



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

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

December 19, 2014

Sherrie L. Nunez, Administrator  
Trinity Mission Health & Rehab of Midland, LLC  
46 North Midland Boulevard  
Nampa, ID 83651

FILE COPY

Provider #: 135076

Dear Ms. Nunez:

On **December 5, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Trinity Mission Health & Rehab of Midland, LLC by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Sherrie Nunez, Administrator  
December 19, 2014  
Page 2 of 4

return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 2, 2015**. Failure to submit an acceptable PoC by **January 2, 2015**, may result in the imposition of civil monetary penalties by **January 22, 2015**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **January 9, 2015 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **January 9, 2015**. A change in the seriousness of the deficiencies on **January 9, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 9, 2015** includes the following:

Sherrie Nunez, Administrator  
December 19, 2014  
Page 3 of 4

Denial of payment for new admissions effective **March 5, 2015**. [42 CFR §488.417(a)]

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

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

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

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **December 5, 2014** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

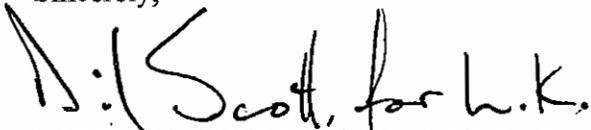
Sherrie Nunez, Administrator  
December 19, 2014  
Page 4 of 4

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

This request must be received by **January 2, 2015**. If your request for informal dispute resolution is received after **January 2, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

A handwritten signature in black ink that reads "D. Scott, for L.K.". The signature is written in a cursive style.

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

LKK/dmj  
Enclosures

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

PRINTED: 12/22/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/05/2014
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NAME OF PROVIDER OR SUPPLIER  TRINITY MISSION HEALTH & REHAB OF MIDLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651
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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><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Sherri Case, LSW, QIDP Susan Gollobit, RN Kristi Stevenson, RN</p> <p>The survey team entered the facility on December 1, 2014, and exited on December 5, 2014.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide CSC = Clinical Services Coordinator DON/DNS = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = Milligram NN = Nurses Notes PRN = As Needed RNA = Restorative Nuse Aide r/t - Related to s/sx = Signs and Symptoms SBAR = Situation, Background, Assessment, Request TAR = Treatment Administration Record UM = Unit Manager w/c = wheelchair</p>	F 000	<p>Preparation and submission of this plan of correction by, <b>Trinity Mission Health &amp; Rehab of Midland</b>, does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.</p>	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	F 164		

RECEIVED  
FEB 11 2015  
FACILITY'S STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NNA	(X6) DATE 2-11-15
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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.

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F 164	Continued From page 1  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.  The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.  The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to follow up on and ensure authorization prior to evaluation of a resident by an outside agency. This was true for 1 of 9 sampled residents (#8). This placed the resident at risk for comprised personal privacy. Findings include:	F 164	F164  1. On 12/9/2014 Resident #8 was re-assessed for psychosocial needs related to being assessed by an outside agency by the Social Service Director (SSD) with no concerns noted. On 12/12/2014 Resident # 8 was re-assessed for psychosocial needs related to privacy by the Staff Development Coordinator; no concerns were noted. On 12/15/2014 Resident #8's care plan was reviewed and updated by the Staff Development Coordinator to reflect the resident's current status of Activities of Daily Living (ADL) and transfer status.  2. On 12/8/2014 the Administrator and SSD completed an audit of residents who received assessments from outside agencies to ensure resident privacy and that family and facility have coordinated authorization of assessment per the resident's plan of care. All identified concerns were addressed and resolved at that time.  3. The following systemic changes were implemented to ensure that the facility will identify and implement preventative measures to decrease the risk of failing to		

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F 164	Continued From page 2  Resident #8 was admitted to the facility on 7/21/14 with diagnoses including dementia with behavior disturbance, muscle weakness and anxiety. Nurse's Notes for 10/16/14 documented, "When walked into resident's room found two ladies in room moving mattress on the floor and taking her blankets off ....they said they were here from ALF... to evaluate resident per [family member's] request." The resident's medical record did not include documentation that the facility was aware of this prior to the evaluation and/or of follow-up with the resident's family member to ensure authorization for the evaluation. On 12/4/14 at 11:25 AM, the Administrator stated she would check for documentation by social services or the family member to determine if authorization had been given for the ALF to evaluate Resident #8. On 12/8/14 the facility provided a statement signed by the son on 12/8/14 stating he had requested the ALF evaluation. The facility did not provide any documentation that the information was obtained at the time of the incident.	F 164	protect the resident's privacy. A root cause analysis was conducted by the IDT on 12/8/2014. Based on the results of this analysis, the facility began a new discharge referral process that includes a written permission form that the resident or the responsible party has consented to the evaluation and release of information to outside agencies. Beginning 12/9/2014 staff were re-educated by the Staff Development Coordinator on notifying the Social Service Director, Administrator or Director of Nursing of outside agency request to evaluate residents to ensure the facility has prior authorization by the resident or the responsible party to evaluate resident.		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION  When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.  This REQUIREMENT is not met as evidenced	F 244			

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F 244	Continued From page 3 by: Based on resident group interview, review of the facility's Resident Council Meeting minutes, and staff interview, it was determined the facility did not ensure that concerns brought forward by the resident council were addressed. This was true for 3 of 7 residents in the resident group interview and had the potential to result in unresolved concerns for residents in the facility. Findings include:  On 12/2/14 at 2:00 PM, during the resident group meeting, the residents stated that while the facility ensured the Resident Council had a place to meet monthly, the Council did not receive feedback from the facility as to the status of their concerns. One resident stated she had reported an air leak from her window but they (staff), "Think they don't need to talk with us." Another resident reported s/he had filed a grievance but was never told what happened with the grievance. A third resident stated when the council reported concerns, they were referred to "Corporate" but the Council was never informed of the decision from Corporate.  On 12/5/14 at 10:00 AM, the Administrator was asked about Resident Council meeting minutes, documentation of the facility's response to identified concerns, and documentation of follow-up provided to the residents regarding their concerns. The Administrator stated the residents were informed of how their concerns were followed up at the following month's Council meeting. At that time the Administrator was asked to provide documentation from the 9/4/14 Council meeting regarding the issues of ice water "mugs" not being clean or filled up. The Administrator looked at the October Council minutes and stated	F 244	4. Beginning the week of 1/4/2015 the Social Service Director or designee will conduct audits weekly of resident privacy for 4 weeks, monthly for 2 months and quarterly thereafter to ensure resident dignity and privacy needs are being met upon evaluation of outside agencies by confirming prior authorization. A report will be submitted to the Quality Assurance Performance Improvement Committee for three months. The Quality Assurance Performance Improvement Committee will review the results and determine if further interventions are needed at that time. The Administrator is responsible for monitoring and follow-up.  Date of compliance: 1/4/2015  F244  1. On 12/8/2014 the Administrator followed up with those residents who were in attendance of the resident council meeting and there	
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F 244	Continued From page 4 the minutes did not document the concerns had been addressed. Additionally, the October minutes documented residents' water was not being filled at night, not enough water on dining tables and concerns with the "...menu getting it up and running..." The November Council minutes did not document the concerns had been followed up on or the results reported to the Council.	F 244	were no unresolved concerns or complaints reported. On 12/17/2014 the Administrator reviewed concerns of mugs being cleaned and filled with ice water and concerns were addressed at that time and was communicated to the resident counsel by the Administrator.		
F 252 SS=E	On 12/5/14 at 3:00 PM, the Administrator, and DNS were informed of the surveyor's findings. The facility offered no further information. 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT  The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  This REQUIREMENT is not met as evidenced by: Based on observation, review of facility Record of Concern reports, and resident, resident group and staff interview, it was determined the facility did not ensure 1 of 13 (# 4) sampled residents, 1 (#16) random resident, and 2 of 7 residents in the group meeting were provided a home like environment. Resident rooms and public areas that were dirty and/or unkept and a window that let in the cold had the potential to result in residents being embarrassed or uncomfortable in their living environment. Findings include:  1. The facility's Record of Concern reports documented resident and family "Nature Of	F 252	On 12/17/2014 the Administrator reviewed concerns of mugs not being filled with ice water at night and having enough water at the dining tables and menus. Concerns were addressed at that time and communicated to the resident counsel by the Administrator. On 12/22/2014 the Administrator followed up with the resident council president regarding the lack of follow up to the concerns brought forward in resident council for the past 90 days; no unresolved concerns were reported. On 12/4/14 and on 12/11/2014 the Maintenance Director re-assessed the seal of resident # 16's window; concerns were addressed at that time.		

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F 252	<p>Continued From page 5</p> <p>Complaint," concerns with the facility environment as follows:</p> <p>*6/9/14: The resident's bedside drawers were dirty.</p> <p>*7/20/14: Public bathrooms were "unkept" and out of toilet paper. Pt rooms on A Hall did not have garbage bags or paper towels. The floors in 3 resident rooms were dirty and sticky.</p> <p>*7/20/14 [A second concern form]: Dirty public restroom.</p> <p>*7/23/14: Housekeeping concerns related to bathroom not being cleaned regularly.</p> <p>*7/25/14: Bathroom floor was dirty.</p> <p>*9/16/14: Resident's bathroom floor was not being cleaned "good enough."</p> <p>2. During the initial tour of the facility on 12/1/14 at 11:25 AM, the floor in Resident #4's room was observed to have a mat on the floor that had visible dirt particles. The area beside the bed had multiple pieces of paper, raspberry colored stickers, 2 new clothing stickers, Kleenex tissues, wadded up candy wrappers and a silk flower was on the floor. At 11:45 AM, the UM was brought to the room and was asked if she thought it was messy. The UM agreed and stated, "It needs to be vacuumed." The UM left and got the housekeeper to come to the room and clean it.</p> <p>3. On 12/2/14 at 2:10 until 3:25 PM, during the group meeting, concerns were identified as follows:</p> <p>* When asked about the cleanliness of the building, 2 of 7 residents stated they had problems with the floors not being clean in their room, including black marks and colored pencil shavings on the floor.</p> <p>*Resident #16 stated there was a cold air leak in the window in her room, the corner leaked water</p>	F 252	<p>On 12/8/2014 Resident #16 was reassessed by the Social Services Director for concerns related to report of an air leak in window not being followed up with to the resident's satisfaction; no concerns were noted.</p> <p>On 12/9/2014 Resident # 16 was re-assessed by the RN nurse manager for concerns related to concern of an air leak in window; no concerns were noted.</p> <p>2. On 12/8/2014 the SSD interviewed residents in regards to outstanding concerns or complaints and reported concerns were followed up with at that time.</p> <p>3. The following systemic changes were implemented to ensure that the facility will identify and implement preventative measures to decrease the risk of residents not provided feedback regarding concerns. A root cause analysis was conducted on 12/8/2014. Based on the results of this analysis, the facility implemented a new process where the resident council minutes will be reviewed by the IDT. Concerns noted will be incorporated into the facility grievances process and will be reviewed and followed-up with by the Administrator weekly to ensure resolution of the individual concerns.</p>		

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F 252	Continued From page 6 and the area felt drafty when she sat at the desk by the window.  On 12/4/14 at 11:50 AM, 2 surveyors observed Resident #16's window in her room. The widow area had cool air around it both when seated at the desk below the window and when the window was felt with the hand. The window also had water marks to the ledge of the window in the corner of the right side.  On 12/4/14 at 1:15 PM, the resident was asked if she had talked to the facility staff about the window. The resident stated she had talked to the maintenance department and stated, "I think they think they don't need to talk with us (residents)." There were no changes to the window after talking to the maintenance man.  On 12/4/14 at 1:25 PM, when asked if he had checked the window in the resident's room, the maintenance man stated, "I checked out [resident's name] window and it seemed fine."  On 12/5/14 at 12:25 PM, the Administrator and DON were informed of the findings. On 12/8/14 additional information was provided; however, it did not resolve the concerns.	F 252	Beginning 12/9/2014 staff were re-educated by the Staff Development Coordinator on guidelines for reporting concerns or grievances and communicating and documenting the follow-up of what was done to resolve the concern.  4. Beginning the week of 1/4/2015 the Administrator will conduct audits of concern and grievance follow-up weekly for 4 weeks, monthly for 2 months and quarterly thereafter to ensure concerns and grievances are followed up with to include resolution of the individual concerns and resident satisfaction. A report will be submitted to the Quality Assurance Performance Improvement Committee for three months. The Quality Assurance Performance Improvement Committee will review the results and determine if further interventions are needed at that time. The Administrator is responsible for monitoring and follow-up.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	Date of compliance: 1/4/2015  F252  1. On 12/1/2014 Resident #4's room was cleaned by the housekeeper. A root cause analysis was completed by the IDT on 12/11/14		

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NAME OF PROVIDER OR SUPPLIER  TRINITY MISSION HEALTH & REHAB OF MIDLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651		
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F 309	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to follow a resident's care plan for toileting. This was true for 1 of 9 sampled residents (#8). This created the potential for a decline in ADL skills. Findings include:</p> <p>Resident #8 was admitted to the facility on 7/21/14 with diagnoses that included dementia with behavior disturbance, muscle weakness and anxiety. The resident's 7/22/14 ADL and Bladder Care Plans included to toilet the resident with cares, before meals, rest periods and as needed. On 12/1/14 at 1:05 PM, staff took the resident from the dining room to her room. CNAs #3 and 4 and Unit Manager (UM) #1 used the mechanical lift to place the resident in bed. The resident was not offered the use of the toilet before being placed on the bed. On 12/2/14 at 10:15 PM, the resident was in bed. CNA #5 checked the resident's incontinence brief and told the DON that the resident was dry. They assisted the resident out of bed with the mechanical lift and put her in her wheelchair. She was not given the opportunity to use the toilet. On 12/3/14 at 8:47 AM, the resident was assisted from the dining room by CNA #5. UM #1 and CNA #5 used the mechanical lift to assist the resident to bed. CNA #5 checked the resident's incontinence brief and stated the resident was dry. The resident was not offered the use of the toilet. On 12/4/15 at 11:25 a.m. the Administrator and DNS were informed of the above concern. The</p>	F 309	<p>to determine why the resident's room was messy. Upon completion of the analysis it was identified that due to the type of mat, vacuuming was more effective to remove particles than the use of the sweeper. The housekeeper will use the vacuum to clean the floor mats and increase checks of resident's room.</p> <p>On 12/4/2014 a contracted window professional completed a root cause analysis of Resident # 16's windows related to the seal of the window with no leaks in the seal identified. It was determined that the cool air felt was the result of the cold window surface causing air movement also known as a convection loop.</p> <p>On 12/8/2014 Resident #16's room was temped and the seal to the window was assessed by the Maintenance Director; there continues to be no leaks to the window seals and the room temperature was 75.3 degrees.</p> <p>On 12/8/2014 Resident #16 was re-assessed by the Social Service Director for concerns related to report of an air leak in window with no further complaints of cool air noted.</p>		

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

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F 309	Continued From page 8 Administrator stated she would get back to the surveyor with information. The facility provided no further information.	F 309	On 12/9/2014 Residents #16's care plan was reviewed and updated as indicated by the Staff Development Coordinator.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interview, it was determined the facility failed to provide care and services to prevent the development of pressure ulcers. This was true for 1 of 4 (#2) residents sampled for pressure ulcers. Failure to ensure implementation of a wheelchair cushions, failure to notify the physician timely of changes in skin integrity and failure to ensure physician orders to discontinue or begin treatment were signed placed the resident at risk recurrence of pressure ulcers. Findings include:  Resident #2 was admitted to the facility on 1/27/14 with diagnoses that included chronic ischemic heart disease, diabetes mellitus, dementia, muscle weakness, difficulty in walking, and chronic pain.	F 314	On 12/8/2014 the Administrator followed up with those residents who were in attendance of the resident council meeting related to the cleanliness of the facility, there were no unresolved concerns or complaints reported.  2. On 12/11/2014 the Administrator conducted an audit of resident rooms, including Resident #16, to ensure resident rooms were cleaned, kept in neat order and comfortable temperatures for residents any concerns were addressed at that time.  On 12/8/2014 the SSD interviewed residents in regards to outstanding concerns or complaints related to cleanliness of the facility and their rooms; no concerns were reported at that time.  On 12/8/2014 the Maintenance Director checked the seals of all resident room windows with no further concerns identified.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 9</p> <p>The 1/27/14 Initial Nursing Summary did not document any skin integrity issues to the resident's buttocks.</p> <p>The resident's initial Care Plan documented on 1/27/14, a focus for "Skin: risk for impaired skin integrity..." Interventions included:</p> <ul style="list-style-type: none"> <li>- Turn and reposition when in bed (frequency not indicated)</li> <li>- Pressure reducing cushion to wheelchair (WC)</li> <li>- Daily skin inspection during cares. Notify LN</li> <li>- Apply protective barrier cream after each incontinent episode</li> <li>- Avoid friction and shearing. Use turn sheet for repositioning.</li> </ul> <p>The 2/13/14 Admission MDS, documented the resident's cognition was intact and he was at risk of developing pressure ulcers.</p> <p>The Nurses Notes (NN), Telephone Orders (TO), TAR and Condition Change Form (CCF) documented:</p> <ul style="list-style-type: none"> <li>- NN 3/31/14 - 4/8/14, Resident #2 had six complaints about a sore bottom. The NN documented the resident had a red bottom and that barrier paste had been applied. One entry documented the resident did not have any redness to the buttocks. The notes documented the resident refused to reposition to bed and remained in the recliner.</li> <li>- NN 4/10/14 at 4:00 AM, "Dressing intact to L (left) buttock."</li> <li>- TO 4/10/14 at 9:30 PM, "Duoderm to buttocks to promote skin integrity. Change every 72 hours and PRN (as needed). Use adhesive remover to</li> </ul>	F 314	<p>On 12/8/2014 the Maintenance Directed checked temperatures of all resident rooms and observed temperatures ranging between 71 and 80 degrees.</p> <p>12/8/2014 the SSD completed interviewed with residents and/or families regarding any concerns related to the temperature or comfort of their rooms; no concerns reported at that time.</p> <p>3. The following systemic changes were implemented to ensure that the facility will identify and implement preventative measures to decrease the risk of resident rooms having dust bunnies and particles on floor mats to ensure cleanliness, and the feel of a draft in the room.</p> <p>The facility will incorporate in addition to the weekly checks on both window seals and room temperatures by the Maintenance Director a routine preventative check of all windows to include the seals in the fall, winter, spring and summer seasons. Concerns will be addressed immediately.</p> <p>The facility has implemented an auditing tool for the housekeeping manager or designee to conduct daily room rounds to ensure cleanliness of rooms including</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 314	<p>Continued From page 10 remove dressing." This order was not signed by the physician.</p> <p>- NN 4/11/14 at 1:00 PM, "...duoderm placed to buttocks r/t [related to] incon[inence] dermatitis."</p> <p>- NN/CCF 4/11/14 at 4:00 PM, the resident experienced an "increase in the number of loose stools over the past 7 days with periodic episodes of incontinence."</p> <p>- NN 4/18/14 at 3:20 AM, "Buttock open area without change. Resident refused to lay [sic] on the bed to decrease pressure."</p> <p>- NN 4/20/14 at 4:10 PM, "Area to L buttock cleansed and duoderm applied to promote skin integrity. Resident educated on repositioning every 2 hours and to keep duoderm to area to protect."</p> <p>- 4/22/14, The resident presented to his primary physician with "open wound concerns." The physician documented, "...has persistent sacral, perianal changes. The sacral area has some superficial ulcers," and "Decubitus skin ulcer." No physician orders were attached to this visit note.</p> <p>- NN 4/24/14 at 10:30 AM, "Continues to have open area to buttocks r/t incontinence. Trial Boudreaux Butt Paste but appeared to dry buttocks out, so changed to duoderm. Resident stated that he doesn't like the duoderm and feels like it's tearing the skin off and continues to be dry. Resident states today that he 'itches' and picks at it because it's dry. Will trial TAO [triple antibiotic ointment] with island dressing. Will be at increased risk for poor healing d/t [due to] diabetes, incontinence, diarrhea, as well as</p>	F 314	<p>bedside floor mats, under the bed and behind the furniture. Concerns identified will be addressed immediately, including evaluating the need for increasing the number of times a room is cleaned daily. These findings will be reviewed the Administrator. The Administrator or designee will conduct weekly environmental rounds to ensure a clean and comfortable environment is being maintained. The facility Administrator or designee will follow up bi-weekly with the residents in forum regards to the cleanliness and temperatures of their rooms. Additional concerns at that time will be addressed as indicated.</p> <p>On 12/23/2014 the Housekeeping Manager was re-educated by supervisor on routine monitoring of the cleanliness of the facility.</p> <p>Beginning 12/9/2014 staff were re-educated by the Staff Development Coordinator on providing a clean and comfortable environment for residents and process of reporting concerns for follow up.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 11 compliance and choice to remain in recliner for resting periods."</p> <p>-Nurse Practitioner (NP) note 5/1/14, The resident presented to the wound clinic with a coccyx wound that "developed a few weeks ago." The the following was documented: A wound to the coccyx region, length 1 cm, width 0.5 cm, depth 0.1 cm.; Wound bed is 100% granular with defined wound edges; Resident admits to sleeping in chair and not ever lying in bed; He has difficulty getting off of his backside d/t musculoskeletal issues and back pain; Coccyx wound d/t pressure; Utilize Barrier Ointment on the coccyx area twice daily (Signed physician order provided); Memory foam for chair (Signed physician order provided).</p> <p>-NN on 5/8/14 at 10:50 AM documented, "Resident was seen at [the wound clinic] on 5/1/14," and "...barrier cream to buttocks BID (twice daily), memory foam for chair."</p> <p>The facility had identified the resident sat in a recliner for long periods of time but did not implement pressure relief until the resident developed a pressure ulcer and the physician ordered memory foam for the chair.</p> <p>-Wound Clinic 5/15/14, The NP documented the following: L[eft] gluteal wound measurements as, length 1 cm, width 0.4 cm, depth 0.1 cm; The wound bed is 100% granular with defined edges; Stage 2. A plan was documented as, "The resident was</p>	F 314	<p>4. Beginning the week of 1/4/2015 the Administrator or designee will conduct audits weekly of the facility environment for 4 weeks, monthly for 2 months and quarterly thereafter to ensure a safe, clean and comfortable environment continues to be provided as required. A report will be submitted to the Quality Assurance Performance Improvement Committee monthly for three months to review the results and determine if any further interventions are needed at that time. The Administrator is responsible for monitoring and follow-up.</p> <p>Date of compliance: 1/4/2015</p> <p>F309</p> <p>1. On 12/9/2014 Resident #8 was re-assessed by the Social Service Director for concerns related to report of bladder care plan not being followed; no change in mood or behavior noted.</p>		

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F 314	<p>Continued From page 12 encouraged to get off his gluteal region on a regular basis, turning every 1 hour to relieve pressure to the gluteal region" and "Barrier cream to L gluteal wound 3 times daily" (Signed physician order provided).</p> <p>-TO 5/23/14 at 4:05 PM, documented a change to the treatment to the buttocks with "Mepilex Ag and hypafix tape 3 times a week." The form was signed by the LN and indicated the resident's family was notified of the change. The order was not signed by the physician</p> <p>- Wound Clinic 6/6/14, the resident presented to the wound clinic "to recheck buttocks wounds ..." The physician documented, "Left gluteal fold. Keep dry, just ensure pressure ulcer protection and follow up as needed."</p> <p>A 8/1/14, Quarterly Review Skin assessment using the Braden Scale, documented the resident was a "2" indicating a minimal risk to develop a pressure ulcer. On 11/6/14, the resident was screened for pressure ulcer risk on the Norton Plus Pressure Ulcer Scale. The resident's score of "11" indicated the resident was a high risk for developing pressure ulcers.</p> <p>Throughout this survey, the resident was observed, on several occasions, seated in the recliner for long periods of time including the following: 12/2/14 at 1:32 PM and 2:58 PM, on 12/3/14 at 9:37 AM, 1:00 PM and 2:00 PM, on 12/4/14 at 8:30 AM and again at 10:52 AM.</p> <p>On 12/3/14 at 9:37 AM, the resident was asked by the surveyor if he ever had a memory foam or pressure reducing cushion to sit on while in his chair to relieve pressure. The resident replied,</p>	F 314	<p>On 12/12/2014 Resident #8 was re-assessed by the Staff Development Coordinator related to toileting needs. The assessment revealed that resident #8 is not a candidate for bladder retraining related to her functional and cognitive impairment. The toileting plan for resident #8 will be providing incontinent care 2-3 times a shift and as needed.</p> <p>On 12/15/2014 Resident #8's elimination care plan was reviewed and updated by the Staff Development Coordinator to reflect resident #8's current toileting plan. The C.N.A care card was has been updated to reflect current toileting needs.</p> <p>A root cause analysis was completed by the IDT on 12/22/14 to determine why the staff was not toileting the resident. It was determined the resident's care plan was updated to reflect resident's current toileting needs, however when the new care plan was printed the changes made were not carried to the newly printed care plan.</p> <p>The reprinted care plan was updated to reflect resident current needs based on assessment.</p> <p>2. On 12/22/2014 an audit of resident toileting needs was completed by the Unit Manager and the Director of</p>	
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F 314	<p>Continued From page 13</p> <p>"No, I haven't had a cushion to sit on." When asked about bottom pain when sitting, the resident responded, "It hurts. I think they started using Bag Balm on my bottom last week."</p> <p>On 12/3/14 at 9:45 AM, LN#2 was asked if he/she provided skin care to the resident's bottom. LN#2 replied, "Yes, I've done it already today. He doesn't always wipe clean." LN#2 was asked if staff provided assistance to the resident with peri-care. The LN#2 replied, "Not always, he wants to be pretty independent."</p> <p>On 12/4/14 at 3:55 PM, the DON was interviewed regarding the documented pressure ulcer and the physician order to provide a memory foam cushion to the resident's chair. The DON stated, "When the doctor diagnosed a stage 2 pressure ulcer, I got on the phone with him and talked to him about the resident's diarrhea and peri care. He changed the diagnosis to "related to peri care." The DON continued, "I don't know anything about the memory foam pad."</p> <p>On 12/5/14 at 10:00 AM, the resident agreed to let this surveyor look at the skin on his/her bottom. LN#1 and LN#7 assisted the resident with exposing the skin. LN#1 said, "The skin is pink and intact, no rashes." The surveyor observed the skin on the buttocks and in the gluteal fold to be red but intact and without rashes or evidence of skin breakdown. The surveyor did observe a bath towel and a cloth chucks pad, both wrinkled, on the recliner. The surveyor noted the absence of a pressure reducing or memory foam cushion on the resident's recliner.</p> <p>On 12/5/14 at 2:40 PM, the Administrator and the DON were notified of the findings. No additional</p>	F 314	<p>Nursing (DON) to ensure toileting needs are reflected on the plan of care and C.N.A care card.</p> <p>3. The following systemic changes were implemented to ensure that residents' current toileting needs reflect residents' current status on both the care plan and C.N.A care card.</p> <p>Upon printing of the resident's comprehensive plan of care by the MDS nurse, it will be reviewed by the IDT to ensure that resident's current toileting needs reflect resident's current status on both the care plan and C.N.A care card. This review will include comparison of previous or initial care plan.</p> <p>The plan of care will be reviewed by the IDT on admission, re-admission, quarterly and significant changes to ensure it reflects the resident current toileting needs.</p> <p>Beginning 12/9/2014 nursing staff were re-educated on assessing residents toileting needs, by the Staff Development Coordinator to ensure residents receive toileting care needs per resident's care plan, care plans reflect the residents current needs, and reporting to the nurse when there is a change in the resident's toileting status.</p>		

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F 314  F 318 SS=D	<p>Continued From page 14 information was provided.</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility did not ensure 2 of 6 residents (#1 &amp; 15) with range of motion (ROM) limitations were provided a ROM program and discontinued a physician order for an RNA program. This created the potential for for further decline in their physical abilities. Findings include:</p> <p>1. Resident #15 was admitted to the facility on 9/19/12 with multiple diagnoses that included neuropathy, bipolar disorder, and anxiety.</p> <p>The most recent Quarterly MDS Assessment, dated 9/7/14, and most recent Annual MDS Assessment, dated 12/6/14, both documented the resident's cognition was intact, did not have behaviors of rejecting care, had upper extremity functional limitations in ROM on one side, and had lower extremity functional limitation in ROM on both sides. The resident needed extensive assistance of one person for bed mobility, transfers, walk in room, walk in corridor, dressing, toilet use, personal hygiene, and bathing.</p>	F 314  F 318	<p>4. Beginning the week of 1/4/2015 the Director of Nursing or designee will conduct audits weekly for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure care plans continue to be reflective of residents toileting needs and continue to be followed as required. A report will be submitted to the Quality Assurance Performance Improvement Committee for three months. The Quality Assurance Performance Improvement Committee will review the results and determine if any further interventions are needed at that time. The Director of Nursing is responsible for monitoring and follow-up.</p> <p>Date of compliance: 1/4/2015</p> <p>F314</p> <p>1. On 12/8/2014 Resident #2 was re-assessed by the Social Service Director for psychosocial needs with no change in mood and behavior noted.</p>	

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F 318	<p>Continued From page 15</p> <p>The resident's ROM program documented the resident had participated in the RNA program but had been discharged from the program in September 2014.</p> <p>Review of the Nursing Rehabilitation Functional Maintenance/Wellness Program Tracking, for the months of May and June 2014, documented under the monthly review section, "Discontinue per resident OOF (out of facility) times 3 days per week and cannot fulfil requirements of RNA."</p> <p>Physician recapitulation orders, dated August 2014, and signed by the physician on August 13, 2014, documented the resident had started on a RNA program on 3/28/13. A line was drawn through the order with a note to "D/C (discontinue)" hand written next to it.</p> <p>A Telephone Order - Physician Please Sign and Return form signed and dated by an LN on 9/5/14 at 11:00 PM documented, "Nursing order to D/C from RNA Program." The date ordered section documented, "Clarification," with no date provided. The section of the form that documented when resident or family had been notified of the above treatment change was not completed. The signature of the physician and date section was blank.</p> <p>On 12/4/14 at 1:45 PM, LN #1, Nurse Manager (NM) for the RNA program, stated the resident was no longer on the RNA program because she attended a life skills program outside of the facility from 9:00 AM to 2:30 PM on Tuesday, Wednesday and Thursday. LN #1 did not explain why a ROM program was not developed for a resident who was out of the facility for 3 days.</p>	F 318	<p>On 12/12/2014 Resident #2 was re-assessed by the Staff Development Coordinator for the type of cushion needed to promote skin integrity, to ensure physician had been notified of changes in status, and ensure physician's orders were signed and followed.</p> <p>A root cause analysis was completed by the IDT on 12/22/14 to determine why the resident refuses to reposition into the bed. The resident spent most of his time in the recliner prior to admission to the facility. The resident is more comfortable in the recliner and the family brought the recliner per the resident's request. Resident has agreed to the use of memory foam in his recliner per physician's signed orders. The resident remains with intact skin.</p> <p>On 12/15/2014 Resident #2's care plan was reviewed and updated by the Staff Development Coordinator to reflect the resident's current status and interventions to promote skin integrity.</p> <p>A root cause analysis was completed by the IDT to determine why the physician was not notified timely related to change in skin integrity. The resident's slight skin irritation initially responded well with nursing interventions and</p>	
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F 318	<p>Continued From page 16</p> <p>She then stated that nursing could discontinue residents from the RNA program. LN #1 stated the corporation had revamped the RNA Manual and she had recently taken over the RNA program. LN #1 was asked how a resident with limitations was referred to the RNA program and she did not respond. When asked if she had criteria or a system for residents with limitations who needed RNA, LN #1 did not respond.</p> <p>On 12/5/14 at 8:55 AM, the DON was asked if it okay for a nurse to discontinue a physician order and she stated, "It's not."</p> <p>On 12/5/14 at 12:25 PM, the Administrator and the DON were informed of the findings. Additional information was provided by the facility on 12/8/14 which did not resolve the concern.</p> <p>2. Resident #1 was re-admitted to the facility on 5/5/14 after experiencing a fall on 4/29/14 that resulted in a right (R) hip fracture. Diagnoses include status post open reduction internal fixation to R hip, sepsis (possibly due to aspiration pneumonia), atrial fibrillation, and chronic respiratory failure.</p> <p>The resident's Initial Nursing Summary, dated 5/5/14, documented intact cognition and ROM limitations to the R lower extremity (RLE).</p> <p>The resident's initial Care Plan dated 5/6/14 included, a focus for "... self-care deficit, DVT r/t (deep vein thrombosis related to) fracture, immobility, pain, and surgical wounds." Interventions included: *PT eval (Physical Therapy evaluation) and treat as ordered, and *OT (Occupational Therapy) eval and treat as</p>	F 318	<p>barrier cream, once the barrier cream was no longer effective the physician was notified. The licensed nurses were re-educated to notify the physician related to change in resident's skin integrity including skin irritations.</p> <p>A root cause analysis was completed by the IDT, including the Medical Records Clerk, on 12/22/14 to determine why the physician did not sign the telephone order written at the facility. It was determined there were two reasons for the missed signature from the physician.</p> <ol style="list-style-type: none"> <li>A. The physician acknowledged, signed and agreed with requested orders through the facility communication sheets.</li> <li>B. The staff wrote a telephone order related to this request.</li> <li>C. The medical records clerk sent out to the physician's office a yellow copy (carbon copy) instead of the original copy (white copy).</li> <li>D. The yellow copy (carbon copy) was signed by the physician on 5/1/14.</li> </ol> <ol style="list-style-type: none"> <li>A. Recommendation from the wound clinic dated 5/23/14 signed by the wound clinic physician was faxed to the resident's primary physician.</li> </ol>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 318	Continued From page 17 ordered  PT Daily Treatment Notes documente the resident started PT services on 5/6/14 and discharged on 6/6/14, "...with minimal gains in strength, balance and transfers due to increased RLE pain and increased behaviors." The documentation included: - On 6/2/14, "Patient very afraid of falling and kept yelling out when trying to stand up. Patient has very poor standing balance, safety awareness, and endurance." - On 6/3/14, "Patient stood well and participated with transfer. Patient refused several times to ambulate or do Omnicycle today." - On 6/4/14, "Patient did not want to even enter the therapy room today and screamed "NO" several times." - On 6/5/14, "Patient's behaviors have worsened this week and last day of PT will be 6/6/14." - On 6/6/14, "Patient is discharged to routine nursing care due to non-participation with PT. Patient refused to enter PT room, will not perform the ex (therapy exercises), standing, or transfers anymore. Patient's behaviors have increased." - On 6/11/14, the Physical Therapy Plan of Care documented the reason for referral was, "...necessary for strengthening, ROM, safety, balance... to return to PLOF (previous level of function). Without therapy, the patient is at risk for further debility, more falls, pneumonia, and death." The Discharge Plan of Care was documented, "Remain at SNF with Functional Maintenance Program."  There was no evidence the facility implemented a Functional Maintenance Program or re-evaluated the resident for a ROM program when discharged from the PT program to ensure the resident did	F 318	B. A telephone order was written based on the recommendations of the wound clinic physician. C. The telephone order was not sent to the primary physician. Medical records clerk and staff concluded the wound clinic recommendations signed by the wound clinic physician stands as an acceptable signed telephone order.  2. On 12/22/2014 an audit of residents was conducted by the  IDT to identify residents at high risk for skin impairment to ensure preventive measures were in place and care planned was updated. The physician was notified for any changes in skin conditions identified and orders were obtained as needed. Medical Records conducted audit to ensure that original telephones order were signed by the physicians.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 318	<p>Continued From page 18</p> <p>not experience a decline in function or decreased range of motion.</p> <p>On 8/18/14, PT screened the resident to "improve transfer status." PT observations included, "Pt [patient] able to complete pivot transfer x1 person from W/C [wheelchair] to toilet, W/C to bed consistently with CNA/nursing staff." PT documented the reason for not providing treatment as, "Patient refused to work with therapy staff and shook head "no" to completing more therapy for anything today."</p> <p>On 12/5/14 at 10:47 AM, LN#1 was asked if the resident had been evaluated for the RNA program documented in the PT discharge plans. LN#1 replied, "The resident was on the RNA program prior to the hip fracture and has not been in the program since being readmitted." LN#1 further stated, "The resident refused to participate in the PT program. She wouldn't participate in ambulation or standing. She even refused to go into the therapy room." When asked if the resident had been evaluated for an active/passive ROM program, LN#1 replied, "No, but I'll look into it." No additional information was provided.</p>	F 318	<p>3. The following systemic changes were implemented to ensure the facility will improve its ability to identify and implement preventative measures to decrease the risk of changes in skin condition related to, resident refusals of interventions, physician orders signed and timely notification to the physicians of changes in skin conditions.</p> <p>The facility will identify skin issues through, but not limited to, incidents and accident reports, 24 hr. report, and morning clinical meeting. Skin issues identified will be evaluated to ensure a plan of care has been developed.</p> <p>Resident's identified with skin issues will be reviewed weekly and PRN to ensure, but not limited to:</p> <ol style="list-style-type: none"> <li>1. Monitor for decline and progress.</li> <li>2. Notify MD of any changes in skin condition including refusal of treatment.</li> <li>3. Initiate alternative interventions related to resident's refusal of treatment.</li> <li>4. Evaluate effectiveness of the plan of care developed.</li> </ol>	
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p>	F 323	<p>The facility has also incorporated a new tracking tool. The tracking tool will provide a comprehensive overview of measures implemented for wound healing. The tracking tool will be utilized during weekly clinical rounds to ensure measures are in place and issues are addressed.</p>	

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F 323	<p>Continued From page 19</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and review of the facility's incident reports, it was determined the facility failed to ensure residents received adequate supervision and/or assistive devices to prevent multiple falls and a fall with injury requiring surgical intervention. This was true for 2 of 9 (#'s 5 &amp; 7) sampled residents. Resident #5 continued to fall after sustaining a fracture and was placed on hospice for failure to thrive. Resident #7's multiple falls with the facility's continued reliance on assistive devices placed the resident at risk for significant injury. Findings include:</p> <p>1. Resident #5 was admitted to the facility on 7/30/14 with diagnoses of right greater trochanteric fracture, dementia without behavior disturbances, muscle weakness, difficulty in walking, and bone and cartilage disorder. The resident was readmitted on 10/4/14 with a fracture of the left femoral neck. The 8/6/14 Admission MDS coded the resident had severely impaired cognition and required extensive assistance of two or more persons for transfers, toileting, and bed mobility. The 10/18/14 Admission MDS coded the resident required total assistance of two people for transfers. The Initial Nursing Summary, dated 10/4/14, documented the resident had a BIMS score of 2. Directly to the left of the BIMS scoring, the nursing summary listed potential 1:1 as a nursing intervention for scores of 0-7. The care plan, dated 7/31/14 and 8/14/14, identified Resident #5 was at risk for falls related to: History of falls, decreased safety awareness, non-weight bearing status related to a right hip</p>	F 323	<p>The medical records clerk was re-educated by the Administrator that original (white copy) telephone orders will be sent to physician's office for signature. The medical records clerk will perform a chart audit weekly to ensure all original telephone orders (white copy) have been signed by the physician.</p> <p>Beginning 12/9/2014 staff were re-educated by the Staff Development Coordinator on ensuring residents at high risk for skin impairment have preventive measures and interventions are care planned and in place, physicians are notified timely of changes in status regarding skin integrity and that physician's orders are followed and signed by the physician</p>	
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F 323	Continued From page 20 fracture, weakness, dementia, and psychotropic drug use. Care plan interventions, dated 7/31/14, included: two person assist with transfers, pressure alarm when in bed, and monitor for changes in condition that warrant increased supervision/assistance. On 8/1/14 an intervention of every checking the resident every 15 minute was added. Nurse's Notes (NN) from 8/2/14 through 12/2/14 documented the resident had episodes of confusion, was non-compliant with using the call light, had multiple attempts to self transfer and staff needed to anticipate his needs. An Incident Report (IR) dated 9/30/14 documented, "...At approximately 8:15 PM a loud noise was heard from outside resident's room and upon entering resident's room he was lying supine on the floor in the doorway between his bathroom and bedroom. The resident explained to the LN he was trying to get back to his bed [after] using the restroom. There were no signs of injury, however the resident complained of left knee pain and sustained a 3.8 cm x 1.2 cm skin tear to the left elbow." Safety devices in place prior to the fall included an alarm to the resident's bed. The IR documented, "Approx[imately] 15 min[utes] prior [to the fall], this LN helped resident get into bed. Alarm sounded when resident sat on alarm pad. Non-skid socks in place ..." The facility replaced the alarm due to a "short in the alarm or something that was inconsistent." NN dated 10/1/14 at 10:30 AM, documented, "LN reports resident c/o [complains of] L[eft] knee pain this AM. No complaints of pain upon palpation from hip/thigh on left side down to foot. Asked resident if he has any pain again, states it only hurts 'here' and points to L[eft] medial aspect of the knee...Adduction of LUE [left upper extremity] resident grimaced and c/o pain,	F 323	4. Beginning the week of 1/4/2015 the Director of Nursing or designee will conduct audits weekly of residents at high risk for skin impairment for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure care plans continue to be reflective of residents needs related to skin, preventive measures and interventions continue to be care planned and in place, physicians are notified timely of changes in status regarding skin integrity, and that physician's orders are signed and followed. A report will be submitted to the Quality Assurance Performance Improvement Committee monthly for three months. The Quality Assurance Performance Improvement Committee will review the results and determine if any further interventions are needed at that time. The DON is responsible for monitoring and follow-up.  Date of compliance: 1/4/2015		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 21 immediately stopped and asked where pain was located and resident pointed to top of L[eft] knee. Order received by Medical Doctor (MD) to x-ray of the left knee and hip. "Knee x-ray consistent [with] arthritis, [zero] acute injury noted. L[eft] hip x-ray conclusion reads acute [fracture] on L[eft] intertrochanteric region." On 10/1/14, Resident #5 was transported to a local hospital where the Operative Report documented the resident had an open reduction internal fixation of his left hip. The hospital History and Physical dated 10/1/14 documented, hospital admission was related to an acute fracture of the left femoral neck. Additionally, the resident had a closed fracture of the right greater trochanter. The physician documented the resident was admitted in 7/2014 for a right hip fracture and was placed in a nursing home, "as he was, falling too many times at home." An IR, dated 10/4/14 at 7:15 PM, documented, "Residents [sic] alarms sounding prompting nursing staff to immediately entire [sic] room. Apon [sic] nurse entering the RM [room] resident had BLE [bilateral lower extremities] hanging off bed when the alarms went off. Nurse was able to assist resident to the floor...no injury, denied pain." Safety devices in place prior to fall included, "bed alarm and socks." Interventions implemented after the fall included: "Resident provided with urinal, to be kept within reach while in bed; one to one [1:1] started 10/5/14 for [increased] supervision and patterning/monitoring [times] 72 [hours] for any latent injuries." On 10/22/14 an order was received for a hospice consult, evaluation and treatment. The resident's care plan included a problem of "failure to thrive" with a start date of 10/22/14. On 12/4/14 at 9:00 AM, the DON, Administrator,	F 323	F318  1. On 12/9/2014 Resident #15 was re-assessed by the Social Service Director for psychosocial needs related to ADLs and no change in mood and behavior noted. On 12/12/2014 Resident #15 was re-assessed by the Staff Development Coordinator for current physical needs, including range of motion and based on the assessment and review by the IDT, the resident was referred to physical and occupational therapy for new straps to leg braces and ambulation to ensure needs are identified and met per plan of care.  On 12/15/2014 Resident #15's care plan was reviewed for ADLs and updated as indicated by the Staff Development Coordinator to reflect current status. A root cause analysis was completed by the IDT on 12/22/14 to determine why the resident's restorative range of motion was discontinued. It was determined that the resident was out of the facility three times a week participating in a life skills program and the facility did not provide alternative time for restorative program.		

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F 323	Continued From page 22 and CSC were interviewed related to the falls on 9/30 and 10/4/14. The DON stated for the fall on 9/30/14 the facility determined the "pressure alarm either had a short or something that was inconsistent" in the alarm. She stated the resident was not independent, had not been using his call light, and was placed on 15 minute checks on 8/1/14. The DON stated the 15 minute checks should be on the 8/14/14 fall care plan; however, the checks were not carried over from the temporary care plan. The DON stated that after the fall on 10/4/14 the facility made sure a urinal was within the resident's reach, continued the 15 minute checks and added bolsters and an air mattress to the resident's bed. When asked if these interventions had been added to the resident's care plan, the DON stated the 15 minute checks were on the fall care plan but the bolsters and air mattress which should be on the skin care plan were not. NOTE: The facility provided documentation for the 15 minute checks from 8/1/14 through 11/10/14. There were inconsistencies in the resident's location and initials of who performed checks. The 10 PM to 6 AM shift was not filled out for 9/11 and 11/1, the 2 PM to 10 PM section was not filled out for 11/10, and there was no documentation for 9/23, 25, 26, 27, and 28. The facility was unable to provide documentation of the 15 minute checks from 11/11/14 through 11/30/14. An IR dated 11/22/14 at 8:00 PM, documented, "Taking another resident to their room. When I heard the alarm go off. Went in he was sitting on the floor with his back against the bed." Five minutes prior to the fall the CNA removed the resident's non-skid socks per his request. The safety interventions identified at the time of the fall was an alarm. Interventions implemented	F 323	A root cause analysis was completed by the IDT on 12/22/14 to determine why the facility did not obtain a physician's discharge order from the restorative program for resident #15. It was determined that the understanding of the facility was that the restorative program was not required to have physician's orders due to it being a nursing facilitated program.  On 12/9/2014 Resident #1 was re-assessed by the Social Service Director with no psychosocial concerns noted. On 12/19/2014 Resident #1 was re-assessed by the Director of Nursing for her current physical needs. Assessment of resident #1 reveals that there were no changes in resident's range of motion. Functional range of motion was provided by the C.N.A during bathing and dressing activities. Assessment also reveals that there was a decrease in residents behaviors related to refusal of care. Resident #1 is now currently on Restorative Program. A root cause analysis was completed by the IDT on 12/22/14 to determine why the resident's restorative range of motion was not initiated when discharged after rehabilitation therapy. It was determined that the resident was under physical therapy treatment from 5/7/14-6/5/14 and 6/11/14-6/25/14.		

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F 323	<p>Continued From page 23 after the fall included: CNA educated on alerting the nurse of refusal of footwear; and, a rug placed at bedside to decrease risk of futher occurrences.</p> <p>An IR dated 11/25/14 at 4:00 PM; documented, "Resident's alarm sounded and upon staff entering resident's room he was sitting on the foot in front of his bed [with] his legs extended out in front of him. Resident was unable to explain why he was wanting up when asked. Continues on 15 min[ute] checks for [increased] supervision." Safety devices in place prior to fall included pressure alarm, non-skid socks, and a mat at the side of the bed. Interventions implemented after the fall included: "Monitor resident times 72 hours for latent injury, will request family to ok room closer to nurses station and will [change] pressure to tab alarm to notify staff earlier of attempts to self transfer."</p> <p>On 12/4/14 at 9:25 AM, the DON, Administrator and the CSC were interviewed related to the resident's falls. The DON stated, for the 11/22/14 fall, the pressure alarm on the resident's bed was found on the floor with the resident. The Administrator stated, "We re-educated staff individually regarding bare feet and non-skid footwear and we added a non-skid rug." For the fall on 11/25/14, the DON stated they added the pull tab alarm to the resident's shoulder to help staff respond sooner and requested a room change closer to the nurse's station. She stated it was only two doors down but was the room closest to the nurse's station. When asked about adding 1:1 supervision or line of site to increase the supervision, the DON stated the resident was on 15 minute checks and moved closer to the nurse's station which was increased</p>	F 323	<p>The citation on the 2567 was based on a daily progress note from physical therapy dated 6/11/14. The final rehabilitation therapy discharge summary dated 6/25/14 recommended that the resident will remain at the skilled nursing facility on routine nursing and that the resident was not appropriate for restorative nursing program due to lack of participation and behaviors.</p> <p>On 12/19/2014 Resident #1's care plan was reviewed for ADLs and updated by the Staff Development Coordinator to reflect current status.</p> <p>2. On 12/22/2014 an audit was completed by the Unit Manager of the residents that have been discharged from the restorative program within the last 90 days to identify if any resident was discharged from the program related to time accommodation. No other residents were identified. The facility ensured that a physician's order to discharge resident from the restorative program was obtained.</p>	

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

PRINTED: 12/22/2014  
FORM APPROVED  
OMB NO. 0938-0391

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F 323	<p>Continued From page 24 supervision.</p> <p>The facility was aware the resident was at high risk for falls, related to a history of falls and a fracture of his right hip in July 2014, confusion, not using the call light, multiple attempts to self-transfer, and an inability to always communicate his needs. The resident fell in the facility on 9/30/14 and required surgical intervention for a left hip fracture.</p> <p>2. Resident #7 was admitted to the facility on 3/20/14 with multiple diagnoses which included dementia with behavior disturbances, muscle weakness, and difficulty in walking. The 3/27/14 Admission MDS documented the resident was severely cognitively impaired but did not have signs of delirium, psychosis and did not exhibit behavioral symptoms. The resident required two persons to assist with transfers and toilet use. For locomotion on and off the unit, the resident required the assistance of one person.</p> <p>The 9/27/14 Quarterly MDS documented the resident was severely cognitively impaired, did have fluctuating signs of delirium which resulted in inattention and disorganized thinking but did not exhibit behavior symptoms. The resident required extensive assistance of two persons for transfers and one person for toilet use. For locomotion on and off the unit, the resident required supervision and setup help only.</p> <p>A 3/20/14 Fall Risk Assessment Profile documented the resident was at high risk for falls.</p> <p>The 3/21/14 Fall care plan documented the resident was at risk for falls related to unsteady gait, history of falls, dementia, poor safety</p>	F 323	<p>3. The following systemic changes were implemented relating to the restorative program and physician's orders were obtained for residents that were discontinued from restorative program. The DON or designee and IDT will review residents who are currently on the restorative program weekly to ensure resident's needs are met including consideration of resident's schedule. Residents who are discharged from Rehabilitation Therapy treatment will be evaluated by therapy to determine the need for a restorative program. The DON or designee will ensure that physician's orders are in place to start or discontinue the restorative program per recommendation of the therapy department.</p> <p>Beginning 12/9/2014 staff were re-educated by the Staff Development Coordinator on ensuring residents that have a noted decrease in their range of motion or change in ADLs are re-evaluated for the need of the restorative nursing program, and resident receives restorative per their schedule or daily routine, and the need to have a physician's order to discontinue the restorative nursing program.</p>		

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F 323	<p>Continued From page 25 awareness, use of psychotropic and narcotic medication, anxiety and self transferring. Interventions included, "Pressure alarm in place when in bed/wheelchair."</p> <p>Record review documented the resident experienced 10 falls from April through November 2014.</p> <p>Fall #1. An IR, dated 4/10/14, documented the resident fell at 10:30 AM while attempting to self transfer from her w/c to a recliner (which belonged to her neighbor). The resident's pressure alarm in her w/c did not sound, appeared to have been pushed back in the w/c due to resident's frequent positioning to front of w/c. The facility added interventions of placing a recliner in the resident's room and to trial a lap buddy restraint to help with her position in the w/c.</p> <p>Fall #2. An IR, dated 4/11/14, documented the resident fell at 4:30 PM from her recliner. The pressure alarm sounded and the resident was found kneeling on the floor facing the recliner. The interventions included a change of the resident's room to the Friendship Cove for added supervision and specialized activities.</p> <p>Fall #3. An IR, dated 4/12/14, documented the resident fell at 8:50 AM, the pressure alarm was not on, and she was discovered lying on her right side on the padded mat at her bedside with a pillow under her head. A One To One Inservice/Counseling Record, dated 4/12/14, documented, "Resident with a fall every day times 3 days. Pressure alarm in place on bed and turned off. After resident fell it was found to be off." A CNA was counseled to check the alarms, at the beginning of her shift and with all cares, to</p>	F 323	<p>4. Beginning the week of 1/4/2015 the Director of Nursing or designee will conduct weekly audits for 4 weeks of residents currently receiving restorative nursing services to ensure resident's needs are met including consideration of resident's schedule and that physician's orders are in place to start or discontinue the restorative program per recommendation of the therapy department, then monthly for 2 months and quarterly thereafter.</p> <p>A report will be submitted to the Quality Assurance Performance Improvement Committee for three months. The Quality Assurance Performance Improvement Committee will review the results and determine if any further interventions are needed at that time. The Director of Nursing is responsible for monitoring and follow-up.</p> <p>Date of compliance: 1/4/2015</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 26</p> <p>ensure they were on and working. Additionally, the resident was placed on 1:1 supervision for 72 hours and added to the bowel and bladder program so she would have a toileting routine.</p> <p>Fall #4. An IR, dated 4/22/14, documented the resident fell at 1:30 PM, when she was found crawling out of her room with the tab alarm behind her. It was determined the resident removed the tab alarm. The resident had a small skin tear to her right forearm. The added interventions included staff education to place 1:1 supervision as needed and placed pressure alarm and tab alarm.</p> <p>Fall #5. An IR, dated 4/27/14, documented the resident fell at 4:20 PM, when she attempted to stand independently. The alarms sounded, staff were within sight but were unable to reach her before she fell. The added interventions included 1:1 supervision in the evenings for 72 hours, auto-lock brakes were added to her w/c and a sentinel seatbelt was to be applied while she was in the w/c.</p> <p>Fall #6. An IR, dated 5/7/14, documented the resident fell at 7:00 PM, when the pressure alarm sounded and she was found on the floor beside her bed. She had been put to bed at her request after receiving a medication for anxiety, which was effective. The intervention added was a low bed with padded mat.</p> <p>Fall #7. An IR, dated 7/6/14, documented the resident fell at 10:26 PM, when she was found with her head in the doorway of her room, lying on her left side facing her bed. Staff were re-educated on alarm checks and to check alarms with rounds at shift change. This</p>	F 323	<p>F323</p> <p>1. On 12/9/2014 Resident #5 was re-assessed by the Social Service Director for psychosocial needs related to falls and no change in mood or behavior noted. On 12/19/2014 Resident #5 was re-assessed for current safety needs by the DON. A new fall assessment was completed to evaluate resident's current fall risk. As a result of the fall assessment, the Resident was placed on 1:1 for increased supervision and remains on 1:1 during the nocturnal shift at this time.</p> <p>On 12/19/2014 Resident #5's fall care plan was reviewed by the Staff Development Coordinator and the DON and updated to reflect current status per fall risk assessment.</p> <p>On 12/9/2014 Resident #7 was re-assessed by the Social Service Director for psychosocial needs related to falls with no change in mood or behavior noted.</p> <p>On 12/19/2014 Resident #7 was re-assessed for current safety needs by the DON. A new fall assessment was completed to evaluate current fall risk and a review current psychotropic medications were</p>		

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F 323	<p>Continued From page 27 intervention, however, was not found on the resident's Fall care plan.</p> <p>Fall #8. An IR, dated 7/25/14, documented the resident fell at 4:00 PM, when the alarm sounded and she was found lying on her back on the floor mat. Staff were re-educated that if the resident was laying awake in bed to assist resident to the w/c and take her to the common area.</p> <p>Fall #9. An IR, dated 9/14/14, documented the resident fell from the w/c when her sentinel seatbelt was not replaced following a shower. A One to One Inservice/Counseling Record documented a CNA was counseled to always place the sentinel seatbelt back on after showering.</p> <p>Fall #10. An IR, dated 11/9/14, documented the resident fell at 7:00 PM, when she was found in the hallway lying in front of her w/c on her right side. It was determined the sentinel seatbelt had not been replaced after supper and staff received education regarding application of sentinel seatbelt after meals. A NN, dated 11/9/14, documented, "Resident was propelling self down hallway and leaned too far forward in w/c and fell out of chair. Bumped head on bumper on walls. Bruise and bump on left forehead. Bruise to top of left hand. No other injuries noted."</p> <p>On 12/4/14 at 10:15 AM, the DON was interviewed in the presence of the Administrator and CSC in regard to the aforementioned falls. The DON gave explanations for each of the interventions added after each fall. She stated the pressure and tab alarms worked when the resident was positioned in the w/c and had not scooted too far forward. When asked if the</p>	F 323	<p>evaluated. Adjustments were made per physician orders.</p> <p>On 12/19/2014 Resident #7's fall care plan was reviewed and updated to reflect current status by the Staff Development Coordinator per the fall risk assessment.</p> <p>A root cause analysis was completed by the IDT on 12/22/14 and it was determined that the facility did not consistently re-evaluate the effectiveness of the interventions put into place for both residents</p> <p>2. On 12/22/2014 an audit was conducted by the IDT to identify residents at high risk for falls to ensure interventions were care planned and in place for safety, supervision, and effectiveness; concerns were addressed as indicated.</p> <p>3. The following systemic changes were implemented to ensure that the facility will identify and implement preventative measures to decrease the risk of residents who are at risk for falls.</p>		

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F 323	Continued From page 28 pressure alarm had been turned on for Fall #3, she stated, "I will have to look at the alarm checks." The DON later provided a copy of the inservice which documented the alarm was found to be off. She stated the resident was a "sort of Houdini" and removed an alarm which had been velcroed to the bed. She stated the facility trialed a lap buddy for a short time but that it did not work for this resident since she could easily remove it. She stated the addition of the sentinel seatbelt had been helpful, but acknowledged the seatbelt had not been replaced after the resident was given a shower. The CNA, who was brand new, was re-educated on making sure seatbelts were placed after showers. She stated staff have been re-educated on alarm checks, especially with rounds at shift change. When asked about the seatbelt which was not replaced after supper, the DON stated that staff was educated to make sure seatbelts were replaced after meals.  On 12/4/14 at 4:55 PM, the Administrator, DON, CSC, and Regional Vice President were informed of the concerns with the falls. On 12/8/14 at 5:02 PM, the facility hand delivered additional information which did not resolve the concern. The facility continued to rely on alarms or other assistive devices as a means of fall prevention for Resident #7 in spite of multiple falls related to the position of alarms in the w/c, alarms not working even though staff had checked them, removal of the alarm or staff not securing assistive devices as needed.	F 323	The DON or designee will review the 24 hour report with the IDT for residents with a change in condition, review incidents and accidents including falls in the morning clinical meeting to ensure effective interventions are implemented. Residents with a fall will be reviewed by the IDT weekly for no less than 4 weeks to ensure effectiveness of current interventions.  Beginning 12/9/2014 staff were re-educated by the Staff Development Coordinator on ensuring safety measures, supervision and safety devices are in place per assessment and care plan, and continue to be effective.  4. Beginning the week of 1/4/2015 the Director of Nursing or designee will conduct audits weekly of residents at high risk for falls for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure safety measures, supervision and devices continue to be in place and effective. A report will be submitted to the Quality Assurance Performance Improvement Committee for three months. The Quality Assurance Performance Improvement Committee will review the results and determine if any further interventions are needed at that time. The Director of Nursing is responsible for monitoring and follow-up.		
F 329 SS=E	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329			

Date of compliance: 1/4/2015

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F 329	<p>Continued From page 29</p> <p>drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure 5 of 9 sample residents (#3, 4, 7, 8 &amp; 9) were free from unnecessary medications. The facility failed to ensure justification for use of psychopharmacological medication and monitor behaviors related to its use, failed to ensure clinical indication for the use of an antipsychotic medication for residents with dementia, and failed to provide justification for duplicate therapy. This practice placed residents at risk for unanticipated declines or newly emerging or worsening symptoms. Findings included:</p>	F 329	<p>F329</p> <p>1. On 12/9/2014 Resident #8 was re-assessed by the Social Service Director for psychosocial needs related to prescribe medication regimen with no concerns noted. On 12/12/2014 Resident #8's physician was contacted by the Staff Development Coordinator regarding resident's behaviors, care plan and current medication regimen; no new orders or recommendations were given.</p> <p>On 12/12/2014 Resident #8 was re-assessed for psychopharmacological needs by the Staff Development Coordinator and no concerns were noted.</p> <p>On 12/15/2014 Resident #8's care plan and behavior monitors were reviewed for psychopharmacological needs and updated by the Staff Development Coordinator and the Social Services Director to reflect current status.</p> <p>On 12/18/2014 the Medical Director was informed by the DON of Resident#8's medication regimen, behaviors and care plan for recommendations and no additional orders were given.</p>		

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F 329	Continued From page 30  1. Resident #8 was admitted to the facility on 7/21/14 with diagnoses which included dementia with behavior disturbance, muscle weakness and anxiety. The 7/21/14 physician Admission orders included Zyprexa (antipsychotic) 10 mg every night and 2.5 mg every morning. The 7/21/14 Care Plan for, "Alteration in mood/behaviors related to diagnosis of Alzheimer's....with behaviors, anxiety, insomnia and hallucinations resulting in...restless/fidgeting, history of striking out at others throwing things" included the following approaches: -Give support and reassurance when anxious -Observe for changes in mood -Determine source of anxiety and precipitating events/observe antecedents to behaviors such as quick approaches, too many directions, physical comfort -Monitor hours of sleep -Reinforce physical activity -Engage in conversation about being in the military -Family reported history of hallucinations of grabbing at air and nonsensical talk to others not present  The care plan did not include specific criteria what "restless/fidgeting looked like (rocking in chair, attempting to get out of chair, grabbing at air etc.) or specify what striking out was (verbal aggression, slapping, kicking etc.). Additionally the CP did not include if the "striking out" and "throwing things" occurred during cares, when in dining room etc. or what the resident was trying to communicate with the behavior (fear, pain, hallucinations etc.). The CP documented the	F 329	On 12/8/2014 Resident #9 was re-assessed by the Social Service Director for psychosocial needs related to medication regimen including duplicate therapy, resident continues to benefit from current medication regimen.  On 12/15/2014 Resident # 9 was re-assessed for psychopharmacological needs by the Staff Development Coordinator for duplicate therapy of antidepressant and residents voices that mood continues to improve and she feels better.  On 12/15/2014 Resident #9's care plan and behavior monitors were reviewed by the SDC and SSD and updated to reflect resident's behaviors displayed to indicate signs and symptoms of depression.  On 12/15/2014 Resident #9's physician was contacted by the Staff Development Coordinator regarding resident's behaviors, care plan and current medication regimen and no new recommendation or orders were given.  On 12/18/2014 the Medical Director was informed by the DON of Resident # 9's medication regimen, behaviors and care plan for recommendations and no additional orders were given.		

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F 329	<p>Continued From page 31</p> <p>family reported a history of hallucinations but it did not indicate the facility had observed the hallucinations being harmful to the resident.</p> <p>A 7/22/14 Psychotropic Medication Care Plan included in the Approach section to administer medication, observe for side effects and identified the Black Box warning for Zyprexa as increased risk mortality in elderly patients with dementia-related psychosis and "is not approved for treatments of patients with dementia-related psychosis."</p> <p>Nurse's Notes, dated 8/14/14, documented the physician was notified that the resident had not had any behaviors.</p> <p>An 8/18/14 physician's telephone order documented the 2.5 mg morning dose of Zyprexa had been discontinued and the 10 mg order was reduced to 5 mg. December 2014 Physician's Orders (recapitulation) continued the order for Zyprexa 5 mg at bedtime for dementia with hallucinations and aggression.</p> <p>Nurse's Notes from 8/20-27/14-8/27/14 documented the resident had not had an increase in behaviors, mood swings or anxiety and/or the resident appeared more alert due to the reduction in the antipsychotic medication.</p> <p>A 9/24/14 Psychotropic and Psychopharmacological Review and Summary (PPRS) documented the resident had no behavioral episodes in 9/2014, was sleeping 5-6 hours per night and had received an antibiotic for a urinary tract infection. The form included a recommendation section to decrease the antipsychotic medication to 2.5 mg at bedtime.</p>	F 329	<p>Resident # 3 was discharged from the facility on 12/18/2014.</p> <p>On 12/9/2014 Resident #7 was re-assessed by the Social Service Director for psychosocial needs related to medication regimen including use of antipsychotic and no concerns noted.</p> <p>On 12/15/2014 Resident #7 was re-assessed by the Staff Development Coordinator for psychopharmacological needs and use of antipsychotic use based on resident's behaviors; recommendation for decrease would cause instability or danger to others.</p> <p>On 12/15/2014 Resident #7's care plan and behavior monitors were reviewed by the SDC and SSD and updated to reflect resident's displayed behaviors.</p> <p>On 12/15/2014 Resident #7's physician was contacted by the Staff Development Coordinator regarding resident's behaviors, care plan and current medication regimen to include recommendation of a Gradual Dose Reduction; no further recommendation's were given.</p>		

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F 329	<p>Continued From page 32</p> <p>The physician had checked the box "Resident is on optimal dose and is clinically stable " and had written, "No reduction." The physician also checked the box "lower dose causes resident danger to self and/or others." The PPRS did not document how the behaviors were harmful to the resident or others.</p> <p>Monthly Psycho-pharmacological Records (PRs) for monitoring the Zyprexa had an area for each day of the month to document the number of incidents. The behaviors were listed as, "picking at things in the air", "hitting out" and "throwing things." Zero behaviors were documented for the month of 11/2014 and 12/1/14 -12/3/14.</p> <p>On 12/1/14 at 1:05 PM, UM #1 was observed assisting CNAs #3 and 4 use the mechanical lift to transfer the resident. The resident did not display behaviors during the transfer. UM #1 stated the resident did not display behaviors and the facility had requested the medication be decreased but the physician had refused.</p> <p>During at least 15 observations, lasting 10-20 minutes each, from 12/1/14 -12/5/14 the resident was observed in the dining room, the common area, during cares and during activities. The resident did not display behaviors of hitting or picking at things in the air.</p> <p>On 12/4/14 at 11:25 AM, UM #1 and the Administrator was informed the care plan did not include how the behaviors were displayed. The Administrator stated the behaviors were listed on the behavior monitor sheet. When asked how the behaviors were harmful to the resident, the Administrator stated the grabbing at air could cause the resident to fall. The Administrator</p>	F 329	<p>On 12/18/2014, the Medical Director was informed by the DON of Resident #7's medication regimen, behaviors and care plan for recommendations and no additional orders were given.</p> <p>On 12/19/14 had an offsite visit with her mental health care provider and medications were adjusted related to displayed behaviors.</p> <p>On 12/8/2014 Resident #4 was re-assessed by the Social Service Director related to duplicate therapy of antipsychotic therapy with no psychosocial concerns noted.</p> <p>On 12/12/2014 Resident #4 was re-assessed by the Staff Development Coordinator for duplicate therapy of antipsychotic and no concerns were noted. Resident was also seen by mental health provider and AIMS</p> <p>was negative for any abnormal movement. No change in orders was given, and continues need for duplicate therapy of antipsychotic for diagnosis of chronic condition of schizophrenia.</p> <p>On 12/15/2014 Resident #4's care plan and behavior monitors were reviewed and updated as needed by the SDC and SSD to reflect clinical need and displayed behaviors.</p>		

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

PRINTED: 12/22/2014  
FORM APPROVED  
OMB NO. 0938-0391

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F 329	<p>Continued From page 33</p> <p>stated she would provide documentation the behaviors were harmful to the resident.</p> <p>On 12/2/14 at 4:40 PM, the DON stated the Medical Director would be contacted when the facility identified a medication needed to be reduced and the physician did not approve the reduction. However, the facility provided no documentation that the Medical Director had been informed of the failure of the physician to decrease the resident's Zyprexa.</p> <p>On 12/8/14 at 5:02 PM, the facility provided a 7/22/14 Nurse's Note which documented the resident was, "observed to flex forward...reach for unseen things by feet." A Status Change form was also provided which documented the resident was "at bedside on floor." An undated addendum for a 7/28/14 Social Service Note documented the son had stated, "...last time any changes had been attempted on her psychotropic medications she went into a bad tail spin." All information provided was prior to the Nurse's Notes from 8/20/14- 8/27/14 that documented the resident was more alert with no increase in behaviors after the reduction in medication.</p> <p>2. Resident #9 was admitted to the facility on 8/12/14 with diagnoses which included venous insufficiency, heel pressure ulcer, and depression.</p> <p>The 11/19/14 Quarterly MDS assessment documented the resident was cognitively intact.</p> <p>An 11/14/14 telephone Physician Order documented the resident was to receive Remeron (antidepressant) 15 mg at bedtime for depression. On 12/1/14 the medication was</p>	F 329	<p>On 12/15/2014 Resident #4's physician was contacted by the Staff Development Coordinator regarding resident's behaviors, care plan and current medication regimen to include recommendation of a Gradual Dose Reduction and no new orders were given.</p> <p>On 12/18/2014 the Medical Director was informed by the DON of resident #4's medication regimen, behaviors and care plan for recommendations and no additional orders were given.</p> <p>A root cause analysis was completed by the IDT team on 12/20/14 concerning to the lack of documentation related to justification if medication and behavior monitoring for psychopharmacological medications. It was determined the nurses need to be re-educated on completing care plans need to provide more specific behaviors that need to be monitored. The physician needs to be reminded of the requirement of providing more supporting documentation for the clinical indication for the use of antipsychotic medications.</p>	

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

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F 329	<p>Continued From page 34</p> <p>increased to 30 mg at bedtime. A 12/2/14 Nurse's Note documented the resident complained of feeling overly drowsy and stated, "I feel like I can't wake up all the way." The physician was contacted and reduced the medication to 22.5 mg.</p> <p>The resident's 8/26/14 Care Plan for Depression documented the resident was at risk for self isolating as exhibited by withdrawal from activity and putting self on bed rest. The Approach section included to observe for changes in mood, tearfulness, sad/pained facial expression, withdrawal from acts of interest, crying, decreased appetite, increased insomnia, feelings of worthlessness and decreased concentration or thought of death. The care plan did not include how feelings of worthlessness was exhibited (statements of being no good, stupid, not able to be independent etc.) or how decreased concentration was exhibited (not able to follow request, respond to questions etc.).</p> <p>PRs for monitoring depression listed behaviors of sad facial expression, self isolation, change in appetite and change in sleep pattern. The PRs did not include an area to document crying, feelings of worthlessness, decreased concentration or stating thoughts of death.</p> <p>The resident's 11/2014 MAR documented the resident received Remeron 15 mg from 11/14/14-11/30/14.</p> <p>The resident's PR for 11/2014 documented the resident had behaviors of "sad facial expression" and "change in appetite" on the day shift, after the medication was started, on 11/15/14, 11/22/14 through 11/24/14. The 12/2014 PR documented 0</p>	F 329	<p>2. On 12/20/2014 an audit of residents on psychotropic medications, care plan, behavior monitoring and Gradual Does Reductions was conducted by the Social Service Director and the IDT to ensure residents were free from unnecessary medications and that care plans and behavior monitors reflect the residents current status; concerns were addressed as indicated.</p> <p>3. The following systemic changes were implemented to ensure that the facility will identify and provide justification for the use of psychopharmacological medications, monitor behavior related to its use and ensure clinical indication for the use of antipsychotic medications for the residents with dementia and provide justification for duplicate therapy.</p>	

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

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F 329	<p>Continued From page 35 incidents of behaviors.</p> <p>On 12/4/14 at 9:00 AM, the Administrator was asked what nonpharmacologic interventions were attempted prior to increasing the medication. The Administrator stated the nurse could identify when the resident was depressed and the resident could tell you if she was depressed. The surveyor stated the care plan did not include to document statements of depression on the PR. The Administrator replied the nurses would document the information in the Nursing Notes.</p> <p>On 12/4/14 3:30 PM, CNA #s 6, 8, and 9 were asked how the resident displayed depression. CNA #s 8 and 9 stated Resident #9 would tell you when she was depressed. The CNAs stated the resident had been sleeping a lot this week as she did not feel well but CNA #9 did not think the resident was depressed. CNA #8 stated the resident had been observed coloring in her room which was an activity the resident enjoyed but the resident had been in bed a lot as she did not feel well. The CNAs stated if they observed signs of depression they would report it to the LN who would document the behavior.</p> <p>3. Resident #3 was admitted to the facility on 7/14/13 with diagnosis which included neuroleptic malignant syndrome, bipolar, depressive disorder, and anxiety state.</p> <p>The resident's 11/2014 Physician Orders (recapitulation) included orders for Trileptal (anticonvulsant) 1200 mg every morning and 600 mg every day for mood disorder, Lamictal (anticonvulsant) 200 mg for bipolar disorder and Ativan (anxiolytic) 1 mg every night at bedtime for depression.</p>	F 329	<p>The facility has implemented a tracking tool that includes justification for the use of psychopharmacological medications and monitoring of resident behaviors. The IDT will develop a comprehensive plan of care for residents identified with behavior and MD orders for psychoactive medications. The care plan will include the clinical indication of use for the psychotropic medication, historical behavior, current presenting behavior and both non-pharmacological and pharmacological interventions. The IDT and pharmacy consultant will meet monthly to review current medication regimen, duplicate therapy, and gradual dose reductions. IDT will present recommendations to physicians. If physician declines the IDT recommendation the facility will ensure that the physician provides supporting documentation for the clinical indication for the use of antipsychotic medications in residents with dementia, justification of the continued need of psychotropic medication and duplicate therapy as needed.</p> <p>Beginning 12/9/2014 staff were re-educated by the Staff Development Coordinator on ensuring residents</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	<p>Continued From page 36</p> <p>The resident's 8/21/14 Care Plan for diagnoses of bipolar and anxiety documented in the Problem Onset, "She will be delusional and believes in a different dimension, vampires, werewolves out to get her, hx (history) of neuromuscular malignant syndrome." It further stated the resident had trouble concentrating, loss of interest in pleasurable activities (her Tablet) and was easily annoyed. The plan did not identify how "trouble concentrating" was exhibited (not able to answer questions, blank stare, following conversation etc.) or how "easily annoyed" was exhibited (telling others to get out of her room, name calling, derogatory statements etc.).</p> <p>The approach section of the plan included to observe for changes in the resident's mood, environmental changes and to monitor for patterns of target behaviors. The care plan did not include how the change in mood was exhibited (crying, statements of self loathing, continual sleep, needing less than 2 hours sleep per day, continual talking etc.) or what environmental changes were (dark room, pulling privacy curtain at all times etc.) It also documented to observe for signs of hyperactivity exhibited by increased compulsive spending, agitation and/or decreased socialization. The care plan did not include how compulsive spending or agitation was exhibited.</p> <p>The resident's 11/2014 PR for monitoring anti-psychotic medication listed behaviors of trouble concentrating, loss of interest in pleasured activities i.e.. tablet, easily agitated and change in sleep. Zero behaviors were documented on the PR. However, the resident did not receive an anti-psychotic medication. Zero behaviors were</p>	F 329	<p>are free from unnecessary medications, care plans and behavior monitors reflect residents current status and interventions are followed and specific behaviors are monitored.</p> <p>4. Beginning the week of 1/4/2015 the DON or designee will conduct audits weekly of residents on psychotropic medication, care plans and behavior monitors for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure residents are free from unnecessary medications by having documented gradual does reduction and of clinical indications in residents with dementia, justification of the use of the medication and that care plans and behavior monitors reflect the residents current status and interventions are followed and behaviors are tracked. A report will be submitted to the Quality Assurance Performance Improvement Committee for three months. The Quality Assurance Performance Improvement Committee will review the results and determine if any further interventions are needed at that time. The Director of Nursing is responsible for monitoring and follow-up.</p> <p>Date of compliance: 1/4/2015</p>		

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

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F 329	<p>Continued From page 37 documented on the PR.</p> <p>The resident's 11/2014 PR for depression listed behaviors of withdrawal from activities of interest, mood changes, tearful, self isolating. The PR did not include what the activities of interest were, how mood changes were identified or what self isolating looked like. Zero behaviors were documented for the month.</p> <p>The resident's 11/2014 PR for monitoring anxiety listed behaviors of restless movement and not able to stay still for long periods. The PR did not document how restless movement was exhibited (pacing hall, rocking back and forth etc.) or define long periods of time (15 minutes, 1 hour etc.) for staying still.</p> <p>On 12/4/14 at 2:00 PM Social Service staff stated the care plan did not include to monitor delusions. The resident had a history of delusions, but did not display them currently. Social Service staff also stated when the resident was agitated, she "rummaged" through her things. The surveyor explained behaviors needed to be observable and measurable to ensure staff were consistent in monitoring behaviors of agitation, restless movement, mood changes etc.</p> <p>On 12/4/14 3:30 PM, CNAs #s 6, 8, and 9 were asked how the resident displayed depression. They all stated they did not know. CNA's #6 and 8 stated the resident would hide her emotions and not show when she was angry or depressed.</p> <p>On 12/5/14 the Administrator and DON were informed of the above concerns. On 12/8/14 at 5:02 PM the facility provided a copy of the 11/2014 behavior monitor for anti-depressant</p>	F 329	<p>F368</p> <p>1. On 12/8/2014 the Administrator followed up with those residents who were in attendance of the resident council meeting regarding bed time snacks and concerns were addressed at that time.</p> <p>A root cause analysis was completed by the IDT team on 12/9/14 to determine why the HS snacks may not have been offered to each resident. It was determined the CNAs needed to be re-educated on the requirements of offering all resident a HS snack not just residents with orders for a snack.</p> <p>2. On 12/9/2014 the Social Service Director conducted an audit by interviewing residents regarding receiving bed time snacks; concerns noted were followed up with at that time.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	<p>Continued From page 38</p> <p>monitoring and the bipolar care plan listed in the above citation. Additionally, the facility provided a CNA Daily Care Guide which documented for "episodes of sad/bipolar..." to "encourage her to talk about what is bothering her, she enjoys listening..." The intervention was highlighted but did not include observable or measurable behaviors for the resident.</p> <p>4. Resident #7 was admitted to the facility on 3/20/14 with multiple diagnoses which included dementia with behavior disturbances, muscle weakness, and difficulty walking.</p> <p>The Admission MDS, dated 3/27/14, documented the resident was cognitively severely impaired, did not have signs of delirium, psychosis or exhibited behaviors. The resident required total dependence on staff needing the assistance of two persons for transfers and toilet use. For locomotion on and off the unit, the resident required the assistance of one person.</p> <p>The Quarterly MDS, dated 9/27/14 documented the resident was cognitively severely impaired, did have fluctuating signs of delirium which resulted in inattention and disorganized thinking but did not exhibit behavior symptoms. The resident required extensive assistance of two persons for transfers and one person for toilet use. For locomotion on and off the unit, the resident required supervision and setup help only.</p> <p>The Physician's Orders for November 2014 (Recapitulation Orders), documented an order for Seroquel 100 mg PO at 5 PM, for the diagnosis of behaviors/aggression, with a start date of 3/20/14.</p>	F 329	<p>3. The following systemic changes were implemented to ensure that the facility will offer bedtime snacks to all residents. The facility has implemented a new process where staff document resident acceptance and refusals of HS snacks offered on a tracking tool. The facility snack cart will be taken to each unit and snacks will be offered by assigned staff during the HS hours. The IDT will review the acceptance and refusal list of residents who were offered a snack during the morning clinical meeting to ensure residents are being offered HS snacks daily. The Administrator will follow up with residents bi-weekly to ensure they are getting offered their snacks as desired and request additional input.</p> <p>Beginning 12/9/2014 nursing staff were re-educated by the Staff Development Coordinator related to the requirements of ensuring residents are offered snack at bedtime even if they do not have an order for a snack.</p> <p>4. Beginning the week of 1/4/2015 the Administrator or designee will conduct audits weekly of staff offering bedtime snacks for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure staff are offering the residents bedtime snacks as resident desires. A report will be submitted to the Quality Assurance Performance</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	<p>Continued From page 39</p> <p>The care plan for behaviors, with a start date of 3/20/14, documented behaviors of yelling, screaming, hitting, slapping, and kicking.</p> <p>The Psycho-Pharmacological Record, for the month of November 2014, documented the facility monitored behaviors of yelling, screaming, hitting, kicking and slapping.</p> <p>Record review did not include documentation by a physician that a gradual dose reduction (GDR) had been attempted or addressed for the antipsychotic medication, Seroquel.</p> <p>On 12/4/14 at 11:20 AM, the DON was asked for physician documentation of a GDR. The DON said she would have to contact the resident's local mental health agency to get that information.</p> <p>On 12/4/14 at 4:55 PM, the DON, Administrator, CSC and Regional Vice President were made aware of the GDR concern.</p> <p>On 12/5/14, information was provided just prior to exit, from the resident's mental health agency. A fax addressed to Whom It May Concern, dated 12/5/14 at 2:07 PM, documented the risks and benefits of Seroquel for this resident and was signed by the physician. However, this information was not available for review during the survey.</p> <p>5. Resident #4 was admitted to the facility on 2/26/10 with multiple diagnoses including schizoaffective disorder, intellectual disability, and presenile dementia.</p> <p>The resident's Annual MDS assessment, dated 7/15/14, and Quarterly MDS Assessment, dated</p>	F 329	<p>Improvement Committee for three months. The Quality Assurance Performance Improvement Committee will review the results and determine if any further interventions are needed at that time. The Administrator is responsible for monitoring and follow-up.</p> <p>Date of compliance: 1/4/2015</p> <p>F371</p> <p>1. On 12/1/2014 the 2 cups that were observed to have food debris or a film on the inside and the third cup that was observed to be pitted and marred was immediately removed and discarded by the Administrator.</p> <p>On 12/11/2014 the current dishwasher was replaced.</p> <p>A root cause analysis was completed by the IDT team on 12/11/14 to determine why the cups had food debris. It was determined the dish machine needed to be replaced and put on the functional maintenance program. The dietary staff needed to be re-educated on monitoring the dishes to ensure they are clean prior to use.</p>		

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F 329	<p>Continued From page 40</p> <p>10/15/14, documented the resident was moderately impaired cognitively, required extensive assistance of one person for bathing, required supervision and setup help only for all other activities of daily living. The resident did not have delusions, manifest behavioral symptoms, and did not reject care by caregivers.</p> <p>Physician's Orders for November 2014 documented the resident was taking two antipsychotic medications: Zyprexa 10 mg PO daily, Zyprexa 5 mg at noon, Zyprexa 20 mg PO at HS (hour of sleep), and Geodon 80 mg po twice daily all for the diagnosis of schizoaffective disorder.</p> <p>Federal Guidance at F-329, specifically regarding duplicate therapy, "refers to multiple medications of the same pharmacological class/category or any medication therapy that substantially duplicates a particular effect of another medication that the individual is taking."</p> <p>During record review it could not be determined why the addition of a second antipsychotic medication was needed.</p> <p>On 12/4/14 at 11:20 AM, the DON was interviewed in the presence of the CSC and asked if the facility had physician justification for the use of duplicate therapy as the resident was taking two antipsychotic medications for the diagnosis of schizoaffective disorder. The DON said she would check with the resident's psychiatric provider.</p> <p>On 12/4/14 at 4:55 PM, the Administrator, DON, CSC, and Regional Vice President were made aware of the concern regarding duplicate therapy.</p>	F 329	<p>2. On 12/11/2014 the Administrator conducted an audit of the current dishware to ensure it was clean and in good condition; no concerns were noted.</p> <p>On 12/11/2014 the Administrator conducted an audit of the kitchen for sanitation to include inspection of equipment; no concerns were noted.</p> <p>3. The following systemic changes were implemented to ensure that the facility will identify and implement preventative measures to decrease the risk of dirty or marred cups identified as clean. The facility implemented a new process for the Administrator to review preventative maintenance reports of the dishware machine. The dietary manager or designee will conduct daily audits of dishware and dishwashing equipment. Any noted concerns will be corrected immediately and reviewed with the Administrator. The Administrator will conduct weekly rounds of the dietary department to ensure equipment is functioning, and the cups are free from being marred or pitted and free of debris. Beginning 12/9/2014 staff were re-educated by the Staff Development Coordinator on ensuring dishware that are used for residents are clean and in good condition prior to resident use.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  TRINITY MISSION HEALTH & REHAB OF MIDLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 41	F 329	<p>On 12/11/2014 the Certified Dietary Manager was re-educated by the Administrator on inspection of clean dishes prior to use and on communicating concerns about equipment.</p> <p>4. Beginning the week of 1/4/15 the Administrator or designee will conduct audits weekly of dishware and equipment for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure dishware is clean and in good condition and equipment is functioning as required. A report will be submitted to the Quality Assurance Performance Improvement Committee for three months. The Quality Assurance Performance Improvement Committee will review the results and determine if any further interventions are needed at that time. The Administrator is responsible for monitoring and follow-up.</p> <p>Date of compliance: 1/4/2015</p>		
F 368 SS=E	<p>Additional information was provided by the facility on 12/8/14, which did not resolve the concern.</p> <p>483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME</p> <p>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident group interview and staff interview, it was determined the facility failed to ensure residents were offered a snack at bedtime for 3 of 7 residents who attended the resident group meeting and had the potential to affect any resident who may enjoy or need a snack at bedtime. Lack of a bedtime snack created the potential for altered nutritional status of residents. Findings included:  On 12/2/14 at 2:10 PM, the resident group was asked about bedtime snacks. Three of 7</p>	F 368			

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

PRINTED: 12/22/2014  
FORM APPROVED  
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F 368	Continued From page 42 residents present stated they were not offered a snack at bedtime, but knew they could request a snack. One resident stated s/he would watch for the snacks and would go to the cart herself to get a snack because the staff did not bring the snacks to the room. Another resident stated they did not offer a bedtime snack but you could request a snack.  On 12/4/14 at 3:30 PM CNA #s 6, 7 and 9 stated the kitchen staff sent snacks with specific resident's name on the snack and those residents received a snack. If a resident requested a bedtime snack, the CNA would get them a snack and sometimes they (CNAs) would offer residents snacks whose names were not on a snack. CNA #7 stated there was one resident who would go to the snack cart and get a bedtime snack.  On 12/5/14 at 3:00 PM, the Administrator and DON were informed of the above concern. The facility provided no further information.	F 368	F514  1. On 9/13/2014 Resident #10 discharged from the facility. A root cause analysis was completed by the IDT team on 12/22/14 related to the lack of documentation for discharged residents. It was the determined the nurses needed to be re-educated requirements of documenting when a resident goes on leave of absence or discharged from the facility and who that resident leaves with and the time they leave.  2. On 12/22/2014 the Medical Records clerk conducted an audit of residents who were discharged within the last 90 days to ensure the medical record is complete; concerns were corrected as indicated.		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by:	F 371			

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F 371	Continued From page 43 Based on observation and staff interview, it was determined the facility failed to ensure dishes used for the serving of food were washed and maintained under sanitary conditions. This had the potential to affect any resident who dined in the facility including sample residents #1-9. This practice created the potential for contamination of food and exposed residents to potential sources of disease causing pathogens. Findings include:  On 12/1/14 at 8:30 AM, the head cook stated a rack on the counter had clean cups. Upon inspection, 2 of the 9 cups were observed to have food debris or a film on the inside. A third cup was observed to be pitted and marred.  On 12/3/14 at 12:15 PM, the Dietary Manager was informed of the above concerns. The Health Care Services Manager was present and stated the dishwasher had not been working correctly.  On 12/5/14 at 3:00 PM, the Administrator and DON were informed of the above concern. The facility provided no further information.	F 371	3. The following systemic changes were implemented to ensure that the facility will be better able to identify and implement preventative measures to decrease the lack of documentation regarding a resident's leave of absence either discharged or not. The facility has implemented a tracking tool to assist in the identification of missing documentation in addition to the review of the 24 hour report for residents who have discharged or left the facility for a leave of absence. A record review will be conducted upon in the clinical morning meeting to ensure documentation is present in the clinical record. The LPN assigned to Resident #8 at the time, was re-educated on 12/8/14 on ensuring documentation is in the resident's clinical record when resident leaves the facility. Beginning 12/9/2014 nursing staff were re-educated by the Staff Development Coordinator on		
F 514 SS=D	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	F 514			

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NAME OF PROVIDER OR SUPPLIER  TRINITY MISSION HEALTH & REHAB OF MIDLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651
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F 514	<p>Continued From page 44</p> <p>preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to maintain accurate, complete, and organized clinical records on each resident. This was true for 1 of 15 sampled residents (#10) reviewed for clinical records. This created the potential for medical decisions to be based on inaccurate information. Findings include:</p> <p>Resident #10 was admitted to the facility on 9/11/14 with difficulty in walking, muscle weakness and anxiety state. The resident was discharged on 9/14/14. The 9/14/14 Nurse's Note documented, "Remains out of facility. Phone call placed to Resident home at 1:15 a.m. Resident stated she left this afternoon with her daughter and would not be coming back..." The resident's medical record did not document who the resident left the facility with or the time the resident left. On 12/5/14 at 11:55 AM, the Administrator stated the record should include information regarding the resident leaving the facility and she would check for documentation. Later that day, the Administrator provided documentation that she spoke to the nurse (on 12/5/14 at 1:50 PM) who was working on 9/14/14 when the resident left the facility. The Administrator documented the nurse said the resident had informed the nurse at breakfast she was leaving the facility with her daughter. The nurse informed the resident she needed to be back by midnight.</p>	F 514	<p>ensuring medical records have complete information in the medical record upon discharging from the facility, including who the resident leaves with and the time they leave.</p> <p>4. Beginning the week of 1/4/2015 the Director of Nursing or designee will conduct audits weekly of discharged resident records and residents on leave of absents for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure the documentation is complete as required. A report will be submitted to the Quality Assurance Performance Improvement Committee for three months. The Quality Assurance Performance Improvement Committee will review the results and determine if any further interventions are needed at that time. The Director of Nursing is responsible for monitoring and follow-up.</p> <p>Date of compliance: 1/4/2015</p>	
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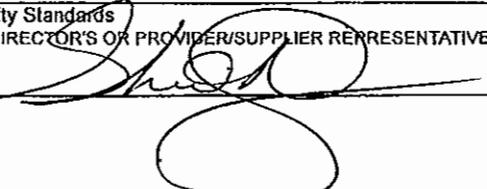
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001480</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/05/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TRINITY MISSION HEALTH &amp; REHAB OF MIDL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>48 NORTH MIDLAND BOULEVARD NAMPA, ID 83651</b>
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C 000	<p><b>16.03.02 INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the State licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Sherri Case, LSW, QIDP, Susan Gollobit, RN, and Kirsti Stevenson, BSN</p>	C 000	<p>Preparation and submission of this plan of correction by, <b>Trinity Mission Health &amp; Rehab of Midland</b>, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.</p>	
C 147	<p><b>02.100,05,g Prohibited Uses of Chemical Restraints</b></p> <p>g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Please refer to F-329 as it relates to gradual dose reductions.</p>	C 147	<p>C 147 Please refer to F 329</p>	<p>RECEIVED FEB 11 2015 FACILITY STANDARDS</p>
C 297	<p><b>02.107,05,a Bedtime Snacks</b></p> <p>a. Bedtime snacks of nourishing quality shall be offered, and between-meal snacks should be offered. This Rule is not met as evidenced by: Please refer to F368 as it relates to bedtime snacks.</p>	C 297	<p>C 297 Please refer to F 368</p>	
C 325	<p><b>02.107,08 Food Sanitation</b></p> <p>08. Food Sanitation. The</p>	C 325	<p>C 325 Please refer to F 371</p>	

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>NHA</b>	(X6) DATE <b>2/11/15</b>
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C 325	Continued From page 1  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 relates to sanitary conditions.	C 325	C 362 Please refer to F252  C 386 Please refer to F252	
C 362	02.108,07,a Interior Surfaces Clean & Sanitary  a. Floors, walls, ceilings, and other interior surfaces, equipment and furnishing shall be kept clean, and shall be cleaned in a sanitary manner. This Rule is not met as evidenced by: Please refer to F-252 as it relates to housekeeping concerns.	C 362	C 664	
C 386	02.120,03,a Building/Equipment in Good Repair  a. The building and all equipment shall be in good repair. This Rule is not met as evidenced by: Please refer to F-252 as it relates to resident complaint of cold air draft from window.	C 386	1. The facility Infection Control Committee minutes were reviewed on 12/12/2014 by the facility consulting pharmacist.  2. On 12/12/14 the Administrator reviewed the facility Infection Control Meeting minutes, to ensure that they were reviewed by the Medical Director and the Quality Assurance Performance Improvement Committee including the consulting pharmacist; no concerns were noted.	
C 664	02.150,02,a Required Members of Committee  a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by:	C 664	3. The following systemic changes were implemented to ensure that the facility will identify and implement	

Bureau of Facility Standards

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C 664	Continued From page 2  Based on staff interview it was determined the facility failed to ensure the Pharmacist attended/participated in quarterly Infection Control Committee (ICC) meetings. This failure created the potential for a negative effect for all residents, staff and visitors in the facility. Findings include:  On 12/4/14 at 2:25 PM, the Staff Development Coordinator/ Infection Control nurse (ICN) was asked what staff attended the quarterly meetings. The ICN stated the pharmacist did not attend the meetings.  On 12/5/14 at 12:25 PM, the Administrator and DON were informed of the findings. No additional information was provided.	C 664	preventative measures to decrease the risk the facilities consulting pharmacist not in attendance of the infection control committee meeting. Beginning 12/9/2014 the IDT were re-educated by the Staff Development Coordinator on ensuring the Infection Control Committee meeting and those who are required to be present. On 12/12/14 the Pharmacy Consultant was re-educated on the requirement of quarterly attendance of the Quality Assurance Performance Improvement (QAPI) Committee by the Administrator.	
C 784	02.200,03,b Resident Needs Identified  b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F309 as it relates following a resident's care plan.	C 784	4. Beginning the week of 1/4/2015 the Administrator or designee will conduct audits monthly of the infection control minutes for 3 months and quarterly thereafter to ensure that the Pharmacy Consultant is in attendance of the QAPI meeting as required. A report will be submitted to the Quality Assurance Performance Improvement Committee for three months. The Quality Assurance Performance Improvement Committee will review the results and determine if any further interventions are needed at that time. The Administrator is responsible for monitoring and follow-up.	
C 786	02.200,03,b,ii Body Alignment, Exercise, Range of Motion  ii. Good body alignment and adequate exercises and range of motion; This Rule is not met as evidenced by: Please refer to F-318 as it relates to ROM.	C 786		
			Date of compliance: 1/4/2015	

Bureau of Facility Standards

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C 789	Continued From page 3	C 789		
C 789	02.200,03,b,v Prevention of Decubitus  v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 related to pressure ulcer prevention.	C 789	C 784 Please refer to F309  C 786 Please refer to F318  C 789 Please refer to F314	
C 790	02.200,03,b,vi Protection from Injury/Accidents  vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F-323 as it relates to falls.	C 790	C 790 Please refer to F323	
C 820	02.201,01,a 30-Day Review of All Meds  a. Reviewing the medication profile for each individual patient at least every thirty (30) days. The attending physician shall be advised of drug therapy duplication, incompatibilities or contraindications.  This Rule is not met as evidenced by: Please refer to F-329 as it relates to duplicate therapy.	C 820	C 820 Please refer to F329	



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

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

January 20, 2015

FILE COPY

Sherrie Nunez, Administrator  
Trinity Mission Health & Rehabilitation of Midland  
46 North Midland Boulevard  
Nampa, ID 83651

Provider #: 135076

Dear Ms. Nunez:

On **December 5, 2014**, a Recertification & Complaint Investigation survey was conducted at Trinity Mission Health & Rehab of Midland. Kirsti Stephenson, RN, Susan Gollobit, RN, Becky Thomas, RN, and Sherri Case, LSW, QIDP, conducted the complaint investigation.

The complaint was investigated in conjunction with a Recertification and State Licensure survey of the facility. During the survey, the identified resident's medical records were reviewed, observations of residents were completed, and resident's and family members were interviewed.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006697**

**ALLEGATION #1:**

The complainant stated the identified resident did not consent to be admitted to the facility and was forced to stay at the facility when she was discharged from the hospital. The complainant stated the identified resident left the facility the following day.

**FINDINGS:**

A Care Management form from the hospital, dated September 9, 2014, documented a list of long term care facilities was given to the identified resident to review. After reviewing the list, the resident met with staff from the identified facility and chose to go to that facility.

Sherrie Nunez, Administrator  
January 20, 2015  
Page 2 of 3

The resident's discharge records from the hospital included a Final Report, dated September 10, 2014, which documented the plan was to discharge the resident to a skilled nursing facility in the next twenty-four hours.

A Care Management note, dated September 11, 2015, documented the resident decided to go to a skilled nursing facility as recommended. The note also documented a Preadmission Screening and Resident Review was completed and a van would take the resident to the facility by 3:30 p.m.

The identified resident's medical record at the long term care facility included a Preadmission Screening and Resident Review signed on September 11, 2014 in the Medicaid section .

Nursing Notes from the facility, dated September 11, 2014 at 4:30 p.m., documented the resident was admitted to the facility with a chief complaint of pain. The Nurses' Notes documented the resident stated she was being admitted related to a spinal block. Additionally, the notes documented the resident stated the order for a "no added sodium" diet was incorrect. The notes did not document the resident stated she was upset about being admitted to the facility.

The identified resident's medical record also included a September 14, 2014 Nurses' Note, which documented the facility called the resident at home at 1:15 a.m. The note documented the resident was educated regarding leaving the facility against medical advice, however the resident chose not to return to the facility. There was no other documentation in the medical record regarding the date, time, or with whom the resident left the facility.

A Medication Administration Record documented the resident did not receive a medication at 5:00 p.m. as she was out of the facility. The resident was out of the facility at least eight hours prior to the 1:15 a.m. phone call.

During observations across shifts from December 1, 2014 through December 5, 2014, staff were observed treating residents with respect and assisting them when needed. Residents did not voice any concerns regarding not wanting to live at the facility.

Four residents and two family members were interviewed regarding life at the facility. All stated the facility treated the residents with respect and that residents could choose how to spend their day.

Seven residents who attended a meeting with surveyors stated they chose how to spend their day at the facility and staff treated them with dignity and respect. One resident at the meeting stated staff would "bend over backwards to help us,"

The complaint was not substantiated; however, the facility was cited at F 514 for failure to have complete and accurate records.

Sherrie Nunez, Administrator  
January 20, 2015  
Page 3 of 3

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the identified resident was not diabetic but the facility tested her blood glucose level and administered insulin.

FINDINGS:

The identified resident's Medication Administration Record and Nurses' Notes were reviewed.

Nursing Notes, dated September 12th and September 13, 2014, documented the resident's temperature, pulse, respirations, and oxygen saturation level. The Nursing Notes did not include any information regarding checking the resident's blood glucose level or administering insulin.

The identified resident's medical record included a Medication Administration Record, which documented the resident had a blood draw for a Comprehensive Metabolic Panel and Complete Blood Count on September 12, 2014. The resident's records included the results from the laboratory, dated September 12, 2014, which documented the blood draw was completed the morning of September 12, 2014 at 7:25 a.m.

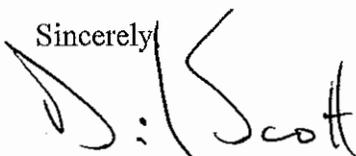
A second Medication Administration Record for September 11 through September 13, 2014 documented the resident received medications for pain, constipation, and seizures. The Medication Administration Record did not document any information regarding insulin.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Although the complaint findings were not substantiated, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

Sincerely,

A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large, stylized "D" and "S".

DAVID SCOTT, RN, Supervisor  
Long Term Care

DS/lj