



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 2007

December 4, 2013

Greg L. Maurer, Administrator
St Luke's Elmore Long Term Care
895 North 6th East, PO Box 1270
Mountain Home, ID 83647-1270

Provider #: 135006

Dear Mr. Maurer:

On **November 22, 2013**, a Recertification and State Licensure survey was conducted at St Luke's Elmore Long Term Care 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.

After each deficiency has been answered and dated, the administrator should sign both the Form

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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.

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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)

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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 cursive script that reads "Loretta Todd".

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

LT/dmj
Enclosures

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

AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNEs AND NFs	PROVIDER # 135006	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 11/22/2013
NAME OF PROVIDER OR SUPPLIER ST LUKE'S ELMORE LONG TERM CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 895 NORTH 6TH EAST MOUNTAIN HOME, ID	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 281	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure professional standards of quality were maintained. This was true for 1 of 3 residents (#1) observed during the medication pass observation when a medication was initialed prior to administration. Findings included:</p> <p>Resident #1's November 2013 Physician Orders included an order for Zofran 4 mg (milligrams) per peg every six hours PRN (as needed) for nausea with a start date of 10/18/13.</p> <p>On 11/19/13 at 8:38 AM, LN #11 was observed to sign her initials to the resident's MAR indicating she had administered the medication prior to actually administering the medication to Resident #1. The surveyor asked LN #11 if this was her normal practice and she stated that she normally initialed the MAR before actually giving the medication and if the resident did not take the medication then she would come back and circle the MAR and document why the resident did not take the medication. LN #11 asked the surveyor if this was the way it should be done and the surveyor explained the standard of practice was to sign her initials on the MAR after actually giving the medication.</p> <p>Note: Informational Letter #97-3, dated April 16, 1997: The Medication Distribution Technique Clarification To Informational Letter, 96-14, from the Bureau of Facility Standards, stated, "The issue arose when the Board of Nursing received information that long term care facility staff were signing medications as given at the time of the medication preparation, not after the resident actually received the medication. ...the Board's expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do."</p> <p>On 11/19/13 at 4:10 PM, the DNS was informed of the pre-initialing observation. No further information was provided.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

1. Corrective actions accomplished for those residents found to have been affected by the deficient practice:

Resident #1 was affected by this practice. The staff member involved with the incident received education the day ✓ the incident was reported and acknowledged an understanding and compliance the facility's Safe Administration Policy MEDADM.m.4

2. Other residents having the potential to be affected by same deficient practice and corrective actions taken:

This practice has the potential to affect all residents in the facility. DNS has instructed licensed staff regarding safe ✓ medication practices, and has observed medication passes subsequently and determined that licensed nursing staff are following the facility's policy and are not signing out medications before they are administered.

3. Measures that will be put into place and changes made to ensure that the deficient practice does not recur:

- Increase LN staff awareness of safe medication practices by discussing the Safe Medication Administration Policy and Informational Letter #97-3 at LN staff meeting 12/18/13.
- Add Informational Letter #97-3 to LTCU ✓ nurse orientation.

4. Corrective actions will be monitored to ensure the deficient practice does not recur:

✓ DNS will continue to perform random audits of med pass 5x week x 2 weeks ✓ starting 12/23/13. If there continues to be 100% compliance with practice of not initialing medications until they have been administered, the audits will be discontinued.

5. Date when corrective action will be completed: December 28, 2014



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2013
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NAME OF PROVIDER OR SUPPLIER ST LUKE'S ELMORE LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 895 NORTH 6TH EAST MOUNTAIN HOME, ID 83647
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual Federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Karen Marshall, MS, RD, LD, Team Coordinator Rebecca Thomas, RN</p> <p>The survey team entered the facility on Monday, 11/18/13, and exited the facility on Friday, 11/22/13.</p> <p>Survey Definitions:</p> <p>ADL = Activities of Daily Living CAA = Care Area Assessment CP/POC = Care Plan/Plan of Care CNA = Certified Nurse Aide DM = Dietary Manager DON/DNS = Director of Nursing/Director Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RD = Registered Dietitian ROM = Range of Motion SP = Speech Pathologist ST = Speech Therapy</p>	F 000	<p>1. Corrective actions accomplished for those residents found to have been affected by the deficient practice: Resident #13 was affected by this practice. The staff involved was made aware at the time and recognized that personal information had been disseminated in a public place, which could have been overheard by other residents, staff and visitors.</p> <p>2. Other residents having the potential to be affected by same deficient practice and corrective actions taken: This has the potential to affect all residents in the facility and the following corrective actions will be taken: •Agenda item on the December 18th Licensed Nurse Meeting will be the HIPPA Policy review and will identify with staff areas of practice that are at risk for divulging private resident information and where situational awareness is needed when having conversations with residents, other staff members, family members and visitors. •Introduce awareness campaign activities starting 12/20/13. •Agenda item on December 19th Certified Assistive Personnel (CAP) meeting will be HIPPA Policy review and will identify with staff areas of practice that are at risk for divulging private resident information and where situational awareness is</p>	12/28/13
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p>	F 241		

RECEIVED
DEC 17 2013
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Greg L. Mauer</i>	TITLE <i>ADMINISTRATOR</i>	(X6) DATE <i>DECEMBER 17 2013</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2013
NAME OF PROVIDER OR SUPPLIER ST LUKE'S ELMORE LONG TERM CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 895 NORTH 6TH EAST MOUNTAIN HOME, ID 83647		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined the facility failed to ensure staff communicated personal resident information in a manner that protected the confidentiality of the information and dignity of the resident. This affected 1 of 3 (#13) random residents. This practice created the potential to affect the resident's feelings of self-worth and well-being. Findings included:</p> <p>Random Resident #13 was admitted to the facility on 2/23/09 with multiple diagnoses including cerebellar stroke, cervical fracture, and venous embolism and thrombosis.</p> <p>The resident's 10/30/13 quarterly MDS coded severely impaired cognition and minimal depression.</p> <p>On 11/20/13 at 2:37 p.m., Random Resident #13 was observed sitting in her wheelchair beside the medication cart. The medication cart was located across the corridor from the nurse's station. A minimum of six different people were in direct vicinity of the nurse's station and medication cart at that time. CNA #1 removed a thermometer from Resident #13's mouth, looked at the thermometer, and said out loud, "97.2."</p> <p>On 11/20/13 at 3:45 p.m., the surveyor asked CNA #1 about taking Resident #13's temperature and what the resident's temperature was. CNA #1 stated, "It [Resident #13's temperature] was 97.2. A family member wanted her temperature taken. It is usually so noisy out here at the nurse's</p>	F 241	<p>needed when having conversations with residents, other staff members, family members and visitors.</p> <ul style="list-style-type: none"> •Introduce awareness campaign activities starting 12/20/13. <p>3. Measures that will be put into place and changes made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> •Start an awareness campaign and put reminders on pocket care plans and 24-hour report sheets daily starting 12/20/13 and ending 01/24/14. ✓ <p>4. Corrective actions will be monitored to ensure the deficient practice does not recur:</p> <ul style="list-style-type: none"> •During the 4-weeks of the awareness campaign DNS will interview staff members and identify if there is an understanding of the relationship between keeping information confidential and resident dignity and feelings of self-worth. •If concerns are identified a corrective work performance plan will be implemented for the individual staff person and followed through a progressive counseling process. 	12/28/13	

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NAME OF PROVIDER OR SUPPLIER ST LUKE'S ELMORE LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 895 NORTH 6TH EAST MOUNTAIN HOME, ID 83647
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F 241	Continued From page 2 station, no one hears it." On 11/22/13 at 1:15 p.m., the Administrator and the DNS were informed of the observation. The facility did not provide any additional information.	F 241	<p>1. Corrective actions accomplished for those residents found to have been affected by the deficient practice: Resident #1 was affected by this practice and it was corrected at the time identified.</p> <p>•Resident care plan now addresses placement of call light to account for resident's deficits. •Information added to Pocket Care Plan regarding placement of call light for resident See Attachments F246A and F246B.</p> <p>2. Other residents having the potential to be affected by same deficient practice and corrective actions taken: This has the potential to affect all residents in the facility. Staff were instructed on 11/19/13 to ensure all call lights were placed appropriately for resident use.</p> <p>3. Measures that will be put into place and changes made to ensure that the deficient practice does not recur: •Agenda item at LN staff meeting 12/18/13 and CAP staff meeting 12/19/13 to focus on the importance of call light placement and that this information will be addressed on resident Care Plans and Pocket Care Plans for those residents that have deficits that would impair use and require specific instruction to ensure there is proper placement of call light. A focus audit will</p>	12/28/13
F 246 SS=D	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, record review, and staff and resident interview, it was determined the facility failed to ensure the resident had the call system (cal light) within reach and was able to use it. This affected 1 of 6 (#1) sampled residents. This practice created the potential for the resident's needs to not be met should the resident require assistance with cares. Findings included: Resident #1 was originally admitted to the facility on 1/15/13 and readmitted on 10/18/13 with multiple diagnoses including cerebrovascular accident with left sided hemiplegia, depression, and anxiety. The resident's significant change 10/23/13 MDS coded severe cognitive impairment, severe depression, extensive assistance of at least one	F 246		

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F 246	<p>Continued From page 3</p> <p>person for ADLs, and upper and lower extremity limitations in ROM.</p> <p>On 11/19/13 at 8:20 a.m., the resident was laying in her bed. The call light cord was hanging over the top left corner of the mattress. The light was approximately two feet from the resident's left shoulder. The surveyor asked the resident if she could reach her call light. The resident tried to reach over her shoulder with her right hand but was not able to see or find the call light.</p> <p>On 11/19/13 at 8:23 a.m., the surveyor asked the DNS to observe the placement of the resident's call light. The DNS immediately placed the call light within reach of the resident.</p> <p>On 11/22/13 at 1:20 p.m., the Administrator was informed of the finding. The facility did not provide any additional information.</p>	F 246	<p>be conducted Dec 20-Jan 24 and compliance rate of 100% is required. See Attachment F246-C.</p> <ul style="list-style-type: none"> •Staff will be advised that housekeeping and contract therapy staff will be instructed to be aware of call light locations when they are in the room and instructed to notify staff if there appears to be a concern. •DNS to advise housekeeping and contract therapy staff to be aware when they are in the rooms of call light locations within reach of resident and of the process to notify LTCU staff if they have a concern. Contract Therapy staff will be oriented to use of pocket care plan and where to look for information if they have a question about call light location for a resident. <p>This will be completed by 12/20/13.</p>	12/28/13
F 279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under</p>		<p>4. Corrective actions will be monitored to ensure the deficient practice does not recur:</p> <p>DNS or designated person (Licensed Nurse, MDS Coordinator, or Social Service Advocate) will determine if call light placement is appropriate for each resident and when specific direction for call light placement are provided in the care plan they are followed appropriately. Focused daily audits will be performed, starting 12/20/13, of 10 residents when they are in their rooms. Audits will continue until there are 4-weeks of 100% compliance. Once 100% compliance is achieved audits will occur quarterly. Results of audit will be reported at staff meeting.</p>	

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F 279	<p>Continued From page 4</p> <p>§483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, it was determined the facility failed to ensure care plans were developed after the resident was admitted to the facility, not before; and all care areas triggered by the RAI process and identified as care planned, were care planned; and the care plans (CPs) were updated as changes occurred. This affected 4 of 9 (#s 1, 4, 6, & 9) sampled residents. This practice created the potential for residents' assessed needs to not be met due to lack of direction in the residents' care plans. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 9/24/13 with multiple diagnoses including hepatic encephalopathy, dehydration, Diabetes Mellitus II, and pain.</p> <p>The resident's most recent Significant Change MDS assessment, dated 10/25/13, documented the resident's cognition was moderately impaired, had mild depression and was dependent on at least one person for assistance with her activities of daily living.</p> <p>The Care Plan for Personal Cares documented a start date of 7/22/10 with an update of 7/25/10 for interventions "hearing aids at home - not being used."</p>	F 279	<p>1. Corrective actions accomplished for those residents found to have been affected by the deficient practice: This practice affected residents #1, 4, 6 and 9. Resident #6 and #9 have been discharged from the facility Corrective action has been taken for Resident #1 and #4 to review residents care plan and ensure all items triggered by the RAI process are addressed. See attachments F279-A; F279-B 12/28/13</p> <p>2. Other residents having the potential to be affected by same deficient practice and corrective actions taken: This practice has the potential to affect all residents in the facility. Corrective actions include: •DNS met with the MDS Coordinator to identify barriers for ensuring care plans are reviewed and accurately reflect residents' conditions and interventions, and that dates are documented correctly for the time care was provided. • An action plan was developed to ensure goals will be met to achieve these expectations of the MDS Coordinator and the responsibility for the oversight and maintenance of the care plan. See attachment F279-C. •The MDS Coordinator will audit 100% of residents' care plans to ensure all areas triggered by RAI are addressed and dates on care plan accurately reflect dates care was provided. This will be completed and a report provided to the DNS by 12/28/13. See attachment F279-D. •The MDS Coordinator will update the Roster/Sample Matrix weekly and submit a report to the DNS that will include updated triggers and corresponding</p>	
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NAME OF PROVIDER OR SUPPLIER ST LUKE'S ELMORE LONG TERM CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 895 NORTH 6TH EAST MOUNTAIN HOME, ID 83647		
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F 279	<p>Continued From page 5</p> <p>On 11/21/13 at 1:45 PM, the DNS was interviewed as to how a care plan, dated with the year of 2010, could be developed prior to the resident's admission. The DNS stated, "that is incorrect and I don't know where that date came from."</p> <p>2. Resident #6 was admitted to the facility on 10/4/13 with multiple diagnoses including rehabilitation, unspecified paralysis, macular degeneration, cataracts, hyperlipidemia, hypertension, and cerebellar stroke.</p> <p>The resident's 10/11/13 admission MDS coded moderately impaired cognition, moderate depression, and was totally dependent on at least one person for assistance.</p> <p>Resident #6's MDS triggered 15 different care areas. Eight of the 15 care areas were not addressed on the resident's CP: cognitive loss, communication, and psychosocial, nutrition, feeding tube, dehydration, dental and physical restraints. One example: the 10/25/13 problem of at risk for mood/behavior column identified, in the following order: poor visual ability and CVA (cerebrovascular accident).</p> <p>On 11/20/13 at 12:22 p.m., the survey team informed the Social Services Advocate (SSA) Resident #6's MDS Section V triggered for cognitive loss, communication, and psychosocial well-being, the care areas were care planned, however the three areas were not included in the resident's CP. The SSA stated, "I do the care planning for cognitive loss, psychosocial, mood and psychotropic medications." The SSA also said there may have been updates made to the</p>	F 279	<p>interventions in care plans. The Care Area Summary (CAA) for each resident will be located in the Resident Care Plan Book and reviewed <u>weekly</u> at Stand-Up and Resident at Risk Committee Meetings. Weekly reports from the MDS Coordinator to the DNS will start the week of <u>12/30/13</u>.</p> <ul style="list-style-type: none"> •QI process will be developed for the above processes and reported weekly at stand-up meetings that include the DNS, Unit Staff, Social Services Advocate and MDS Coordinator. <p>12/28/13</p> <p>3. Measures that will be put into place and changes made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> •QI process developed for the continual evaluation of the Care Planning process will integrate a weekly Roster/Sample Matrix review and update, and a weekly care plan review. The MDS Coordinator will be responsible to ensure care plan updates are provided at stand-ups, care conferences, discipline coordination, Resident at Risk, and when there are changes in a resident's condition. <p>4. Corrective actions will be monitored to ensure the deficient practice does not recur:</p> <ul style="list-style-type: none"> •Expectations will be developed and defined to ensure the MDS Coordinator is providing oversight and that Resident 	

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F 279	<p>Continued From page 6</p> <p>resident's care plan in the computer and would get back to the survey team about the resident's care plan.</p> <p>On 11/20/13 at 2:40 p.m., the SSA provided the surveyor with what appeared to be an updated copy from a page of the resident's CP. The 10/25/13 problem of at risk for mood/behavior column documented, in the following order, "New to unit, CVA, Cognitive Loss, Hard of hearing, Decreased mood, and Poor visual ability." The survey team asked the SSA when the updates in this column were made to the CP. The SSA indicated the updates were made on 11/20/13. The survey team informed the SSA the CP updated on 11/20/13 did not resolve the concern the triggered care areas were not included on the CP as a result of the RAI process.</p> <p>The resident's CP also included the resident received nutrition by way of a feeding tube and was at risk for nutrition due to being NPO (no food by mouth), required a hooyer for transfers and was dependent on staff to propel the unit. On 11/18/13 at 3:13 p.m., Resident #6 stated, "I walk with the walker with PT. I brush my own teeth. I use my wheelchair to get around. I eat on my own with little assistance."</p> <p>On 11/18/13 at 12:10 p.m., Resident #6 was observed eating lunch independently in the main dining room. The resident was conversing with other residents and sitting in her wheelchair.</p> <p>On 11/19/13 at 1:30 p.m., the resident was observed self-propelling her wheelchair.</p> <p>On 11/20/13 at 1:08 p.m., the surveyor and the DNS discussed the resident's CP was not</p>	F 279	<p>Care Plans are appropriate for the needs of the resident, all RAI triggers are addressed, and care plans are concurrently updated and reviewed at meetings with care providers.</p> <p>•The DNS will evaluate if expectations regarding the management of Resident Care Plans are met, using the QI Process and developed Action Plan, and if intervention\$ are needed to ensure continuity of the care plan process.</p>	12/28/13	

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F 279	<p>Continued From page 7</p> <p>updated to reflect the resident's current status and not all the triggered areas were care planned as documented in Section V of the MDS. The DNS agreed the resident's CP was, "not updated as the resident's abilities improved."</p> <p>3. Resident #9 was originally admitted to the facility on 11/26/10 and readmitted on 11/4/13 with multiple diagnoses including aspiration pneumonia.</p> <p>The resident's 11/11/13 admission MDS Section V triggered for nutritional status and dehydration/fluid maintenance. The MDS coded moderately impaired cognitive skills, mechanically altered diet, eating required one person supervision, and one-sided upper extremity, and lower extremity functional ROM limitations on both sides.</p> <p>The resident's Care Plan (CP) identified a 11/15/13 problem of aspiration pneumonia and at risk for complications. The CP contained an additional page that documented, 11/5/13, SLP (speech language pathologist), "No thin liquids" and "...dysphasia..." Diet - mechanical soft "nectar thick liquids swallow strategies [and] supervision [with] po [intake by mouth]."</p> <p>Further review of the CP revealed although the resident's admission MDS Section V triggered for nutritional status and dehydration/fluid maintenance. The CP did not include individualized problem interventions for nutrition and dehydration/fluid maintenance.</p> <p>Federal guidance at F279 indicated, "The care plan must reflect intermediate steps for each outcome objective if identification of those steps</p>	F 279			

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F 279	<p>Continued From page 8</p> <p>will enhance the resident's ability to meet his/her objectives. Facility staff will use these objectives to monitor resident progress. Facilities may, for some residents, need to prioritize their care plan interventions."</p> <p>On 11/21/13 at 9:00 a.m., the facility's RD provided the survey team with evidence the resident's alteration in nutrition care plan had been updated. One of the problem interventions was fluids per Speech Language Pathologist.</p> <p>4. Resident #1 was originally admitted to the facility on 1/15/13 and readmitted on 10/18/13 with multiple diagnoses including cerebrovascular accident with left hemiplegia, depression, and anxiety.</p> <p>The resident's significant change 10/23/13 MDS coded severe cognitive impairment, severe depression, total assistance of at least one person for ADLs, and upper and lower extremity functional limitations in ROM. Section V of the MDS triggered for the care areas of delirium, cognitive loss, communication, and psychosocial well-being.</p> <p>Review of the resident's CP revealed the care areas identified in the above paragraph were not care planned as problems or included in problem interventions.</p> <p>On 11/20/13 at 12:22 p.m., the survey team informed the SSA Resident #1's MDS Section V triggered for delirium, cognitive loss, communication, and psychosocial well-being and documented the areas were care planned. However, these four identified areas were not included in the resident's CP.</p>	F 279		
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F 279	Continued From page 9 On 11/20/13 at 2:40 p.m., the SSA stated, "These types of care areas would come under alteration in mental status." Note: The resident's care plan did not include a care area or problem of alteration in mental status. On 11/21/13 at 2:15 p.m., the survey team discussed the care plan concerns with the DNS. The DNS acknowledged the care plans required more attention. On 11/22/13 at 1:20 p.m., the Administrator and the DON were informed of the surveyor concerns with the care planning process.	F 279		
F 283 SS=D	483.20(I)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure appropriate discharge planning and communication of necessary information was provided to the continuing care home health agency. This was true for 1 of 1 (#10) resident sampled for review of the discharge summary.	F 283	1. Corrective actions accomplished for those residents found to have been affected by the deficient practice: This practice affected Resident #10 who was discharge from the facility prior to identification of the deficiency. 2. Other residents having the potential to be affected by same deficient practice and corrective actions taken: This practice has the potential to affect all resident discharged from the facility to an independent living situation. Corrective actions taken: •A Resident Discharge and Call Back ✓ Process has been developed and will be implemented with discharges starting 12/23/13.	12/28/13

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F 283	<p>Continued From page 10</p> <p>This created the potential for harm should residents not receive the continuation of medical services, care and medications. Findings included:</p> <p>Resident #10 was admitted to the facility on 7/22/13 with diagnoses which included in part S/P (status post) right ankle replacement and osteoarthritis.</p> <p>Resident #10 was discharged from the facility on 8/9/13 to her home with orders for home health which included PT (Physical Therapy), OT (Occupational Therapy) and Skilled Nursing.</p> <p>Upon record review, no communication to the receiving home health agency was found.</p> <p>On 11/21/13 at 10:15 AM, the Health Unit Clerk (HUC) #6 was interviewed. She stated the resident went to her scheduled physician appointment about a week after her discharge from the facility and told him she was not getting home health. The physician called the HUC #6 to let her know the home health agency had not yet visited the resident. The HUC #6 stated she called the home health agency who stated they had not received anything by fax. The HUC #6 stated she faxed the information a second time; however, she was not able to provide any information which proved the facility faxed the necessary information to the home health agency.</p> <p>On 11/16/13 at 4:00 PM, the DNS was made aware of the lack of communication with the home health agency and stated she was already aware.</p>	F 283	<ul style="list-style-type: none"> •A practice will be implemented as part of the Resident Discharge and Call Back Process to ensure all aspects of continuum of care are documented in the medical record. •Staff will be educated about the Resident Discharge and Call Back Process at the LN staff meeting 12/18/13 and CAP staff meeting 12/19/13. See attachment F283-A. <p>3. Measures that will be put into place and changes made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> •Tasks will be added to the Chart Analysis at Discharge Form to ensure documentation on discharge instructions support call back was completed, referrals to home health or other agencies and appointments for follow-up visits were completed. HUC will forward analysis sheet to DNS for review. •Discharge Instructions for resident will be attached to the 24-hour report sheet at discharge and will be reviewed at the next Stand-Up meeting by DNS, MDS Coordinator, Social Service Advocate and Activity Coordinator. See attachment F283-B. <p>4. Corrective actions will be monitored to ensure the deficient practice does not recur:</p> <ul style="list-style-type: none"> •DNS will evaluate compliance with Resident Discharge and Call Back Process with <u>each discharge</u>. The DNS will be responsible to evaluate non-compliance and develop an action plan for improvement if 100% compliance is not achieved. See attachment F283-C. 	12/28/13
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F 314 F 314 SS=G	Continued From page 11 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to provide the necessary nursing care and services to promote healing and to prevent a pressure ulcer from reopening after it had closed. This was true for 2 of 2 (#s 3 and 5) sampled residents reviewed for pressure ulcers. Resident #5 was harmed when the facility failed to assess and monitor a recently closed Stage II pressure ulcer from 11/8/13 to 11/16/13, allowing a Stage II pressure ulcer to redevelop. There was potential for harm to Resident #3 when staff applied a barrier cream starting at a contaminated area, introducing bacteria, to a Stage II pressure ulcer. Findings included: 1 a. Resident # 5 was admitted to the facility on 10/15/13 with multiple diagnoses including malignant neoplasm of upper lobe (cancer of the lung), anxiety, pressure ulcer, and chronic obstructive pulmonary disease (COPD). The resident's Admit MDS, dated 10/23/13,	F 314 F 314	1. Corrective actions accomplished for those residents found to have been affected by the deficient practice: This practice affected Resident #5. ✓ Corrective action for this resident included treatment to the affected area resulting in closure of the open area on 11/25/13 – 12/12/13. See attachment F314-A-1, 2B. Skin Barrier Cream is being used to protect site from moisture. See Attachment F314-B. Resident heels have protective dressing and foot pedals have been removed from wheelchair. See F314-C and F314-D. This practice affected Resident #3. ✓ 12/28/13 Corrective actions include at the time of the deficiency DNS instructed all staff to follow the bathing and grooming policy and to ensure correct technique is used going from front to back when applying topical or performing peri-care. 2. Other residents having the potential to be affected by same deficient practice and corrective actions taken: These practices have the potential to affect all residents in the facility. Corrective Actions include: • Changing process for care of skin impairment to include daily evaluation of a closed wound site for 10 days and if the site remains closed then continue with weekly skin checks. ✓ • Instruction will be given to LN at meeting on 12/18/13 about changes to standing orders and utilization of Resident at Risk Committee to weekly evaluate wound healing progress. See attachment F314-F. • The Bathing and Grooming Policy will be distributed to each staff member and reviewed at LN meeting 12/18/13 and CAP meeting 12/19/13 with emphasis on		

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F 314	<p>Continued From page 12 documented in part: *Moderately impaired with a BIMS Score of 9. *Total assist with 2+ persons for bed mobility, transfer, and toilet use. *Total assist with 1 person for locomotion on and off the unit, personal hygiene and bathing. *Functional limitation in range of motion with impairment on both sides. *Indwelling catheter.</p> <p>The Admission Nursing Assessment, dated 10/15/13, documented in the Skin Assessment section, the resident had a Stage II pressure ulcer, was placed on a Stat II Mattress and had a MD order for Barrier Cream. The Skin Impairment Score section had a box marked "X" by "score of 12 or less OR has any High Risk Indicator." The Resident Status/Condition section documented the resident had an indwelling catheter and the reason for the catheter was due to the pressure ulcer.</p> <p>The care plan for risk for skin impairments, dated 10/28/13, documented interventions in part: "LN (licensed nurse) to do skin assessment with showers and prn (as needed) indicated." "CNA to observe and changes promptly with daily cares." "Anti pressure relieving Stat 2 Air Mattress and cushion in WC (wheelchair)." "Heel boots as she will allow." "Skin barrier with each incontinent cares and BID (twice daily)." "Use of Skin Barrier as ordered - Dimethicone - Desitin." "Turn and reposition every 2 hours day and night and PRN (as needed)." "Cleanse daily with NTWC (non-toxic wound</p>	F 314	<p>proper technique for peri area. LN will be instructed by DNS to be aware of delivery of care when poor or improper technique is used for peri care, and to instruct staff in proper technique in real time and to review the Bathing and Grooming Policy. See Attachment F314-F, F314-G and F314-H.</p> <p>12/28/13</p> <p>3. Measures that will be put into place and changes made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> •Skin Impairment Standing Orders will be modified to include daily skin checks x10 ✓ days after a wound is closed. See attachment F314-E. •The daily skin check for a closed wound will be assigned to a shift and the primary nurse for the resident on that day will be responsible to evaluate site and document on Skin Care Form. •MDS Coordinator and Skin Care Nurse will be responsible to ensure the care plan is updated to reflect wound healing progress and changes in interventions •Revised standing orders will be implemented 12/20/13. •The Bathing and Grooming Policy will be part of all new employee orientation for both LN and CAP. •The Bathing and Grooming Policy will be reviewed annually at LN and CAP staff meetings each fall. 		

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F 314	<p>Continued From page 13 cleanser) - Desitin and peri cares."</p> <p>The Braden Scale for Predicting Pressure Sore Risk, dated 10/15/13, documented the resident's total score at 14 and was at moderate risk for developing a pressure ulcer. The adjustment scoring indicated the resident was "automatically at high risk if one or more areas were indicated." A box marked with an "X" by "has a current pressure sore or has had one in the last 90 days." A second box was marked with an "X" by "is in an end stage disease process."</p> <p>The Treatment Record for November 2013, documented "barrier cream for coccygeal decubitus ulcer" was applied three times per day.</p> <p>The Skin Impairment sheet for Resident #6 documented the following:</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Length/width in cm</th> <th>Stage</th> <th>Comments</th> </tr> </thead> <tbody> <tr> <td>10/15/13</td> <td>4 x 3</td> <td>II</td> <td>Turn and reposition every 2 hours, Stat II air bed, moisture barrier cream.</td> </tr> <tr> <td>10/19/13</td> <td>4 x 3</td> <td>II</td> <td>Blanches, otherwise no changes, continue treatment.</td> </tr> <tr> <td>10/25/13</td> <td>2 x 1</td> <td>II</td> <td>Improved, smaller in size, total .5 cm x .5 cm red open area.</td> </tr> <tr> <td>11/8/13</td> <td>0</td> <td></td> <td>Pink intact skin, will monitor for 1 more week resolving.</td> </tr> <tr> <td>11/16/13</td> <td>.5</td> <td></td> <td>Small skin split at gluteal cleft, continue treatment.</td> </tr> </tbody> </table> <p>The skilled nursing charting sheet, dated 10/21/13, documented orders were received for Ensure and a multivitamin daily to help increase</p>	Date	Length/width in cm	Stage	Comments	10/15/13	4 x 3	II	Turn and reposition every 2 hours, Stat II air bed, moisture barrier cream.	10/19/13	4 x 3	II	Blanches, otherwise no changes, continue treatment.	10/25/13	2 x 1	II	Improved, smaller in size, total .5 cm x .5 cm red open area.	11/8/13	0		Pink intact skin, will monitor for 1 more week resolving.	11/16/13	.5		Small skin split at gluteal cleft, continue treatment.	F 314	<p>4. Corrective actions will be monitored to ensure the deficient practice does not recur: 12/28/13</p> <ul style="list-style-type: none"> •MDS Coordinator will ensure that any resident with a pressure area regardless of stage or open wound will be put on the agenda for Resident at Risk and as part of the weekly risk assessment for skin will document the current condition of the wound. When wound is closed the residents skin condition will continue to be evaluated and documents on the Resident at Risk form until there has been 10 continuous days of wound closure and the resident skin evaluation has been changed to weekly. •MDS Coordinator or DNS will ensure that the Resident Roster Sample Matrix is updated weekly and that it reflects changes in skin condition and is reported weekly during the Stand-Up meeting. ✓ •LN staff will observe delivery of care when in resident room and identify if proper technique is being followed when peri care given, and will intervene in real time if poor or improper technique is used. 	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 14</p> <p>protein for wound healing and health. The skilled nursing charting sheet, dated 10/26/13, documented, "coccyx area improving with use of air mattress and barrier cream. No pain at site. Continue to monitor sight (sic)."</p> <p>On 11/4/13 at 8:25 AM, the nurse's notes documented the foley (catheter) was found out with the balloon inflated. The resident stated she did not know how it came out and wanted it left out. At 9:00 AM, the nurse's notes documented the resident was "voiding both continent and incontinent adequately."</p> <p>On 11/6/13 at 12:55 PM, the physician wrote an order to DC (discontinue) Foley and monitor bedsores.</p> <p>Note: There was no documentation the pressure ulcer was assessed or monitored by licensed staff from 11/8/13 until 11/16/13, when it was documented on the Skin Impairment sheet as reopened.</p> <p>On 11/19/13 at 9:35 AM, the surveyor asked the DNS to come into the resident's room to observe and measure the Stage II pressure ulcer. The DNS measurements were 2 cm (length) x 1 cm (width), which meant the pressure ulcer had continued to increase in size the last three days.</p> <p>On 11/20/13 at 1:45 PM, the DNS was interviewed regarding Resident #5's Stage II pressure ulcer on her coccyx. The DNS stated the resident's nutrition and pain were better. The DNS stated the resident pulled out her catheter and the DNS thought the pressure ulcer was probably due to moisture. The DNS stated the resident needed to be watched more carefully.</p>	F 314			

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F 314	<p>Continued From page 15</p> <p>1 b. On 11/18/13 at 2:40 PM, Resident #5 was observed to be in the Activity Room sitting in her WC. The foot pedals had padding which was duct taped vertically and horizontally to the pedals (like a wrapped package) to hold them in place.</p> <p>On 11/18/13 at 2:50 PM, the AC (Activities Coordinator) stated, the resident kicked off her "problem boots" so they padded the foot pedals with old heel protectors. She stated they spoke with PT (physical therapy), OT (occupational therapy) and the DNS about the problem and they decided to use these for now until they came up with something better.</p> <p>On 11/18/13 at 3:05 PM, the DNS stated the resident was admitted with "mushy heels." She reported they care planned for Prevalon boots and the resident would not leave them on and would tear them off. The DNS stated she spoke with OT who stated just to put something on the foot pedals. The DNS stated the duct tape doesn't look very good, probably wasn't very sanitary, and stated she will check into something else for the resident's feet to rest on.</p> <p>On 11/18/13 at 4:20 PM, the resident was observed sitting in her WC by the nurses station with padded foot pedals, however, no duct tape was observed on the foot pedals.</p> <p>The care plan for skin impairment, with a start date of 10/28/13, documented "heel boots as she will allow."</p> <p>The skilled nursing charting sheet, dated 10/24/13, documented, "heel med-ex boots applied as heels are fragile. Resident does not</p>	F 314			

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F 314	<p>Continued From page 16</p> <p>keep heel booties on at present, she's trying to remove heel med-ex boots. Reminded to leave on for protection. Resident needs constant cuing and reassurance and direction."</p> <p>The skilled nursing charting sheet, dated 10/27/13, documented "fragile skin - heels."</p> <p>On 11/19/13 at 2:20 PM, the surveyor interviewed the PT who stated she "would not recommend using duct tape for any pressure issues."</p> <p>The facility failed to assess and monitor potential changes in skin condition for a resident who was at an increased risk of redeveloping a pressure ulcer. Additionally, the facility failed to adjust interventions when the catheter was removed and the resident experienced increased moisture. The facility failed to promote proper heel protection for a resident who had fragile heel skin by using duct tape, a slick, hard surface, which came in contact with the resident's heels.</p> <p>2. Resident #3 was originally admitted to the facility on 10/15/13 and readmitted on 11/14/13 with multiple diagnoses including Diabetes Mellitus and cerebrovascular accident with left sided weakness.</p> <p>The resident's 9/19/13 annual MDS coded cognitively intact, one sided upper and lower functional ROM limitations, and no pressure ulcers. Section V of the MDS triggered for Pressure Ulcers and the subsequent CAA documented, will proceed to plan of care as needs arise and for preventative cares against pressure ulcer formation.</p> <p>The resident's 11/14/13 "Skin Impairment" form</p>	F 314			

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F 314	Continued From page 17 documented a Stage II pressure ulcer. The comments column documented, "Open bleeding area @ rt [at right] of gluteal cleft. Desitin Ongoing." The resident's Care plan identified the 10/27/10 problem of at risk for skin impairments related, in part, to incontinence and decreased mobility and functioning. The problem interventions included, in part, CNA to notify the LN of any changes to skin promptly. On 11/20/13 at 1:50 p.m., the survey team observed two CNAs providing cares for the resident. CNA #4 apply desitin to the affected area of the resident's gluteal cleft. The CNA applied the desitin by applying in the direction from the rectum area to the gluteal cleft. The CNA did not apply the desitin from the gluteal cleft toward the resident's rectum area. Note: This practice created the potential to contaminate the open area at the right of the resident's gluteal cleft. On 11/20/13 at 2:00 p.m., the survey team informed the DNS of the CNA applying desitin from the resident's rectum area to the gluteal cleft. The DNS indicated that was not the correct procedure to use and the CNA may have been nervous because the surveyors were in the resident's room. On 11/22/13 at 1:20 p.m., the Administrator was informed of the observation. The facility did not provide any additional documentation.	F 314			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328			

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F 328	<p>Continued From page 18</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews, it was determined the facility failed to ensure residents who use oxygen receive the liter flow as ordered by the physician, nor did the physician recapitulation orders include an order for oxygen even though a resident was receiving oxygen. This was true for 2 of 3 (#s 1 and 5) sampled residents reviewed for the proper care and treatment of oxygen therapy. This deficient practice created the potential for more than minimal harm should residents have a drop in oxygen saturations causing them to become anxious, confused and experience respiratory distress. Findings included:</p> <p>1. Resident #5 was admitted to the facility on 10/15/13 with multiple diagnoses including malignant neoplasm of the upper lobe (cancer of the Lung), anxiety, pressure ulcer, and chronic obstructive pulmonary disease (COPD).</p> <p>The resident's Admit MDS, dated 10/23/13, documented in part: *Moderately impaired cognition with a BIMS</p>	F 328	<p>1. Corrective actions accomplished for those residents found to have been affected by the deficient practice: This affected Resident #5. Corrective actions taken: The December physician order recapitulation includes order for oxygen. See attachment F328-A. This affected Resident #1. Corrective actions taken: Interventions added to residents care plan for use of oxygen and December physician order recapitulation includes order for oxygen. See attachments F328-B and F328-C. 12/28/13</p> <p>2. Other residents having the potential to be affected by same deficient practice and corrective actions taken: This has the potential to affect all residents in the facility using oxygen. Corrective Actions: •HUC assigned to review and identify all residents with oxygen orders and ensure orders for oxygen are on the December physician order recapitulation. This has been accomplished and all appropriate residents have oxygen orders on the December recapitulation. •DNS met with HUCS and identified a consistent process to ensure all current physician orders are carried forward from month to month. HUCS will validate <u>previous month's recapitulation with</u> upcoming month to ensure all orders are carried forward, unless there is a</p>	
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3. **Measures that will be put into place and changes made to ensure that the deficient practice does not recur:**
•Process change to preparation and distribution of recapitulations that will ensure standardized process. See attachment F328-D.

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F 328	<p>Continued From page 19</p> <p>Score of 9.</p> <ul style="list-style-type: none"> *Total assist with 2+ persons for bed mobility, transfer, and toilet use. *Total assist with 1 person for locomotion on and off the unit, personal hygiene and bathing. *Functional limitation in range of motion with impairment on both sides. <p>The admission nursing assessment, dated 10/15/13, documented crackles were noted in the bases, was on respiratory treatment, had symptoms of dyspnea (shortness of breath) and was SOB at times.</p> <p>The resident's longterm care admission orders, dated 10/15/13, documented an order for oxygen treatment at 2 Liters via NC (nasal cannula) PRN (as needed) O2 sats < (less than), however, the saturation percentage was not documented.</p> <p>The resident's November 2013 Physician Orders (recapitulations) did not include an order for oxygen.</p> <p>The resident's care plan for oxygen therapy, with a start date of 10/28/13, documented the oxygen liter flow at 2 L (liters)/NC (per nasal cannula), for the diagnosis of Asthma/COPD, documented interventions of:</p> <ul style="list-style-type: none"> *O2 (oxygen) as ordered - 2 L/NC. *Check flow of O2 every shift and PRN (as needed). *Observe tubing for any obstructions or kinks. <p>The skilled nursing charting, dated 10/28/13, documented the resident was "O2 dependent but she takes it (nasal cannula) off at her choosing - will drop to 89% without O2 2 L/NC."</p>	F 328	<p>4. Corrective actions will be monitored to ensure the deficient practice does not recur: 12/28/13</p> <ul style="list-style-type: none"> •DNS will provide oversight to ensure process for recapitulations is followed and evaluate for effectiveness and compliance. 	12/28/13
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F 328	<p>Continued From page 20</p> <p>On 11/20/13 at 5:35 PM, Resident #5 was observed in the dining room, sitting in her WC (wheelchair) at the table waiting for her dinner. The surveyor checked the resident's portable O2 tank for the liter flow and observed the portable O2 tank was empty. The surveyor asked the resident if she was receiving oxygen through her nasal cannula and the resident replied, "no." The surveyor made CNA #9 aware the portable O2 tank was empty. CNA #9 asked CNA #10 to get a new tank for the resident. At 5:45 PM a new tank was delivered to the resident in the dining room and the resident's oxygen saturation was 93% when the new tank was replaced.</p> <p>Perry & Potter's, Clinical Nursing Skills & Techniques, 7th Edition, 2010, states on p. 629, "Treat oxygen therapy as a medication...As with any drug, continuously monitor the dosage or concentration of oxygen. Routinely check the health care provider's orders to verify that the patient is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."</p> <p>On 11/21/13 at 4:00 PM, the DNS was made aware of the O2 administration issue and the DNS stated she was aware of the situation.</p> <p>2. Resident #1 was originally admitted to the facility on 1/15/13 and readmitted on 10/18/13 with multiple diagnoses including cerebrovascular accident with left hemiplegia, depression, and anxiety.</p> <p>The resident's significant change 10/23/13 MDS coded severe cognitive impairment, severe</p>	F 328		

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F 328	<p>Continued From page 21</p> <p>depression, total assistance of at least one person for ADLs, upper and lower extremity functional limitations in ROM, and did not code for oxygen.</p> <p>The resident's care plan did not include a problem or problem intervention related to the use of oxygen.</p> <p>The resident's October 2013 and November 2013 Physician Orders (recapitulations) did not include an order for oxygen.</p> <p>Review of the resident's Nurse's Notes dated 11/2/13 at 5:30 p.m. documented, in part, "...O2 88 - 91 % pt placed on nasal cannula 1 liter... [oxygen saturation level was 88 to 91 percent, patient placed on nasal cannula at one liter per minute]..."</p> <p>On 11/20/13 at 1:10 p.m., the surveyor asked the DNS if the resident's physician ordered oxygen for the resident. The DNS stated, "Yes."</p> <p>On 11/20/13 at 6:20 p.m., the DNS provided the surveyor with a copy of the resident's 1/15/13 admission orders that included, in part, "oxygen at 1-2 liters via nc prn [O2 at 1-2 liters per minute by way of nasal cannula as needed]." Note: The prn oxygen order was not included on the resident's recapitulation orders. At this time, the survey team informed the DNS the survey team had concerns about the accuracy of residents' recapitulation orders including all treatments and medications that may have been ordered by the physician.</p>	F 328			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329			

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F 329	Continued From page 22 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to clarify the rationale and the benefits for duplicate depression medication therapy, approach to monitoring for benefits and adverse consequences, and failed to care plan for all psychotropic medications the resident was administered. This affected 1 of 3 (#1) residents sampled for psychotropic medications. This practice created the potential for more than	F 329	<p>1. Corrective actions accomplished for those residents found to have been affected by the deficient practice: Resident #1 was affected by this practice. Corrective action was taken as follows: 12/28/13</p> <ul style="list-style-type: none"> •Physician documented rationale for using Melatonin and Trazadone. See attachment F329-A ✓ •Additions were made to the care plan that addressed delirium, cognitive loss, communication, psychosocial well-being and the use of Melatonin and Effexor. See attachment F329-B. <p>2. Other residents having the potential to be affected by same deficient practice and corrective actions taken: This practice has the potential to affect any resident taking psychotropic medications that are in the same drug classification. Corrective actions taken:</p> <ul style="list-style-type: none"> •Social Service Advocate (SSA) will audit all resident charts that have drugs in the hypnotic, antidepressant, and antipsychotic classification, to determine if there is duplication without appropriate documentation. If necessary the resident's physician will be contacted requesting documentation of the reasons and benefits of therapy. The Psychotropic Drug Review Committee will evaluate continued benefit and if appropriate for drug reduction for all affected residents. This will be accomplished by 12/28/13. ✓ •The SSA will notify the DNS of the audit results for residents on duplicate therapy. 	

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F 329	<p>Continued From page 23</p> <p>minimal harm should the resident experience unnecessary adverse drug reactions from overuse of the anti-depressants. Findings included:</p> <p>Resident #1 was originally admitted to the facility on 1/15/13 and readmitted on 10/18/13 with multiple diagnoses including cerebrovascular accident with left sided hemiplegia, depression, and insomnia.</p> <p>The resident's 10/23/13 significant change MDS coded severe cognitive impairment and severe depression. Section V of the MDS triggered for delirium, cognitive loss, psychosocial well-being, communication, mood state, and psychotropic drug use. Section V also documented the triggered care areas were care planned.</p> <p>Review of the resident's care plan revealed the resident was not care planned for delirium, cognitive loss, communication, and psychosocial well-being. Note: Please refer to F279 as it related to care plans.</p> <p>Review of the resident's medical chart and review of the care plan revealed there was no rationale or benefits for duplicate anti-depression medication therapy, or approaches to monitoring for benefits and adverse consequences.</p> <p>This review also revealed the care plan was not updated for the use of Melatonin and Effexor, as follows: * 1/28/13, problem of at risk for mood/behavior indicators related to (in the following order): new to unit, alert and oriented, full code, psychotropic medications (meds), and insomnia.</p>	F 329	<p>3. Measures that will be put into place and changes made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> •The DNS counseled with SSA to determine <u>barriers that exist</u> in current practice and improvements that need to be made to ensure all residents are evaluated for duplicate therapy for drugs in the psychotropic drug classification, and that appropriate interventions are in the resident care plan. As a result the following practices will be implemented: <ol style="list-style-type: none"> 1. As part of the MDS assessment the SSA will review and ensure psychotropic drugs, inclusive of hypnotics and antidepressants, are reviewed for duplicate therapy and there is documentation of the reasons and benefits; 2. The reasons and benefits for duplicate therapy will be documented in the resident care plan. 3. Any resident on duplicate therapy will be evaluated at the Psychotropic Drug Committee to ensure continued administration of medications is appropriate and the reasons if they are not a candidate for dose reduction. 4. The HUC will forward any medication changes regardless of classification to the SSA following the same process currently used to notify MDS Coordinator. 5. Residents that have duplicate therapy 	12/28/13
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F 329	<p>Continued From page 24</p> <p>The problem interventions were listed, in the following order, encourage family and friends to visit often, encourage questions, direct questions towards (Resident #1), include spouse in discussions whenever possible, follow wishes for being full code, meds as ordered, follow on sleep monitor, "Trazadone {sic}" 50 milligram (mg) at bedtime, and "Ambien" 5 mg at bed time started on 2/20/13.</p> <p>The resident's 11/13 Physician Orders (recapitulation) contained, in part, the following medication orders.</p> <ul style="list-style-type: none"> -Trazodone 50 mg daily at bed time for insomnia -Effexor 75 mg two times a day for depression -Melatonin 3 mg daily at bedtime for insomnia <p>The 2014 Nursing Drug Handbook identified both Trazodone and Effexor were in the anti-depressant therapeutic class with similar adverse reactions.</p> <p>On 11/20/13 at 12:22 p.m., the survey team informed the Social Services Advocate (SSA) Resident #1's MDS Section V triggered for the above identified care areas however the resident's care plan did not include delirium, cognitive loss, psychosocial well-being, and communication. The SSA stated, "I do the care planning for cognitive loss, psychosocial, mood, and psychotropic medications."</p> <p>On 11/20/13 at 2:40 p.m., the SSA provided the surveyors with what appeared to be an updated copy from the resident's care plan. The 10/23/13 problem of at risk for mood/behavior column documented, in this order, "Decrease in cognition, Decrease in mood, Psychotropic medications: Trazodone, Effexor, Full Code, and</p>	F 329	<p>4. Corrective actions will be monitored to ensure the deficient practice does not recur:</p> <ul style="list-style-type: none"> • The MDS Coordinator will be responsible to ensure all appropriate residents receiving antipsychotics, hypnotics and antidepressants are triggered on the Roster/Sample Matrix and there are corresponding interventions on the care plan. ✓ The Roster/Sample Matrix will be updated <u>weekly</u> by the LTCU Interdisciplinary team at Stand-Up. ✓ • The DNS will ensure compliance with use of Roster/Sample Matrix at Stand-Up and participation of staff. 	12/28/13

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F 329	Continued From page 25 Altered mental status. The problem interventions included, in this order, "Reorient as appropriate. Reassure her that she is safe and that husband will be in as soon as possible. Frequent 1:1's, Bring her to dayroom as tolerated for social interactions, meds as order, Follow on behavior and sleep monitors ...Reassure and comfort as needed, Enjoys being warm, with several blankets. Likes them pulled up to her neck." The survey team asked the SSA when the updates to the care plan were made. The SSA indicated the updates were made on 11/20/13. At 2:47 p.m., the SSA stated, "I should have made some type of entry to show when the care plan was updated." On 11/22/13 at 1:09 p.m., the DNS provided the survey team with a 11/22/13 progress note signed by the resident's physician. The progress note documented in part, "...in our hospital...was on, I believe, Ambien...Ambien was...stopped...began complaining of severe insomnia ...Melatonin...was not effective she was started on Trazodone. The combination [Melatonin and Trazodone] worked well..." On 11/22/13 at 1:30 p.m., the Administrator and DNS were informed the resident's medical record and care plan did not include the rationale or benefits of duplicate medication therapy and approaches to monitoring for benefits and adverse medication reactions. The facility did not provide additional information related to the concern.	F 329			
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN	F 367			

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F 367	<p>Continued From page 26</p> <p>Therapeutic diets must be prescribed by the attending physician.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to provide Resident #9 with the fluid consistency as ordered by the resident's physician. Resident #3's medical chart contained conflicting information as to the fluid consistency the physician ordered. This affected 2 of 9 (#s 3 & 9) residents sampled for diet orders and fluid consistency. This practice created the potential for more than minimal harm should the residents experience choking or aspiration. Findings included:</p> <p>1. Resident #9 was originally admitted to the facility on 11/26/10 and readmitted on 11/4/13 with multiple diagnoses including aspiration pneumonia.</p> <p>The resident's 11/11/13 admission MDS Section V triggered for nutritional status and dehydration/fluid maintenance. The MDS coded moderately impaired cognitive skills, mechanically altered diet, eating one person supervision, and one-sided upper extremity functional ROM limitations.</p> <p>The resident's 11/4/13 to 11/30/13 Physician Orders contained a 11/11/13 diet order: mechanical soft, fortified, and "nectar thick liquids."</p> <p>The resident's Care Plan (CP) identified a 11/15/13 problem of aspiration pneumonia and at risk for complications. The CP contained an</p>	F 367	<p>1. Corrective actions accomplished for those residents found to have been affected by the deficient practice: This practice affected Resident #9. This resident was discharged from the facility 11/21/13. Prior to discharge at the time the deficiency was brought forward the diet was clarified and communicated to staff. 12/28/13 This practice affected Resident #3. Corrective actions accomplished for this resident are: • Dietary orders were clarified see attachment F367-A. • Pocket Care Plan was updated with clarified diet see attachment F367-B.</p> <p>2. Other residents having the potential to be affected by same deficient practice and corrective actions taken: This practice has the potential to affect all residents in the facility. Corrective actions taken: • The DNS directed the HUC to audit 100% of the resident charts and reconcile the current diet order with the list of diets sent to the dietary department. Discrepancies were identified and corrected, and a validated diet orders was sent to dietary department. Diet orders were reconciled on recapitulations. See attachments F357-F. F367F 1.10.13 14:10 hrs telephone DNS</p> <p>3. Measures that will be put into place and changes made to ensure that the deficient practice does not recur:</p>	12/28/13
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•HUC will develop and maintain a list of residents with their current diet orders.
•HUC will reconcile the list as needed but no less than weekly. ✓
•Formal process implemented to ensure diet orders are reconciled weekly. See attachment 357-D. ✓

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F 367	<p>Continued From page 27</p> <p>additional page that documented, 11/5/13, SLP (speech language pathologist), "No thin liquids" and "...dysphasia..." Diet - mechanical soft "nectar thick liquids swallow strategies [and] supervision [with] po [intake by mouth]."</p> <p>Further review of the CP revealed although the resident's admission MDS Section V triggered for nutritional status and dehydration/fluid maintenance, these two care areas were not identified on the resident's CP. Note: Please refer to F279 as it related to care plans.</p> <p>The resident's medical record contained a diet order signed by a Speech Pathologist (SP). Order date 11/17/13, "ST [speech therapy] recommends pt [patient] have nectar thick liquids/water bedside."</p> <p>On 11/20/13 at 5:55 p.m., LN #5 was observed with the resident at his table in the dining room. There was a glass of what appeared to be water of thin liquid consistency on the table in front of the resident. The LN walked away from the resident while the resident was dining. - At 5:56 p.m., the surveyor requested the RD observe the consistency of the water at the resident's place setting in the dining room. The RD removed the glass of water from the resident's place setting and held the glass of water in her hand. The surveyor questioned LN #5 about the fluid consistency the resident was ordered. The LN said, "I'll go check." - At 6:01 p.m., the SP and LN #5 were sitting at the nurse's station. The surveyor asked the SP to evaluate the glass of water the resident received with his meal. The SP evaluated the glass of water and stated, "Not nectar thick."</p>	F 367	<ul style="list-style-type: none"> •MDS Coordinator will take reconciled diet list to Resident at Risk Committee Meeting and collaborate with multi-disciplinary team to ensure diet information listed is being used in developing resident interventions. •MDS coordinator is responsible to ✓ ensure dietary information on care plan accurately reflects current diet orders. •DNS will instruct LN regarding Resident Diet Order Reconciliation Process at the LN staff meeting 12/18/13. See attachment F357-EI. •See F-279 for care plan corrective action. See F-328 for recapitulation corrective action. <p>4. Corrective actions will be monitored to ensure the deficient practice does not recur:</p> <ul style="list-style-type: none"> •The DNS will evaluate to determine if corrective actions are implemented and desired outcomes are achieved. If outcomes are not as desired the DNS will develop an action plan for improvement. •See F-279 for care plan corrective action. See F-328 for recapitulation corrective action. <p><i>wEEKLY PER telephone & DNS 1.10.13 14:10</i></p>	12/28/13
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F 367	Continued From page 28 On 11/21/13 at 2:15 p.m., the surveyor informed the DNS the resident received thin consistency water at the dinner meal the day before and the consistency was verified by the SP. The DNS nodded her head in an up and down motion. On 11/22/13 at 1:20 p.m., the Administrator was informed of the resident receiving thin consistency water when the physician ordered nectar thick fluids.	F 367			
	2. Resident #3 was originally admitted to the facility on 10/15/10 and readmitted on 11/14/13 with multiple diagnoses including Diabetes Mellitus and cerebrovascular accident with left sided weakness. The resident's 9/19/13 annual MDS coded cognitively intact, required supervision of one person for dining, and one sided upper and lower functional limitation in ROM impairments. The resident's plan of care (poc) identified the 10/27/10 problem of alteration in nutrition. One of the problem interventions was, "diet as ordered - mechanical soft - low fat & low cholesterol - with honey thick liquids - small portions." The resident's Physician Orders (recapitulations) documented, in part: * 10/1/13 to 10/31/13, order date 10/13/2011, Low fat, low cholesterol diet, mechanical soft (ms) and "nectar thick liquids (ntl)" * 11/1/13 to 11/30/13, order date 11/14/13, pureed. Note: The order dated 11/14/13 on the recapitulation did not include what liquid consistency the resident was to receive.				

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F 367	Continued From page 29 The resident's medical record contained the following information: * 6/21/13, change diet to small portions ADA (American Diabetes Association), ms, "honey thick liquids (htl)." This order appeared signed by the physician. * 11/14/13, Long Term Care Unit Diet Order, change; consult, Pureed diet with "htl." This order was signed by a LPN. Note: This order was not signed by the resident's physician. * 11/18/13, change diet to ms diabetic. Note: This order was not signed by the physician. * 11/19/13 clarification diet order, mechanical soft diabetic with honey thick liquids. This order was signed by the SP. * 11/19/13 Speech Therapy (ST) clarification order: Recommend 4-6 ST sessions with focus on dysphagia and swallow strategies/precautions and "trial possible thin water between po [oral intake]." On 11/18/13 at 12:25 p.m., during the lunch meal dining observation dietary services provided a tray with a meal and two glasses of fluid at regular thin consistency (water consistency). The tray contained a piece of paper, "11/14/13 Diet card, Pureed diet with htl." CNA #3 was assisting the resident to dine. The CNA took the two glasses of fluids back to dietary services. A few minutes later, the cook was observed bringing two glasses of what appeared to be fluids to the CNA and the resident. The surveyor asked the CNA why she took the 2 glasses of fluid back to the kitchen. CNA #3 stated, "So they could thicken the drinks, tea and milk." The surveyor verified with the CNA, the fluids (tea and milk) were not thickened? The CNA shook her head in	F 367			

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F 367	Continued From page 30 a back and forth motion and stated, "No, they were not. They are now." On 11/19/13 at 4:00 p.m., the survey team informed the DNS of the dining observation of dietary services providing fluids of thin consistency when the diet card directed thickened fluids and the CNA sent the fluids back to the kitchen. The surveyor also informed the DNS the review of the resident's chart revealed conflicting information about the resident's fluid consistency. The resident's care plan documented honey thick liquids with a problem date of 10/27/10. On 6/21/13, diet order was changed to honey thick liquids. October recapitulation orders were nectar thick. November recapitulation orders did not include fluid consistency.	F 367			
F 371 SS=F	On 11/21/13 at approximately 9:00 a.m., the facility's RD provided the survey team with a list of all the residents and their diet orders. The RD stated, "We reviewed all the resident's diet orders." On 11/22/13 at 1:20 p.m., the Administrator was informed of the findings and observations. 483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371			

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F 371	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure kitchen staff did not use a food preparation sink for clean kitchen equipment at the same time the sink contained food to be served. This affected 9 of 9 (#s 1-9) sampled residents and had the potential to affect all residents who dined in the facility. This practice created the potential for chemical contamination of food and exposed residents to potential disease causing substances. Findings included: On 11/18/13 at 10:42 a.m. the Dietary Manager (DM) accompanied the surveyor during the initial tour of the facility 's kitchen. The following was observed. - Water was running from the faucet of a food preparation sink into a metal bowl located in the bottom of the sink. The metal bowl contained 2 packages wrapped in aluminum foil. Cafeteria Worker #2 (CW #2) was observed wiping a slicer with a wiping cloth. The slicer was located approximately four feet from the food preparation sink. The CW #2 walked over to the food preparation sink, positioned the faucet to allow the water to run directly into the sink, not into the metal bowl. The CW #2 then rinsed the wiping cloth under the water running from the faucet, squeezed the cloth, and visible suds were observed going from the wiping cloth into the food preparation sink. - At 10:50 a.m., the DM stated, " Deli meat is wrapped in the foil in the sink. The meat is for	F 371	<p>1. Corrective actions accomplished for those residents found to have been affected by the deficient practice: This action affects Residents #1-9. Corrective Actions taken: 12/28/13 •On 11/18/13 cafeteria staff reminded and received further education on food safety and sanitation. Staff instructed that food preparation sinks are used for food preparation only.</p> <p>2. Other residents having the potential to be affected by same deficient practice and corrective actions taken: This action has the potential to affect all residents in the facility. Corrective action taken: <u>Sign posted on 11/18/13 in preparation area wall that sink is to be used for food preparation only.</u> See attachment F371-A ✓</p> <p>3. Measures that will be put into place and changes made to ensure that the deficient practice does not recur: Every food and nutrition employee will be required to take a food safety and sanitation test on 12/20/13 at the ✓ monthly department in-service. The Dietary Services Manager will calendar this as an annual agenda item for ✓ department staff meetings to keep staff informed and up to date on proper procedure regarding food and patient safety.</p>		

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F 371	Continued From page 32 service in the cafeteria [hospital cafeteria]. " The surveyor questioned the DM and CW #2 about using the food preparation sink to clean the slicer. - At 10:52 a.m., the DM told the CW #2 the sink was not to be used for cleaning. The CW #2 asked the DM what should be used to clean the slicer. The DM told the CW #2 to obtain a separate bucket of water to clean the slicer.	F 371	4. Corrective actions will be monitored to ensure the deficient practice does not recur: The Cook Supervisor will monitor staff <u>daily</u> to ensure sink is used in the appropriate manner. A form has been established for monitoring purpose and will be signed off by the supervising cook at the end of the shift. This has been implemented and will be done <u>daily x 2</u> months and if there is 100% compliance audits will be discontinued. If 100% compliance is not achieved, daily audits will continue until there is 100% compliance for 2 consecutive months. See attachment F317-B.	12/28/13	
	Federal guidance at F371 indicated, " 'Food Contamination' refers to the unintended presence of potentially harmful substances, including, but not limited to ...chemicals ...Chemical Contamination, The most common chemicals that can be found in a food system are cleaning agents (such as ...soaps ...Chemicals used by the facility staff, in the course of their duties, may contaminate food ... " On 11/20/13 at 1:30 p.m., the DM asked the survey team how the observation affected all the long term care residents. The surveyor explained there were employees using the kitchen equipment to prepare food for hospital patients and long term care residents. The food preparation sink was used in the food preparation process for long term care residents and hospital patients. CW #2 was observed rinsing a wiping cloth in the food preparation sink as she was cleaning the slicer. This practice created the potential for any chemical solution in the food preparation sink to come into contact with food prepared and served to the long term care residents. This practice placed the long term care residents at risk for possible chemical contamination.				

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F 371	Continued From page 34 - At 10:50 a.m., the DM stated, "Deli meat is wrapped in the foil. The meat is for service in the cafeteria [hospital cafeteria]." The surveyor then questioned the DM and CW #2 about using the food preparation sink to clean the slicer. - At 10:52 a.m., the DM told the CW #2 the sink was not to be used for cleaning. The CW #2 then asked the DM what should be used to clean the slicer. The DM told the CW #2 to obtain a bucket of water to clean the slicer.	F 371			
F 431 SS=D	On 11/20/13 at 1:30 p.m., the DM asked the survey team how the observation affected all the long term care residents. The surveyor explained the facility had employees using the kitchen equipment for preparing hospital and long term care food. The CW #2, although preparing food for the cafeteria, was cleaning the slicer using a chemical solution. The CW #2 then rinsed the wiping cloth containing the chemical solution in the food preparation sink. The food preparation sink was used for long term care residents and hospital patients. This practice created the potential for any remaining chemical solution to come into contact with food during food preparation when other staff used the food preparation sink. This practice placed all people the kitchen served, including the long term care residents, at risk for possible chemical contamination. 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431			

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F 431	Continued From page 35 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	<p>1. Corrective actions accomplished for those residents found to have been affected by the deficient practice: At the time of deficiency the expired medication was removed and LN verified there was no other expired medications or solutions in medication room</p> <p>2. Other residents having the potential to be affected by same deficient practice and corrective actions taken: This practice has the potential to affect all residents receiving medication and treatments in the facility. Corrective Action: The evening nurse on Wednesdays will be assigned to check the medication room for expired medications and solutions. ✓ 12/28/13</p> <p>3. Measures that will be put into place and changes made to ensure that the deficient practice does not recur: •Evening nurse duties on Wednesday will include surveying the medication room to determine if there are expired medications or solutions. •The HUC and night nurse will ensure task is written for the Wednesday evening nurse to initial. •If expired medications are identified the evening nurse will place items in a bag and write on the 24-hour report that bag needs to be returned to Pharmacy the next day. The day shift nurse will be</p>		
	<p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure outdated medications were removed from the medication room storage shelf for resident use. This failure created the potential for diminished efficacy if Metronidazole was administered after the expiration date. This had the potential to affect any resident who might need Metronidazole.</p>				

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2013
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F 431	Continued From page 36 Findings included: On 11/19/13 at 3:25 PM, the medication room was examined for outdated medications. One bag of Metronidazole Injection, 500 mg (milligram) IV (intravenous) bag, with an expiration date of 8/13 was found on the shelf available for patient use. LN #5 was present and stated the Metronidazole should not be on the storage shelf since it was expired and she will send it to the pharmacy for them to dispose of the medication.	F 431	responsible to ensure expired medicines are returned to pharmacy. •DNS will in-service LN on these tasks and expectation for completion, at the LN meeting on 12/18/13. See attachment F431-A 4. Corrective actions will be monitored to ensure the deficient practice does not recur: •DNS or designee will perform weekly	12/28/13	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain	F 514	audits to determine if any expired medications or solutions are found in the medication room, if reminder is on Wednesday staffing sheet, and if task is initialed as completed x 4 weeks starting week of 12/30/13. If there is 100% compliance at the end of 4-weeks audits will continue quarterly as part of the Environment of Care Audit. If 100% compliance is not achieved, weekly audits will continue until there are 4 consecutive weeks of 100% compliance. The DNS will analyze and develop an action plan for improvement if process is not able to achieve compliance.		

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F 514	Continued From page 37 accurate, complete and organized clinical records on each resident. This was true for 4 of 9 (#s 1, 2, 4 & 5) sampled residents and 1 of 3 random residents (#12) sampled for clinical record accuracy. This created the potential for medical decisions to be based on inaccurate information. Findings included: 1. Resident #5 was admitted to the facility on 10/15/13 with multiple diagnoses including malignant neoplasm of upper lobe (cancer of the lung), anxiety, pressure ulcer, and chronic obstructive pulmonary disease (COPD). Resident #5's medical record was found to contain information of two other residents (#4 and #11) on 11/19/13 at 4:00 PM. Resident #5's medical record contained: *Resident #4's - Physical Therapy Progress Note dated 10/24/13 *Resident #11's - Physical Therapy Evaluation and Plan of Treatment, dated 10/30/13 On 11/19/13 at 4:10 PM, the DNS was shown Resident #5's medical record and she stated, "Oh, I see the problem" and removed the Physical Therapy Progress Note for Resident #4 and the Evaluation and Plan of Treatment for Resident #11 from Resident #5's chart. Additionally, the resident's longterm care admission orders, dated 10/15/13, documented an order for oxygen treatment at 2 Liters via NC (nasal cannula) PRN (as needed) O2 sats < (less than), however, the saturation percentage was not documented.	F 514	<p>1. Corrective actions accomplished for those residents found to have been affected by the deficient practice: This practice affected Resident #5. Corrective action taken: •The DNS directed the HUC to review the resident's medical record and ensure all documents in the chart were for that resident. •Oxygen orders for this resident were added to December's recapitulation. See attachment F514-A This practice affected Resident #2. Corrective action taken: •Oxygen orders for this resident were added to December's recapitulation. See attachment F514-B. •This practice affected Resident #4. Corrective action taken: •A diagnosis was obtained and added for Spironolactone on the recapitulation. See attachment F14CA. F514C This practice affected Resident #12 who was discharged 11/19/13 prior to deficiency being identified.</p> <p>2. Other residents having the potential to be affected by same deficient practice and corrective actions taken: All residents in the facility have the potential to be affected by this practice. Corrective actions: •DNS directed HUC to review all resident charts and ensure all documents in the chart related to the resident named on the chart. This was completed by 12/06/13.</p>	12/28/13
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1.10.13
14:10
telephoned
2 DNS

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F 514	<p>Continued From page 38</p> <p>The resident's most recent Admission MDS, dated 10/23/13, documented the resident received oxygen therapy.</p> <p>The resident's care plan for oxygen therapy, with a start date of 10/28/13, documented the oxygen liter flow at 2 L (liters)/NC (per nasal cannula), for the diagnosis of Asthma/COPD, documented interventions of:</p> <p>*O2 (oxygen) as ordered - 2 L/NC. *Check flow of O2 every shift and PRN (as needed). *Observe tubing for any obstructions or kinks.</p> <p>The resident's November, 2013, Physician Orders (recapitulations) did not include an order for oxygen.</p> <p>2. Resident #2 was admitted to the facility on 1/4/13 with multiple diagnoses including dementia, mood disorder, and chronic pain.</p> <p>The resident's most recent Quarterly MDS, dated 10/9/13, documented the resident received oxygen therapy.</p> <p>An order for "Oxygen 2-6 L/min (liters per minute) nasal cannula to maintain O2 sats > 90% PRN" was written by the resident's physician on 2/5/13.</p> <p>Resident #2's care plan for respiratory distress, dated 2/6/13, documents an intervention "use of oxygen at 2-6 L/NC to maintain saturations > 90%."</p> <p>The resident's Physician Orders (recapitulations) for the month of November, 2013, did not document an order for oxygen therapy.</p>	F 514	<ul style="list-style-type: none"> •HUC reconciled December recapitulations to ensure all residents with oxygen have corresponding orders and medications have a corresponding diagnosis <p>3. Measures that will be put into place and changes made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> •DNS has directed HUC to check charts monthly prior to placing recapitulations in the chart to ensure all documents in chart relate to resident whose name is on chart. •See corrective actions for F-279 •See corrective actions for F-328 <p>4. Corrective actions will be monitored to ensure the deficient practice does not recur:</p> <ul style="list-style-type: none"> •See corrective actions for F-279 •See corrective actions for F-328 	12/28/13	

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F 514	Continued From page 39 3. Resident #4 was admitted to the facility on 9/24/13 with multiple diagnoses including hepatic encephalopathy, dehydration, Diabetes Mellitus II, and pain. The resident's most recent Significant Change MDS assessment, dated 10/25/13, documented the resident's cognition was moderately impaired, had mild depression and needed one person assist with her activities of daily living.	F 514		
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	An order for "Spironolactone 25mg [milligrams] PO (by mouth) BID (twice daily), dx [diagnosis]: edema" was written by the resident's physician on 10/11/13. The resident's November, 2013 Physician Orders (recapitulations) did not document a diagnosis for the Spironolactone order. 4. Random Resident #12 was admitted to the facility on 10/16/13 with diagnosis of Charcot Foot with nonhealing ulcer and cellulitis both legs. On 11/19/13 at 11:15 AM, record review of the Physician Orders (recapitulations) for the month of November, 2013, documented an order for "Levothyroxine 150 mg" PO daily. The actual order written by the resident's physician documented "Levothyroxine 150 mcg [micrograms]" PO daily. Levothyroxine is not supplied in milligrams and is only supplied in microgram form. On 11/20/13 at 6:20 PM, the survey team informed the DNS the survey team had concerns about the accuracy of residents' recapitulation orders including all treatments and medications that may have been ordered by the physician.			
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F 514	Continued From page 40 On 11/21/13 at 3:35, the DNS was made aware of the inaccuracy of the recapitulation orders for Levothroxine. No further information was provided by the facility. 5. Resident #1 was originally admitted to the facility on 1/15/13 and readmitted on 10/18/13 with multiple diagnoses including cerebrovascular accident with left hemiplegia, depression, and anxiety.	F 514		
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	<p>The resident's significant change 10/23/13 MDS coded severe cognitive impairment, severe depression, and did not code for oxygen.</p> <p>The resident's care plan did not include a problem or problem intervention related to the use of oxygen.</p> <p>The resident's October 2013 and November 2013 Physician Orders (recapitulations) did not include an order for oxygen.</p> <p>Review of the resident's Nurse's Notes dated 11/2/13 at 5:30 p.m. documented, in part, "...O2 88 - 91 % pt placed on nasal cannula 1 liter... [oxygen saturation level was 88 to 91 percent, patient placed on nasal cannula at one liter per minute]..."</p> <p>On 11/20/13 at 1:10 p.m., the surveyor asked the DNS if the resident's physician ordered oxygen for the resident. The DNS stated, "Yes."</p> <p>On 11/20/13 at 6:20 p.m., the DNS provided the surveyor with a copy of the resident's 1/15/13 admission orders that included, in part, "oxygen at 1-2 liters via nc prn [O2 at 1-2 liters per minute by way of nasal cannula as needed]." Note: The</p>			
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F 514	Continued From page 41 prm oxygen order was not included on the resident's recapitulation orders. At this time, the survey team informed the DNS the survey team had concerns about the accuracy of residents' recapitulation orders including all treatments and medications that may have been ordered by the physician. Note: Please refer to F328.	F 514			

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the State licensure survey of your facility. The surveyors conducting the survey were:	C 000		
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	Karen Marshall, MS, RD, LD Team Coordinator Rebecca Thomas, RN			
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	Survey Definitions:			
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C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please refer to F241 as it related to obtaining a resident's temperature and verbalizing the resident's temperature in a public setting.	C 125	C125-Please Refer to F241	12/28/13
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C 293	02.107,04,b Therapeutic Diets per Physician Orders b. Therapeutic diets shall be planned in accordance with the physician's order. To the extent that it is medically possible, it shall be planned from the regular menu and shall meet the patient's/resident's daily need for nutrients. This Rule is not met as evidenced by:	C 293	C293- Please Refer to F367	12/28/13
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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>[Signature]</i>	ADMINISTRATOR	DECEMBER 17 2013

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C 293	Continued From page 1 Please refer to F367 as it related to providing residents with the fluid consistency as ordered by the physician.	C 293		
C 295	02.107,04,d Current Diet Manual d. A current diet manual approved by the Department and the patient's/resident's physician shall be available in the kitchen and at each nursing station (the Idaho Diet Manual is approved by the Department).	C 295	1. Corrective actions accomplished for those residents found to have been affected by the deficient practice: The Idaho Diet Manual 10 th edition was placed in the LTCU and Food and Nutrition Department 11/21/13. See attachment C295-A	
	This Rule is not met as evidenced by: Based on observation and diet manual review, it was determined the facility failed to ensure the most current copy of the approved Idaho diet manual was available in dietary services and at the nurse's station. This affected 9 of 9 (#s 1-9) sampled residents and had the potential to affect all residents who resided in the facility. Findings included: The Department approved diet manual for the use in the state was the 2010 Idaho Diet Manual. On 11/21/13 at 9:43 a.m., a 2005 Idaho Diet Manual was located at the nurse's station. The facility's Registered Dietitian (RD) accompanied the surveyor. - At 9:44 a.m., 2 diet manuals, one dated 1998 and another dated 2005, were located in the Dietary Manager's (DM's) office. - At 9:45 a.m., the RD and the surveyor reviewed the diet manual located in the facility's kitchen diet office. The diet manual in the diet office was dated 2005. On 11/20/13 at 11:20 a.m., the surveyor informed		2. Other residents having the potential to be affected by same deficient practice and corrective actions taken: There is a potential to affect all residents in the facility. Corrective action: •The Idaho Diet Manual 10 th edition was placed in the LTCU and the Food and Nutrition Department. 3. Measures that will be put into place and changes made to ensure that the deficient practice does not recur: Dietary Manager will place annual reminder on calendar to check for new editions of manual. 4. Corrective actions will be monitored to ensure the deficient practice does not recur: Dietary Manager will request to be put on the Idaho Diet Manual's distribution list and notified when a new edition is published.	12/28/13

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C 295	Continued From page 2 the DM the current Idaho diet manual was dated 2010. The DM stated, "There is a secretary who orders the manual for us." On 11/22/13 at 1:10 p.m., the DM stated, "We now have the 2010 Idaho Diet Manual."	C 295		
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F371 as it related to potential chemical contamination of a food preparation sink.	C 325	C325-Please Refer to F371	12/28/13
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 patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at	C 393	C393-Please Refer to F246	12/28/13

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C 393	Continued From page 3 all times. This Rule is not met as evidenced by: Please refer to F246 as it related to a resident's call system (call light) not within reach of the resident.	C 393		
C 745	02.200,01,c Develop/Maintain Goals/Objectives c. Developing and/or maintaining	C 745		
C 781	goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Please refer to F-281 as it relates to standards of practice.	C 781	C745-Please Refer to F281	12/28/13
C 781	02.200,03,a,iii Written Plan, Goals, and Actions iii. Written to include care to be given, goals to be accomplished, actions necessary to attain the goals and which service is responsible for each element of care; This Rule is not met as evidenced by: Please refer to F279 and F329 as it related to care plan development for all care areas and for duplicate drug therapy.	C 781	C781-Please Refer to F279 and F329	12/28/13
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: Please refer to F279 as it related to revising resident care plans.	C 782	C782-Please Refer to F279	12/28/13

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C 788	Continued From page 4	C 788		
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Please refer to F-328 as it relates to oxygen.	C 788	C788-Please Refer to F328	12/28/13
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please refer to F-314 as it relates to pressure ulcers.	C 789	C789-Please Refer to F314	12/28/13
C 821	02.201,01,b Removal of Expired Meds b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days. This Rule is not met as evidenced by: Please refer to F-431 as it relates to expired medications.	C 821	C821-Please Refer to F431	12/28/13
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD	C 881	C881-Please Refer to F514	12/28/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001190	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/22/2013
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NAME OF PROVIDER OR SUPPLIER ST LUKE'S ELMORE LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 895 NORTH 6TH EAST MOUNTAIN HOME, ID 83647
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 881	Continued From page 5 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Please refer to F-514 as it relates to maintaining accurate and complete clinical records.	C 881		
C 887	02.203,02,f Progress Notes f. Progress notes by physicians, nurses, physical therapists, social worker, dietitian, and other health care personnel shall be recorded indicating observations to provide a full descriptive, chronological picture of the patient/resident during his stay in the facility. The writer shall date and sign each entry stating his specialty. This Rule is not met as evidenced by: Please refer to F-283 as it relates to recapitulation of the resident's stay.	C 887	C887-Please Refer to F283	12/28/13