p>YES</p>	F 314	<p><u>Measures to Prevent Reoccurrence:</u></p> <p>Interventions related to skin breakdown for all residents identified placed on the TAR to increase nurse awareness and resident care plans were updated accordingly. General staff in-service scheduled for 12/18/13 in which identification of residents with care planned skin breakdown interventions and the proper placement of those interventions will be addressed.</p> <p><u>Monitoring/Assurance:</u></p> <p>Through the use of ongoing audits, the DON or designee will assess and identify all residents for risk of skin breakdown. Identified residents will be referred to the IDT team and/or physician for recommendations related to wound prevention interventions.</p> <p>Audited assessments will be conducted four times a week for four weeks then weekly for four weeks, then monthly for two months. Findings will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate.</p> <p><i>Audits / monitoring to begin 12/2/13 per TC / email admin 1/6/14 ASH</i></p>	

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F 314	<p>Continued From page 13</p> <p>*Stage and number of pressure ulcers- Stage 2-1 present. Oldest 8/9/13</p> <p>The Braden Scale-For Predicting Pressure Sore Risk documented:</p> <p>*Dated 6/4/13 and 6/12/13 Category- "At Risk"</p> <p>*Dated 7/3/13 Category- "Moderate Risk"</p> <p>*Dated 8/1/13, 8/7/13, 8/13/13, 8/15/13, 8/21/13, 8/28/13 Category-"Moderate Risk" [Note: Resident developed a Stage 2 Pressure Ulcer on 8/8/13]</p> <p>*Dated 9/5/13 Category- "Moderate Risk"</p> <p>*Dated 10/23/13 Category- "Moderate Risk"</p> <p>*Dated 11/6/13 Category- "Moderate Risk"</p> <p>*Dated 11/15/13 Category "High Risk"</p> <p>Note: On 11/20/13 a new area was noted on the left heel in the same area as the August Pressure Ulcer. No new interventions were implemented between 11/15/13 when she was assessed as High Risk and 11/20/13 when the new area was found.</p> <p>The resident's Care Plan documented:</p> <p>*Focus: "[Resident] has an ADL self-care performance deficit r/t[related to] Wasting Disease/Depression" Date Initiated: 8/20/13</p> <p>*Interventions: Bed Mobility: "[Resident] is total assist with bed mobility." -"Only use draw sheet to lift [Resident] in bed and to turn (R&L) [right and left]. To be repositioned at least Q [every] 2 hours. Use pillows with positioning. Reposition from side to side using pillows to support back and lower extremities, float heels. On back for meals only. [Resident] has a pressure reducing mattress. Uses a foot cradle to keep covers off of feet." Dated Initiated: 9/16/13 Revision on 10/7/13</p>	F 314		

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F 314	<p>Continued From page 14</p> <p>*Focus: "[Resident] is at risk for potential for pressure ulcer development, R/T decreased mobility, Dx (diagnosis) of: malnutrition, wasting disease, post CVA (Cerebral Vascular Accident), candidiasis." Date Initiated: 9/20/13 Revision on 9/25/13</p> <p>*Interventions: -"Observe skin with ADL's, LN assessment and prn[as needed]. Fill out skin report abnormalities. Notify LN, DON, and physician." Date Initiated: 9/27/13 -"[Resident] needs: monitoring/reminding/assistance to turn/reposition least every 2 hours, more often as needed or requested." Date Initiated: 9/25/13 -"[Resident] requires: Pressure reducing device on bed/WC." Dated Imitated: 9/25/13 Note: This is pressure reducing, as opposed to pressure relieving. -"Teach [Resident]/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes." Date Initiated: 9/25/13 Revision on 9/25/13</p> <p>* Focus: "[Resident] is at risk for side effects from DX[diagnosis] of: Diabetes Mellitus without complications, glucocorticoid deficient." Date Initiated: 8/20/13 Revision on: 9/25/13</p> <p>*Interventions: -"Inspect feet with ADL's for open areas, sores, pressure ulcers, blisters, edema or redness." Date Initiated 9/20/13 Revision on: 9/25/13</p> <p>The Interdisciplinary Plan of Care which was implemented on 8/8/13, the date the resident was found to have a Stage 2 pressure ulcer, included:</p>	F 314			

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F 314	<p>Continued From page 15</p> <p>*Problem: Skin Tear or Skin Integrity, Impairment of R/T [checked] Pressure Ulcer [checked] Left heel 1 cm [centimeter] x[by] 1 1/2 cm.</p> <p>*Interventions -[Checked] Assess/record/report to MD prn: Skin tear status, appearance, Healing process, Size, Depth, Length, Width -[Checked] Keep area clean and dry: avoid skin-to-skin contact -[Checked] Protective/preventive measures [checked] heelbows -[Checked] Apply Silvermesh in wound then cover with tegasorb dressing QOD [every other day]</p> <p>The resident's Nurse Assessment Notes documented: On 6/29/13 [Resident] states, "I am too old to get out of bed. I have to stay in bed." Skin assessment documented Integrity: "Red area intact coccyx."</p> <p>The resident's Progress Notes documented: -7/14/13 Type: Skin/Wound Note "While turning and changing depends, noted red areas on bilateral heels. L[left] 2 cm[centimeter] x[by] 2 cm with dry scab. R[right] 1 cm x 1 cm no scab. Heels floated and padded heel protectors applied. Will follow skin protocol." Note: There was no documentation of another heel assessment until 8/8/13 when the facility found the Stage 2 Pressure Ulcer on the left heel. -8/10/13 Type: Skin/Wound Note "open sore on bottom of left heel improving. no drainage, no odor, redness decreased. wound over all improving. wound cleaned and dressed per MD [Medical Doctor] order. elder c/o [complaint of] foot pain while cleaning and dressing. denies pain</p>	F 314			

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F 314	<p>Continued From page 16</p> <p>to site when done. will continue to monitor. fluids encouraged."</p> <p>-8/17/13 Type: Nursing "...Left heel floated on pillow, heel-bo's in place bilateral. Repositioned..." Note: Heel bo and heel bow are use interchangeably throughout facility paperwork.</p> <p>-8/19/13 Type: Nutrition/ Dietary Note "[Resident] triggered a significant change secondary to having developed a stage 2 ulceration on her left heel. Nursing notes that it is healing..."</p> <p>-8/20/13 Type: Nutrition/Dietary Note "...Spoke with nursing staff, notes that pressure ulcer is healed as of 8/19/13. [Resident] does have a decline in mobility per nursing assessment/restorative care...."</p> <p>-8/24/13 Type: Nursing "Elder in bed side to side with meals on back heels floating off bed blankets on cradle so they are off toes. Elder up to the shower dsg [dressing] to L[left] heel came off in shower redressed with tegaderm foam to protect heel made sure heels were floating above mattress while adjusting sheets for cradle elder wiggled her feet so they were touching the bed so we redirected her about the need to float and the CNA's to check every hour to make sure they continue to float and blankets are off toes will continue to observe for any changes."</p> <p>-8/31/13 Type: Nursing "...states her left foot hurts when laying on the bed. elder encouraged to keep foot on pillow to keep it off the bed..." Note: An assessment of the resident's heel was not documented.</p> <p>-10/22/13 Type: Skin/Wound Type "LN reported that Elder had a c/o on (sic) her left heel. Skin assessed no signs of breakdown. skin intact. Skin blanching. No redness noted on physical assessment. skin slightly pink from old wound that has healed nicely. Heelbows on and heels</p>	F 314		

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F 314	<p>Continued From page 17 floating..."</p> <p>-10/23/13 Type: Skin/Wound Note "Staff reported that Elder c/o pain on left heel. Area assessed skin blanching, skin intact slight pink from healed wound. Barrier spray applied, heelbows on and heels floating on pillows..." Note: There was no documentation related to the resident's heels between 8/31 and 10/22/13.</p> <p>A Wound-Weekly Observation Tool that was implemented on 8/9/13, the day after the Stage 2 Pressure Ulcer was observed, documented:</p> <p>*A. Communication 3. Special Equipment/Preventative measure (i.e. gel mattress/pad, special bed/Mattress, side rail pads etc.) "Heelbos"</p> <p>*B. Observation/Data -1. Location: "Left heel" -2 b. date acquired: "8/8/2013" -3 a. Type: "Pressure" -4. Pressure Ulcer Stage: 4 a. Original "II" [2] -5. Visible Tissue 5 c. [checked] Granulation tissue present (beefy red) -6. Drainage 6 a. Type: "None" -8. Wound Measurements -8 a. Length(mm)[millimeter] 10 -8 b. Width(mm) 15 -8 c. Depth (mm) 0</p> <p>*A Wound-Weekly Observation Tool Dated: 8/19/2013 documented:</p> <p>A. Communication -3. Special equipment/Preventive measure "Heelbos, heels off bed"</p> <p>*B. Observations/Data</p>	F 314			

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F 314	<p>Continued From page 18</p> <p>-1. Location: "L Heel"</p> <p>-5. Visible Tissue</p> <p>-5 a. Overall Impression 1. Healed</p> <p>Physician's Order Sheet dated for 8/8/13 documented "Pressure ulcer [left] heel. Apply absorbnt[sic] silver pad to heal[sic][and]keep covered[with] tegaderm change qod[every other day]. keep pressure off heel.</p> <p>On 11/18/13 at 3:55 pm the resident was observed to be lying in bed on her back. There was a foot cradle in place with 2 pillows between her legs and feet resting on the bed.</p> <p>On 11/19/13 at 7:41 am the resident was observed to be lying on her back, foot cradle in place. Right foot, heel was resting directly on the pillow positioned up the lower leg. Left heel floated off the end of the pillow under the lower left leg. Heel bo's in place.</p> <p>On 11/19/13 at 8:24 am the resident observed to have the head of her bed elevated, eating breakfast. Both feet positioned with heels resting on the bed. Cradle over feet.</p> <p>On 11/19/13 at 8:41 am the resident was observed to be lying on her back. Her breakfast had been removed. Both legs and feet were positioned directly on the bed. There was 1 pillow on the lateral side of each leg.</p> <p>On 11/19/13 at 9:15 am the resident was asleep, lying on her back. Both legs and feet were positioned directly on the bed. There was 1 pillow on the lateral side of each leg.</p> <p>On 11/19/13 at 9:50 am the resident remained on</p>	F 314		

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F 314	<p>Continued From page 19 her back asleep.</p> <p>On 11/19/13 at 11:40 am resident remained on her back, awake at this time. She had pillows under both legs. The left pillow was positioned with the left heel and foot on the pillow. The right heel was positioned with the heel floated off the pillow and bed. The foot cradle was in place and she had heel bo's on bilateral feet.</p> <p>On 11/19/13 at 2:29 pm the resident was observed to be lying on her back with the head of bed in an upright position. The foot cradle was in place. The right foot and heel were positioned directly on the bed. The left foot, at the ankle, was crossed over the right ankle. There was a pillow behind each leg.</p> <p>On 11/19/13 at 3:05 pm the resident was observed lying on her back with the head of the bed in an upright position. Bilateral heels were resting on the bed, pillows were positioned under the legs.</p> <p>On 11/20/13 at 8:04 am CNA#3 was providing care for the resident. When asked how often the heel protectors were taken off and changed for the resident, the CNA stated, "every other day." The CNA exited the room. The resident was observed with head of the bed in an upright position eating breakfast. Both feet with heel bo's on. The right foot/heel was directly on the bed, with a pillow laying to the lateral side of the leg. The left foot was positioned with a pillow under it and the left heel floated off the bed.</p> <p>On 11/20/13 at 8:45 am the resident was observed with head of bed positioned slightly back from upright, and on her back. The right foot</p>	F 314		
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F 314	<p>Continued From page 20</p> <p>and heel remained on the bed. The left foot had the heel barely off the bed. CNA#4 was asked about positioning for the resident. CNA stated, "Every 2 hours we roll her from side to side, put pillows under her feet. When we put her on her side with a pillow behind her back she rolls back over off of it. She likes being on her back the best."</p> <p>On 11/20/13 at 09:50 am the resident was observed lying flat on her back. The foot cradle remained in place. The right foot was positioned off the pillow under her lower leg resting directly on the bed. The left foot and heel were suspended off the pillow.</p> <p>On 11/20/13 at 9:54 am CNA #5 and RN#2 were observed to reposition the resident. The feet were repositioned with both heels off the pillows under the lower legs. A pillow was placed behind the right side of the resident's back. The resident was then offered water, and pulled up in bed by the 2 staff. They then repositioned the head of the bed with the control to an upright position for drinking water. After drinking the water the head of the bed was lowered for comfort. The staff left the room without rechecking the position of the feet after the repositioning.</p> <p>On 11/20/13 at 10:05 am the DON went with surveyor to check the placement of the resident's heels. The right foot and heel were found to be resting on the edge of the pillow. The left foot and heel were suspended off the pillow. When the DON was asked if the right heel was in an acceptable position for the resident, she placed her hand under the right foot depressing the bed to get the hand under the heel, and questioned it herself. When the surveyor asked the DON</p>	F 314			

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F 314	<p>Continued From page 21</p> <p>about the heel bo's only being removed and changed every 2 days and the skin not being seen for 2 days, the DON stated, "Yeah, that could be a problem. I didn't think about that." The surveyor also asked what type of a mattress was on the resident's bed, pressure reducing or pressure relieving. The DON stated, "that mattress is pressure reducing." The DON was asked what happened that the resident no longer got out of bed. The DON stated, "One day [Resident] said I pay you so you are going to take care of me." The DON further stated, "[Resident] does not want to get up and this is what she likes, being in bed."</p> <p>On 11/21/13 at 8:40 am the DON was interviewed about the care plan and changes that had been made after the resident made the decision to go to bed and not get up. No change in care was identified. The DON and surveyor went into the resident's room to assess position of feet. The right heel was observed to be touching the bed and the left heel was suspended from the pillow. The DON moved the pillow down the right lower leg and the heel was then suspended from touching the bed. The DON stated "Resident is really hard [to keep appropriately positioned]."</p> <p>On 11/21/13 at 9:50 am the DON approached the surveyor and stated the Resident had an area of concern to her left heel that had started again "last night." The DON stated the area was the same as it was in August. The area was found the previous night when the boot was removed for the resident's shower. When the surveyor asked the DON when the skin under the heel bo ad last been seen by staff, the DON stated she was unsure as to when the last time the heel was assessed or actually seen by anyone. The</p>	F 314			

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F 314	<p>Continued From page 22</p> <p>surveyor and the DON observed the area to the left heel. The Resident cried out "OW OW" when the boot and Mipiplex dressing was removed. On the back of the left heel was a raised area, with crusting to the top, it was blackened at the base, with red inflammation surrounding the site. The reddened area blanched with touching by the DON. The resident continued to cry out "OW OW" with touching of the area.</p> <p>On 11/21/13 at 1:35 pm the surveyor asked the DON what was done when the LN found the pressure area the night before. The surveyor was provided the Progress Note written by the LN and the Skin Inspection Report. No measurement was found. When asked where this would be documented, the DON stated "she would have wrote it on this report, but did not [pointing to the Skin Inspection Report]."</p> <p>When asked for the facility's Policy and Procedure on Skin, the DON showed the surveyor a very large book and stated that they "were working on putting it on the computer." The surveyor was provided a six page "Skin Packet and Checklist" that the LN's are to fill out when skin issues were found. When asked for a Policy and Procedure directing the LN how to proceed with filling the paperwork, the facility did not have one. The DON provided a copy of the Physician's Progress Notes from the exam on 11/20/13.</p> <p>The Physician's Progress Notes dated 11/20/13 at 6:30 pm documented:</p> <p>- "Nurse reported area on [left] heel reported by shower aid. Noticed today"</p> <p>- "S/P [secondary problem] history of ulceration same area some time ago that had healed."</p>	F 314		

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F 314	Continued From page 23 -"...c/o[complaint of] pain when area on [left] heel examined. circumferential area of erythema [with] core inner area of hardened skin resembling callous" -"AP[acute problem] 1. Callous formation over area of old and healed skin likely secondary to resident insisting on remaining in bed majority of time. No evidence of infection Recommend Mipilex drsg[dressing] for now to see if area can be softened and removed. Re[check] 1-2 days" The resident was harmed when the facility failed to implement interventions to prevent the development of a pressure ulcer to the resident when she had a lifestyle change. The resident developed a pressure ulcer on 8/8/13 that subsequently healed. The facility did not consistently implement interventions to prevent the reoccurrence of pressure ulcers and on 11/20/13 an unstagable pressure ulcer was discovered in the same area as the previously documented pressure ulcer in August. On 11/21/13 at 2:30 pm the Administrator and the DON were informed of the findings. No additional information was provided.	F 314			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318			

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F 318	<p>Continued From page 24</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview and record review, the facility failed to provide range of motion (ROM) to meet the needs of 1 of 9 residents sampled (#1). The deficient practice had the potential to cause more than minimal harm when the resident made a choice to limit her activity by choosing not to get out of bed and the staff did not follow the care plan provided to prevent the possibility of decline in resident's range of motion. Findings include:</p> <p>Resident #1 was admitted to the facility on 4/23/04 and had diagnoses that included, hypertension, depression, malnutrition mild degree, transcerebral ischemia, non-insulin dependent diabetes mellitus without complication, and severe bone pain.</p> <p>The resident's Annual MDS, dated 6/18/13, recorded:</p> <ul style="list-style-type: none"> *BIM score- 7 severe cognitive impairment *Bed Mobility- Extensive 2 physical assist *Walk in Room- Limited assistance 2 person physical assist *Walk in Corridor- Limited assistance 2 person physical assist *Locomotion on Unit- Total dependence 2 person physical assist *Dressing- Total dependence 1 person physical assist *Toilet Use- Extensive assistance 2 persons physical assist *Personal Hygiene- Limited assistance 1 person physical assist *Risk of Pressure Ulcers- Yes *Unhealed Pressure Ulcer- Stage 1 or Higher- No 	F 318	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F318</p> <p><u>Residents with Potential to be Affected:</u></p> <p>All residents care planned for passive range of motion have the potential to be affected.</p> <p><u>Corrective Measures:</u></p> <p>A review of center residents was initiated with the center's Restorative Aide, and residents care planned to have passive range of motion exercises and/or range of motion exercises conducted by licensed nurses or CNA's were identified. The Restorative Aide added all identified residents to her caseload and initiated range of motion exercises with these residents immediately. Staff education regarding passive range of motion exercising was initiated immediately.</p> <p><u>Measures to Prevent Reoccurrence:</u></p> <p>All residents who are care planned for range of motion exercising are referred</p>	<p>11/13/14 12/21/13 Add</p>

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F 318	<p>Continued From page 25</p> <p>The resident's Significant Change MDS, dated 8/19/13, recorded:</p> <ul style="list-style-type: none"> *BIMS Score -99 Unable to interview *Bed Mobility- Extensive 2 physical assist *Walk in Room- Activity occurred only once or twice 2 person physical assist *Walk in Corridor- Activity did not occur *Locomotion on Unit- Activity occurred only once or twice 2 person physical assist *Dressing- Extensive assistance 2 person physical assist *Toilet Use- Total dependence 2 person physical assist *Personal Hygiene- Extensive assistance 1 person physical assist *Risk of Pressure Ulcer- Yes *Unhealed Pressure Ulcer- Stage 1 or Higher- Yes *Stage and number of pressure ulcers- Stage 2- 1 present. Oldest 8/9/13 <p>The resident's Care Plan documented:</p> <p>*Focus: -"[Resident] has constipation r/[related to] decreased mobility, diminished appetite, DX[diagnosis] of: wasting disease, malnutrition, depression." Date Initiated: 9/25/13 Revision on: 9/25/13</p> <p>*Interventions: -"[Resident] requires passive exercises with bathing or morning care." Date Initiated: 9/25/13 [NOTE: These were to be done by the LN and CNA not the Restorative Aide.]</p> <p>*Focus: -"[Resident] has hx[history] of cerebral vascular accident (CVA/Stroke). Date Initiated: 8/20/2013</p>	F 318	<p>to the Restorative Department for ongoing treatment. General staff in-service scheduled for 12/18/13 in which the Physical Therapist or designee will educate staff regarding various methods of range of motion exercises.</p> <p><u>Monitoring/Assurance:</u></p> <p>The Restorative Aide or designee will audit all resident care plans in order to identify residents care planned for range of motion exercises. Identified residents will be referred to the Restorative Department for treatment. The Restorative Department will conduct ongoing audits of resident care plans to assure residents are being appropriately referred to restorative for this level of care.</p> <p>These audits will be conducted four times a week for four weeks then weekly for four weeks, then monthly for two months. Findings will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate.</p> <p><i>Audits / monitoring to begin 11/25/13 per TC / email from Admin 11/6/14 ASR</i></p>	

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F 318	<p>Continued From page 26</p> <p>*Interventions: -"Encourage range of motion exercises several times a day with ADL's. Teach [Resident] how to do correct active range of motion, when she is receptive." Date Initiated: 9/20/13 Revision on: 9/25/13 [NOTE: These are to be done by the LN, CNA, and RNA]</p> <p>Physician Recapitulation Orders for the Month of November 2013 documented: The Resident had orders for the RSA [Restorative Service Aide] program. The date of onset of the orders and the program to be carried out were as follows:</p> <p>****RSA**** -"03/31/11 Active Assistive" -"03/31/11 dining program" -"03/31/11 Ambulation 15 min[minutes]" -"11/02/11 Walk in corridor"</p> <p>On 11/20/13 at 9:54 am the Surveyor observed LN#2 and CNA#5 reposition the resident. When cares were completed, the Surveyor asked the LN about ROM/Exercises for the resident. The LN stated "[Restorative Aide name] does the restorative program. Nurses do not do ROM. We ensure she gets turned and water is offered." [Note: ROM/ Exercises were not observed with the ADL cares performed for the resident. The care plan directed LN and CNA in ROM for the resident]</p> <p>On 11/21/13 at 11:30 am LN#8 and CNA#7 were observed by the Surveyor to perform pericare to the resident. ROM/exercises were not observed to be completed during the cares performed.</p> <p>On 11/20/13 at 8:47 am the Surveyor asked</p>	F 318		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2013
NAME OF PROVIDER OR SUPPLIER ONEIDA COUNTY HOSP & LTC FAC		STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 200 WEST MALAD, ID 83252		
(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 318	<p>Continued From page 27</p> <p>CNA#4 who was responsible for exercises and ROM for Resident #1. The CNA stated "that would be [Restorative Aide name] the Restorative Aide. The CNA stated, "...every 2 hours we roll her from side to side put her feet on a pillow, and she gets up for a shower..."</p> <p>On 11/20/13 at 10:05 am the Surveyor asked CNA#5 who was responsible for ROM with the resident. The CNA stated "I am not sure [Restorative Aide name] our Restorative Aide use to do a lot more with [resident] then what her family lets us do with her now."</p> <p>On 11/21/13 at 8:10 am the Surveyor asked CNA#3 who was responsible for ROM/Exercises for the resident. The CNA stated "it is done by [Restorative Aide name] the Restorative Aide, she does all the ROM if it is done with her, she would be the one." [NOTE CNA#3 was responsible for showering the resident.]</p> <p>On 11/21/13 at 10:10 am the RSA was asked about ROM for the resident. The RSA stated the resident has been "refusing ever since she has been here. She has a long history of refusing." When asked if there was any other plan because the resident was continuing to refuse, the RSA stated "[Resident] used to walk, since June has not been walking. She becomes combative and refuses wants to sleep, sleep. Can't force them."</p> <p>On 11/21/13 at 10:55 am the DON was presented with the information from the care plan on ROM and the answers from staff pertaining to the ROM questions. The DON made a gesture of rolling her eyes and offered no comment.</p> <p>On 11/21/13 at 2:30 pm the Administrator and the</p>	F 318		

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F 318 F 323 SS=D	<p>Continued From page 28 DON were notified of the findings. No new information was provided.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure an environment as free as possible from accident hazards. This was true for 2 of 8 residents (#s 12 and 13) sampled for resident safety. The deficient practice had the potential to cause more than minimal harm if residents should become burned while smoking in an unsafe setting. Findings included:</p> <p>On 11/21/13 at 9:05 AM, during the environmental tour, the maintenance director escorted two surveyors to a location behind the facility designated as the resident smoking area. The area was approximately 10 by 10 feet in size. It consisted of 3 wooden walls and an attached wooden roof. This portion of the structure was attached to a metal shed, which acted as the fourth wall. Just inside the area, along the metal wall, was a stack of office-size trash cans. The top can in the stack was filled with bits of paper and empty cardboard cigarette boxes. Next to the</p>	F 318 F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F323</p> <p><u>Residents with Potential to be Affected:</u></p> <p>All residents with ability to utilize the identified smoking area have the ability to be affected.</p> <p><u>Corrective Measures:</u></p> <p>A fire extinguisher and fire blanket were immediately hung in the identified area. The area was immediately cleaned and all materials deemed to be a potential accident/hazard risk were removed.</p> <p>The center's Social Worker also spoke to the residents who frequent this area and educated them regarding items allowed in the smoking area.</p> <p><u>Measures to Prevent Reoccurrence:</u></p> <p>This area was added to the Administrator's environmental rounds and will remain part of ongoing environmental rounds indefinitely. For the immediate future, specific audits will</p>	<p>11/17/14 12/21/13 ML</p>

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F 323	<p>Continued From page 29</p> <p>trash can were two car batteries stacked atop one another. Next there were two metal framed chairs covered with a shabby gray soiled upholstery. Between the chairs was a small wooden table with most of the finish worn off. On top of the table was a small square box which held a can of latex enamel spray paint, a can of semi-gloss paint, and a liquid repair kit, all of which were identified as flammable. At a 90 degree angle to the metal chairs was a two-seater vinyl bench with each of the cushions split at the front seam, with the foam padding exposed. The vinyl and foam were dusty and soiled. Several disposable cigarette lighters were visible in the area surrounding the seating options, both on the ground and on the top board of the frame of the wooden portion of the structure. Even though cigarette receptacles were available, the ground inside the structure was littered with previously smoked cigarette butts. There was no fire extinguisher, fire blanket, or smoking aprons present.</p> <p>NOTE: At no time during the survey did the surveyors observe any residents smoking in this area.</p> <p>On 11/21/13 at 9:15 AM, the maintenance director was interviewed about the condition of the smoking area. The maintenance director stated one of the residents who smoked liked to "tinker" while he was out smoking, and may have left the painting supplies in that area. The maintenance director was not sure why there was not a fire extinguisher or fire blanket present. The maintenance director immediately informed the DNS and the Administrator of the surveyor's concerns.</p>	F 323	<p>be conducted addressing issues related to identifying and removing all hazardous material from the smoking area.</p> <p><u>Monitoring/Assurance:</u></p> <p>The Administrator or designee will conduct audits of the smoking area four times a week for four weeks then weekly for four weeks, then monthly for two months. Findings will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate. The smoking area will be added to the Administrator's environmental rounds checklist.</p> <p><i>audits / monitoring to begin 12/9/13 pm TC/ email admin 1/6/14 ASL</i></p>	

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F 323	<p>Continued From page 30</p> <p>On 11/21/13 at 9:34 AM, the surveyor again observed the resident smoking area. The trash in the trash can had been emptied. The maintenance director stated there was a fire extinguisher within 25 feet of the smoking area, in the metal shed, but the door to the shed was locked and he was the only one with a key. The maintenance director stated the fire extinguisher would not be readily accessible to anyone who needed it in an emergency.</p> <p>On 11/21/13 at 11:50 AM, the Administrator informed the surveyors a fire extinguisher would be installed immediately, and residents and staff were immediately being educated on safety in the resident smoking area. The Administrator stated a fire blanket would be delivered the next day. The Administrator stated no one would be allowed to smoke in the area until the necessary safety measures had been implemented.</p> <p>On 11/21/13 at approximately 1:30 PM, the Administrator approached the survey team and informed them a fire blanket had been obtained from the hospital next door, and would be installed that afternoon in the resident smoking area.</p> <p>On 11/21/13 at 2:30 PM, the Administrator, DNS, and Social Worker were informed of the surveyor's concerns. The facility offered no further information.</p>	F 323		
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including</p>	F 329		

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F 329	<p>Continued From page 31</p> <p>duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure that a resident and the family of a resident with dementia were informed of the risk of death from using a psychotropic medication. This was true for 1 of 9 (# 5) sampled residents. Not informing the resident's family of all potential side effects, including death, related to the used of antipsychotic medications, placed the resident at risk for harm. Findings include:</p> <p>Note: The 2013 Nursing Drug Handbook, includes that Zyprexa has a Black Box Warning for elderly patients. It states, "Drug may increase</p>	F 329	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F329</p> <p><u>Residents with Potential to be Affected:</u></p> <p>All residents prescribed anti-psychotic medications have the potential to be affected.</p> <p><u>Corrective Measures:</u></p> <p>The care plan and medication record for resident identified as Resident #5 was reviewed by the center's Inter-disciplinary Team with the resident's physician present. The decision was made to discontinue the use of Zyprexa. The resident and her family were notified and were in agreement with this decision.</p> <p>All other residents receiving anti-psychotic drug therapy, and/or their representatives, were given updated informed consents that include the medication's black box information. The center's Social Worker spoke with individual residents and/or their representative and informed them of the risk vs. benefits of continued use of</p>	<p>11/27/14 12/2/13 ML</p>

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F 329	Continued From page 32 risk of cardiovascular or infection related death in elderly patients with dementia. Olanzapine [Zypreza] isn't approved to treat patients with dementia related psychosis." Resident #5 was admitted to the facility on 3/14/2006 with diagnoses of paralysis agitans, unspecified psychosis, depressive disorder, Alzheimer's disease, and dementia with psychosis. The most recent Quarterly MDS assessment, dated 10/22/13, documented the resident was severely cognitively impaired, exhibited no behaviors, and did not have hallucinations or delusional behaviors. The resident required limited supervision for transfers, dressing, eating, personal hygiene and bathing. The resident was receiving antipsychotic medications seven days a week. November 2013 Physician Orders included ordered Zyprexa 2.5 mg once daily. The family signed the "Informed Consent" on 6/4/09. The informed consent failed to have documentation of the Black Box Warning of the potential for death with residents using Zyprexa. The DON was interviewed on 11/21/13 at 8:30 a.m. The DON was not aware of the warning. No further information was provided. There was no evidence that the Black Box Warning had been discussed with the resident's family.	F 329	these medications. Each consent was signed and placed in the resident's medical record. <u>Measures to Prevent Reoccurrence:</u> Updated informed consents were created for residents receiving anti-psychotic drug therapy that include the medications black box warning and also included a risk vs. benefits statement related to continued use of the medication. <u>Monitoring/Assurance:</u> The center's Social Worker or designee will conduct an audit of all residents receiving anti-psychotic medications four times a week for four weeks, then weekly for four weeks, then monthly for two months. The Social Worker or designee will continue to monitor the use of these informed consent forms upon admission and during quarterly assessments. Findings will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate. <i>audits/monitoring to begin 12/16/13 per TC/email from admin 1/6/14 ASH</i>		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			

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F 441	Continued From page 33 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced	F 441	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> F441 <u>Residents with Potential to be Affected:</u> All residents have the potential to be affected. <u>Corrective Measures:</u> The Administrator and DON investigated industry standards regarding accepted infection control policies and procedures for: collecting data, processing data, determining nosocomial infections and calculating rates of infection. A policy addressing these practices was created and submitted to the Medical Staff for approval. Also, directions related to the use of the center's infection control form titled "Infection Criteria Checklist" were written and attached to the form for staff use. Education regarding the use of this form was initiated immediately as well. The DON reviewed recommendations from the Center for Disease Control's website as well as the website for the Alliance for the Prudent Use of	11/27/14 12/21/13 ML

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F 441	<p>Continued From page 34</p> <p>Based on observation, policy and procedure review, and staff interview, the facility failed to ensure that:</p> <ul style="list-style-type: none"> *There were policies and procedures for infection control surveillance, *There were policies and procedures for antibiotic usage, and *CNA staff washed their hands after providing bowel care. <p>This had the potential to affect most all residents in the facility including 9 of 9 (#s 1 - 9) sampled residents. There was a potential for harm because without policies there could be inconsistencies in gathering surveillance information and calculating infection rates. In addition, without policies directing medical staff in using antibiotics there could be an over use of antibiotics, which potentially could contribute to drug-resistant organisms. Staff failing to wash their hands could potentially harms other residents by transferring organisms among residents which can lead to infections. Findings include:</p> <ol style="list-style-type: none"> 1. On 11/21/13 at 10:30 a.m. the infection control surveillance program was reviewed with the DON. The facility had data collected and locations identified within the facility where infections were located. There was no policy and procedure for: collecting data, processing data, determining nosocomial infections and calculating rates of nosocomial infections. In addition, forms used by the DON were lacking a procedure for what they were for and how they were to be used in identifying nosocomial infections. 2. Resident #8 had 5 urinalysis done since January 2013. The resident's medical record 	F 441	<p>Antibiotics. Education regarding the direction for antibiotic use as identified on these websites was initiated with the medical staff with the intent to draft policies specific to this issues in Medical Staff Meeting. Also, a sweep of all residents receiving antibiotic therapies was initiated to assure current antibiotic orders are an appropriate course of treatment.</p> <p>CNA#7 was immediately educated regarding hand hygiene. Staff education regarding hand hygiene during cares was initiated.</p> <p><u>Measures to Prevent Reoccurrence:</u></p> <p>Infection control policies and procedures addressing collecting data, processing data, determining nosocomial infections and calculating rates of infection will be reviewed by the center's Medical Staff Committee and adopted. Directions related to the use of the center's infection control form titled "Infection Criteria Checklist" have been written and have been attached to the form for ongoing use. Education regarding the use of this form was initiated immediately and will be addressed in the general staff in-service scheduled for 12/18/2013.</p> <p>Education regarding the appropriate use of antibiotics as indicated by the CDC and APUA will be conducted with the center's medical staff and, if necessary, center policies will be</p>	

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F 441	<p>Continued From page 35</p> <p>documented the physician ordered an antibiotic based on the results for four of the urinalysis. All of the urinalysis were set up for culture, three of the cultures did grow bacteria.</p> <p>The last urinalysis was done on 10/19/13. The urinalysis was abnormal. The resident's nursing progress notes did not document the reason why the cathed urinalysis was done. The nursing progress notes did not document the resident was having any problems with her urine. The physician ordered the antibiotic Augmentin twice a day for 7 days based on the urinalysis results. The urinalysis was set up for a culture and it came back after 48 hours with no growth. The resident continued to receive the antibiotic.</p> <p>On 11/21/13 at 10:30 a.m. the DON was interviewed about Resident #8's frequent use of antibiotics for suspected urinary tract infections. The DON was also asked about the facility's medical staff policy and procedures and a clarification for ordering antibiotics. The DON indicated she was not aware of any policy and did not provide one to review.</p> <p>3. The Facility's Infection Control-Hand Hygiene policy and procedure documented in the Procedure section:</p> <p>"When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or body fluids, wash hands with either non-antimicrobial or microbial soap and water. Use either type of soap and water before eating and after using the restroom."</p> <p>On 11/21/13 at 11:30 am LN#8 and CNA#7 were observed by the Surveyor to perform pericare to Resident #1, both staff were wearing gloves. The resident was noted to be having a BM [bowel</p>	F 441	<p>amended to address these industry standards of practice.</p> <p>Education regarding appropriate hand hygiene was initiated immediately and will be addressed in the center general staff in-service scheduled for 12/18/2013</p> <p><u>Monitoring/Assurance:</u></p> <p>The center's Infection Control Nurse or designee will conduct an audit of all residents receiving antibiotic therapies four times a week for four weeks, then weekly for four weeks, then monthly for two months to assure the adopted center policies are being appropriately followed and to assure that antibiotic therapies are necessary and in accordance with the established guideline recommended by the CDC and APUA.</p> <p>The Infection Control Nurse or designee will audit staff hand hygiene during cares through visual observation four times a week for four weeks, then weekly for four weeks, then monthly for two months to assure staff is using appropriate hand hygiene technique.</p> <p>Findings will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate.</p> <p><i>auditing / monitoring for abx use and handwashing to begin 12/16/13 per TC/email Admin 1/6/14</i></p>	

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F 441	<p>Continued From page 36</p> <p>movement] when the incontinence brief was removed. CNA #7 used multiple wipes to clean the rectal area of the BM. When the area was cleaned, the CNA, using the soiled gloves, opened the resident's bedside stand and got a tube of Barrier cream out of the drawer. The CNA then proceeded to apply the cream to the rectal area. With the same gloves on, she put the top on the cream and returned it to the drawer, closing the drawer with the soiled gloves. The CNA then assisted in putting a new brief on the resident. After the brief was on, the CNA removed her gloves, put them in the garbage and continued with the positioning of the resident. After cares were completed, the Surveyor asked the CNA about changing her gloves after the pericare. The CNA stated, "Yeah. I should have changed them." At this point the surveyor exited the room.</p> <p>On 11/21/13 at 2:30 pm the Administrator and DON was notified of the findings. No additional information was provided.</p>	F 441		

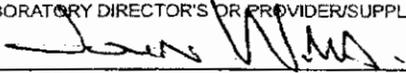
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/22/2013
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NAME OF PROVIDER OR SUPPLIER ONEIDA COUNTY HOSP & LTC FAC	STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 200 WEST MALAD, ID 83252
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual State Licensure survey of your facility. The surveyors conducting the survey were: Arnold Rosling RN, BSN, QMRP Team Coordinator Nina Sanderson LSW Susan Gollobit RN	C 000	<p>RECEIVED</p> <p>JAN 06 2014</p> <p>FACILITY STANDARDS</p>		
C 119	02.100.03,c,iii Informed of Medical Condition by Physician iii. Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research; This Rule is not met as evidenced by: Refer to F329 as it related to the resident being informed of his medication dangers.	C 119		<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>C119</p> <p>Refer to the plan of correction for F-tag 329 as submitted on form 2567 signed 12/14/2013.</p>	12/21/13
C 125	02.100.03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by:	C 125		<p>C125</p> <p>Refer to the plan of correction for F-tag 241 as submitted on form 2567 signed 12/14/2013.</p>	12/21/13

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 12/14/13
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Bureau of Facility Standards

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C 125	Continued From page 1 Refer to F241 as it relates to dignity.	C 125	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
C 342	02.108,04,b,ii Toxics Stored Under Lock and Key ii. All toxic chemicals shall be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Refer to F 323 as it related to chemicals in a smoking area.	C 342	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> C342	12/21/13
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Refer to F252 as it relates to orderly environment.	C 361	Refer to the plan of correction for F-tag 323 as submitted on form 2567 signed 12/14/2013. C361 Refer to the plan of correction for F-tag 252 as submitted on form 2567 signed 12/14/2013.	12/21/13
C 393	02.120,04,b Staff Calling System at Each Bed/Room 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	C 393	C393 Refer to the plan of correction for F-tag 246 as submitted on form 2567 signed 12/14/2013.	12/21/13

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C 393	Continued From page 2 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: Refer to F 246 as it relates to call lights.	C 393	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
C 644	02.150,01,a,i Handwashing Techniques a. Methods of maintaining sanitary conditions in the facility such as: i. Handwashing techniques. This Rule is not met as evidenced by: Refer to F441 as it relates to hand washing.	C 644	C644 Refer to the plan of correction for F-tag 441 as submitted on form 2567 signed 12/14/2013.	12/21/13
C 669	02.150,03 PATIENT/RESIDENT PROTECTION 03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Refer to F441 as it relates to Infection control surveillance.	C 669	C669 Refer to the plan of correction for F-tag 441 as submitted on form 2567 signed 12/14/2013.	12/21/13
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it relates to care planning.	C 782	C782 Refer to the plan of correction for F-tag 280 as submitted on form 2567 signed 12/14/2013.	12/21/13

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C 786	Continued From page 3	C 786	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
C 786	02.200,03,b,ii Body Alignment, Excercise, Range of Motion ii. Good body alignment and adequate exercises and range of motion; This Rule is not met as evidenced by: Refer to F318 as it relates to Range of Motion	C 786		
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: Refer to F314 as it relates to pressure sore development.	C 789	C786 Refer to the plan of correction for F-tag 318 as submitted on form 2567 signed 12/14/2013.	12/21/13
			C789 Refer to the plan of correction for F-tag 314 as submitted on form 2567 signed 12/14/2013.	12/21/13