



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7012 1010 0002 0836 1987

December 18, 2013

Daniel K. Kennick, Administrator
Valley Vista Care Center of Sandpoint
220 South Division
Sandpoint, ID 83864-1759

Provider #: 135055

Dear Mr. Kennick:

On **December 6, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Valley Vista Care Center of Sandpoint by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 31, 2013**. Failure to submit an acceptable PoC by **December 31, 2013**, may result in the imposition of civil monetary penalties by **January 21, 2014**.

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

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

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

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

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CMS-2567 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **January 10, 2014 (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 10, 2014**. A change in the seriousness of the deficiencies on **January 10, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 10, 2014** includes the following:

Denial of payment for new admissions effective **March 6, 2014**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 6, 2014**, if substantial compliance is not achieved by that time.

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

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

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

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Regional Office or the State Medicaid Agency beginning on **December 6, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **December 31, 2013**. If your request for informal dispute resolution is received after **December 31, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

LT/dmj
Enclosures

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/06/2013
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NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF SANDPOINT	STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH DIVISION SANDPOINT, ID 83864
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual Federal recertification survey and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Karen Marshall, MS, RD, LD Team Coordinator Lauren Hoard, BSN, RN Susan Gollobit, RN Nina Sanderson, BSW, LSW</p> <p>The survey team entered the facility on Monday, 12/2/13 and exited the facility on Friday, 12/6/13</p> <p>Survey Definitions:</p> <p>ADL = Activities of Daily Living BIMS = Brief Interview of Mental Status CAA = Care Area Assessment CHF = Congestive Heart Failure CNA = Certified Nurse Aide DM = Dietary Manager DON/DNS = Director of Nursing/Director Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligrams OT = Occupational Therapist/Therapy O2 = Oxygen PT = Physical Therapist/Therapy RD = Registered Dietitian RN = Registered Nurse ROM = Range of Motion WC or W/C = Wheelchair</p>	F 000	<p>Preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because the provisions of federal and state law require it.</p>	
F 221 SS=D	483 13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS	F 221		

RECEIVED
JAN 09 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Don Kennel</i>	TITLE NHA	(X6) DATE 12/27/13
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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 221	<p>Continued From page 1</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to evaluate the use of a less restrictive device, other than a seatbelt, for a cognitively impaired resident. This affected 1 of 7 (#12) residents sampled for the use of physical restraints. This practice created the potential for more than minimal harm should the resident experience contractors, decreased mobility or development of pressure sores. Findings included:</p> <p>Resident #12 was admitted to the facility on 10/17/13 with multiple diagnoses including decreased functional status and muscle weakness.</p> <p>The resident's 10/25/13 admission MDS coded severely impaired cognition, upper extremity one sided functional limitation in ROM, and one person extensive assistance for all ADLs. The MDS did not code for the use of restraints.</p> <p>The resident's 10/17/13 health service report from a local provider documented in part, "Weakness...severity...mild-moderate...problem...worsening...occurs persistently...location includes generalized...has never been told...had a stroke...cannot open...left hand...admitted to skilled care now."</p>	F 221	<p>Corrective Action On 12/6/13, a comprehensive restraint reduction assessment was completed by an occupational therapist. A 72 hour trial without the use of the seatbelt was also initiated at that time, and on 12/9/13, the seatbelt was discontinued.</p> <p>Other Residents As this deficiency has the potential to affect other residents, an audit will be completed by the DNS or nurse designee NLT 1/10/14 on all residents within the facility that have restraints. The auditor will ensure that the resident has orders and a consent for the restraint. Additionally, the auditor will ensure that the care plan and care guidelines are accurate with respect to the restraint. A restraint reduction assessment will be conducted on all residents with restraints by a licensed nurse or therapist NLT 1/10/14.</p>	1/10/14

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F 221	<p>Continued From page 2</p> <p>The resident's 10/17/13 Physician's Admission Orders included orders for physical and occupational therapy to evaluate and treat.</p> <p>The resident's medical record contained a 10/30/13 facility form that documented, "OT [occupational therapy] has assessed it [seatbelt] to be safe. Can we have an order for a seat belt when resident is up in his w/c [wheelchair]. Family is requesting it." The Reply/Response/Comment section of the form contained a handwritten entry, "...Seat belt in wc for safety." The entry appeared signed by the resident's physician on 10/31/13.</p> <p>The resident's care plan, printed 10/17/13, identified, in part, the following:</p> <ul style="list-style-type: none"> - Problem: Potential for Injury: Falls, One of the problem interventions was, "Seat belt in w/c for safety - 10-31-13" - Problem: Restraint Use, related to the use of "seat belt in w/c." <p>On 12/3/13 at 1:35 p.m., the resident was sitting in a wheelchair (wc) near the 200 hall nurses station. There was a fastened seat belt laying across the resident's lap. CNA #4 stated, "[Resident #12] tends to scoot forward in the chair so it [the seatbelt] keeps him from falling out [of the wc]."</p> <p>On 12/5/13 at 8:46 a.m., the resident was sitting in a wc near the 200 hall nurses station. There was a fastened seatbelt laying across the resident's lap. The resident was asked if he could open the clasp of the belt laying across his lap. The resident said no. The surveyor asked the resident if he knew why the seatbelt was on his lap. The resident said no.</p>	F 221	<p>Facility Systems</p> <p>Effective 12/17/13, no restraints will be initiated at Valley Vista Care – Sandpoint without evaluation and/or input from a physical or occupational therapist to determine if less restrictive measures are available or appropriate. Licensed nurses were in-serviced on this protocol change by the administrator at the monthly licensed nurse meeting held on 12/17/13. Furthermore, nurses were instructed by the administrator on 12/17/13 to obtain orders for therapy to evaluate and treat the resident prior to requesting orders for a restraint from the physician. Only after the therapist has assessed the resident and deemed the restraint safe, appropriate and necessary will the nurse request orders for the restraint device.</p> <p>Effective 1/10/14, any resident with a restraint will have a restraint reduction assessment conducted by the MDS nurse at least quarterly in conjunction with that resident's MDS assessment. On 12/17/13, the MDS nurses were in-serviced of this and were instructed to seek input from the appropriate physical and/or occupational therapist to help determine if any less restrictive devices are available or appropriate.</p> <p>Monitoring</p> <p>Beginning in January 2014, an audit will be conducted monthly by the DNS, Administrator or nurse designee to ensure restraint usage compliance and compliance with attempts at reducing restraint usage. The results of these audits will be reviewed at the monthly Quality Assurance meeting, beginning with the next Quality Assurance meeting tentatively scheduled for 1/22/14. This audit will be conducted during each of the next 3 months, at which time the need for continued audits will be re-evaluated.</p>	

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F 221	<p>Continued From page 3</p> <p>Federal guidance at F221 indicated, "Physical Restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body...There are instances where, after assessment and care planning, a least [less] restrictive restraint may be deemed appropriate for an individual resident to attain or maintain his or her highest practicable physical and psychosocial well-being...In the case of a resident who is incapable of making a decision...the legal surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, the facility may not use restraints in violation of the regulation solely based on a legal surrogate or representative's request or approval..."</p> <p>On 12/6/13 at 9:50 a.m., the Director of Therapy provided a copy of a 10/30/13 OT Progress Note. The Note documented, "Pt [patient] seen for self releasing seat belt trial. Pt unable to follow 1 step command to lift hand to notice/attend to seatbelt button. Multiple trials attempted. Pt has been observed to stay within limits of wc seat, however at times slowly 'wiggles' forward in seat. Per pt's family pt was wearing seatbelt when up in wc at home and would benefit from cont [continued] use here at facility to assist [with] upright positioning. Recommending use of a seatbelt...to reduce risk of fall from wc..." The survey team then discussed the use of the seat belt with the DON, the Administrator, Director of Therapy, OT #8, and the Corporate Compliance Registered Nurse. OT #8 stated, "When the resident came</p>	F 221			

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F 221	Continued From page 4 into the facility, the family requested the use of the seatbelt. The family were very involved, very insistent since he used a seatbelt in the wc at home." The survey team asked the OT if other seating systems were ruled out before using the seat belt. The OT stated, "I did not rule out other seating systems due to the family insistence. The seat belt was not assessed as a restraint and was not assessed for safety just assessed to see if he could self-release." The Administrator stated, "The family was adamant about continuing what [Resident #12] was using at home." On 12/6/12 at 10:00 a.m., the Administrator, DON, and Corporate Compliance Nurse were informed of the survey team's above identified concern related to the use of the seat belt for Resident #12.	F 221		
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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to obtain a physician's order and care plan for the use of an abductor wedge and abductor strap. This affected 1 of 1 (#12) residents sampled for use of abductor wedge and abductor strap. This	F 309	Corrective Action An order was obtained for the use of the abductor wedge with straps on 12/5/13. On 12/6/13, a reassessment was completed by the occupational therapist. The straps from the wedge were subsequently removed to afford the resident the ability to reposition his legs without restriction. The residents care plan and care guidelines were updated on 12/6/13 and 12/17/13 to reflect the wedge use without straps, as well as the use of pillows between his legs when in bed. Other Residents This deficiency does not affect other residents as no other residents in the facility utilize an abductor wedge with straps.	1/10/14

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F 309	<p>Continued From page 5</p> <p>practice created the potential for more than minimal harm should the resident experience a lack of freedom of mobility, reduced comfort, or the development of pressure sores. Findings included:</p> <p>Resident #12 was admitted to the facility on 10/17/13 with multiple diagnoses including decreased functional status and muscle weakness.</p> <p>The resident's 10/25/13 admission MDS coded severely impaired cognition, upper extremity one sided functional limitation in ROM, lower extremity functional limitation in ROM on both sides, and one person extensive assistance for all ADLs. The MDS did not code for the use of restraints.</p> <p>The resident's 10/17/13 health service report from a local provider documented in part, "Weakness...severity...mild-moderate...problem...worsening...occurs persistently...location includes generalized...has had increased weakness and difficulty with legs 'scissoring'...admitted to skilled care now."</p> <p>The resident's 10/17/13 Physician's Admission Orders included orders for physical and occupational therapy to evaluate and treat. The admission orders did not include an order for an abductor wedge and abductor strap.</p> <p>The resident's 12/1/13 Physician Order Report (recapitulation) did not include an order for an abductor wedge or abductor strap.</p> <p>The resident's care plan (CP), printed 10/17/13, did not include the use of the abductor wedge</p>	F 309	<p>Facility Systems All physical and occupational therapists will be in-serviced by the Therapy Director no later than 1/10/14. The in-service will include information on what constitutes a restraint and the procedure to assess and obtain an order for the restrictive device if it is deemed appropriate.</p> <p>Monitoring The Therapy Director or designee will conduct a monthly audit of all therapeutic devices that could be construed as a restraint beginning in January 2014. The auditor will ensure that correct assessments for such devices have been completed, consents for use have been obtained, care plans are accurate and a physician's order is present. The results of the audit will be shared at the monthly QA meeting beginning with the next meeting tentatively scheduled for 1/22/14. This audit will be conducted for the next 3 months at which time the need for continued auditing will be reassessed.</p>	

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F 309	<p>Continued From page 6 and abductor strap.</p> <p>On 12/3/13 at 1:35 p.m., the resident was sitting in a wheelchair (wc) near the 200 hall nurses station. There was an abductor wedge between his legs just above the knees. There was also a white abductor strap around the outside of both legs, just above the knees. The strap appeared to secure the resident's legs tightly together. The surveyor made an introduction to the resident. The resident replied, "Hi, my name is [Resident #12's first name]."</p> <p>On 12/4/13 at 5:07 p.m., the resident was sitting in a wc in the main dining room, there was an abductor wedge between the resident's legs and an abductor strap around both legs as in the 12/3/13 observation.</p> <p>On 12/5/13 at 8:46 a.m., the resident was sitting in a wc near the 200 hall nurses station. There was an abductor wedge and strap in the same position as the observations on 12/3/13 and 12/4/13 identified above. The resident was wearing a pair of dark colored sweat pants. The surveyor asked the resident why the device was between his legs. The resident did not know why. The resident was asked if the device between his legs and the strap hurt. The resident said the device and strap did not hurt. The resident was asked if he could remove the device between his legs and the white strap around his legs. The resident said, "I can't" and moved his head in a sideways back and forth motion.</p> <p>On 12/5/13 at 9:34 a.m., the surveyor asked CNA #5, who placed the wedge and strap on Resident #12 today and how the tightness of the strap around his legs was determined? The CNA</p>	F 309			

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F 309	<p>Continued From page 7</p> <p>stated, "I put the strap and wedge on [Resident #12] today. I just put the strap around his legs so he can't cross his legs and get a skin issue. I did not check to determine how tight the strap was."</p> <p>On 12/5/13 at 9:52 a.m., the surveyor asked the Director of Therapy (DT) for information about the use of the abductor wedge and strap for the resident.</p> <p>- At approximately 1:30 p.m., the DT provided the surveyor with a copy of a 11/1/13 Physical Therapy (PT) Progress Note that documented, in part, "Abd block [abductor wedge] placed between thighs, CNAs instructed in their use...will d/c [discharge from PT] as of 11/3/13..."</p> <p>On 12/5/13 at 2:06 p.m., the surveyor, LN #3, and the DT observed the resident's skin just above the knees where abductor wedge and the strap were previously positioned. When LN #3 removed the abductor strap and wedge from between the resident's legs, the resident's knees appeared to move inward involuntarily. The LN held the resident's knees slightly apart for the observation. The resident's skin appeared dry, intact, and without redness.</p> <p>On 12/5/13 at 2:30 p.m., the surveyor asked the DON about the use of the abductor wedge and the abductor strap as the wedge and strap were not on the resident's care plan and the resident's medical record did not include a physician's order for the use of the wedge and strap.</p> <p>- At 3:33 p.m., the DON provided the surveyor with an updated copy of the resident's skin CP. The CP was updated on 12/5/13 for the use of the wedge and strap. The CP entry was signed by LN #3. The hand written entry directed the use of the abductor wedge and strap when out of bed in</p>	F 309			

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F 309	<p>Continued From page 8 wc and off when in bed. Note: The updated CP did not address the following: * An intervention to keep the resident's legs or knees from scissoring or crossing while the resident was in bed and the abductor wedge and strap were not in use. * How frequently the abductor wedge and strap were to be released when the resident was out of bed in his wc. * The possibility of using the abductor wedge without the use of the strap to allow the resident more leg mobility and the freedom to remove the wedge. * An assessment of the effect of the wedge on the resident's quality of life.</p> <p>On 12/5/13 at 3:38 p.m., the DT stated, "We have requested an order for the abductor wedge and abductor strap from the physician."</p> <p>Federal guidance at F309 indicated, "...The facility is in compliance...if staff: Recognized and assessed factors placing the resident at risk for specific conditions, causes, and/or problems; Defined and implemented interventions in accordance with resident needs, goals, and recognized standards of practice; Monitored and evaluated the resident's response to preventive efforts and treatment; and Revised the approaches as appropriate..."</p> <p>On 12/6/13 at 9:45 a.m. the surveyor informed the DON and the Administrator, the use of the abductor wedge and strap was not physician ordered, was not care planned, and an intervention to prevent Resident #12's legs from crossing or scissoring while in bed was not included on the updated care plan.</p>	F 309			

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F 309	Continued From page 9	F 309		
F 314 SS=D	<p>The facility did not provide any additional information that resolved the concerns 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and review of the facility's Skin and Wound Management policy, the facility failed to prevent pressure ulcers when 2 of 4 sampled residents developed a pressure ulcer, (Residents #3, #4) The deficient practice had the potential to cause more than minimal harm when Resident #3 developed a Stage 2 Pressure Ulcer to the left lower leg three days after the use of bilateral lower leg shin splints were implemented. Resident #4's chart had conflicting documentation whether he had one or two Pressure Ulcers and what Stage they were. Findings include:</p> <p>The facility's Nursing Services Policy and Procedure Manual For Skin and Wound Management documented. *Pressure Ulcer Risk Assessment: -General Guidelines</p>	F 314	<p>Corrective Action Resident #3's Stage II pressure ulcer (blister) to his left lower leg resolved on 12/8/13. Resident #4's coccyx skin impairment resolved on 10/17/13.</p> <p>Other Residents The Skin Nurse and/or designee will review all residents who have a current skin impairment by 1/10/14 to ensure accurate skin documentation and correct staging of any pressure ulcers. The skin nurse will also review any residents currently using shin guards or splints by 1/10/14 to ensure that they are not at risk of causing a pressure ulcer.</p>	1/10/14

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F 314	<p>Continued From page 10</p> <ol style="list-style-type: none"> Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area, which destroys the tissues. The most common site of a pressure ulcer is where the bone is near the surface of the body including the back of the head around the ears, elbows, shoulder blades, backbone, hips, knees, ankles, and toes. Pressure can also come from splints, casts, bandages, and wrinkles in the bed linen. Pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on the resident's skin (i.e., perspiration, feces, urine, wound discharge, soap residue, etc.), decline in nutrition and hydration status, acute illness and/or decline in the resident's physical and mental condition. Once a pressure ulcer develops, it can be extremely difficult to heal. Pressure ulcers are a serious skin condition for the resident Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. Immediately report any signs of a developing pressure ulcer to the supervisor. <p>-Assessment</p> <ol style="list-style-type: none"> Skin Assessment. Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. Because a resident at risk can develop a pressure ulcer within 2 to 6 hours of the onset of pressure, the at risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. 	F 314	<p>Facility Systems</p> <p>An in-service will be held on 1/3/14 by a consulting wound nurse practitioner to discuss pressure ulcer and other various skin condition identification, staging, and documentation. The Skin Nurse and/or designee will review all skin impairments weekly beginning on 1/6/14 to ensure proper wound identification, documentation, and treatment. The wound nurse will continue to attend the weekly Resident at Risk Meeting and report on the residents with skin impairments to the Resident at Risk Committee beginning on 1/8/14. In addition, the behavior nurse or representative of the behavior management team will also attend the weekly Resident at Risk meeting to present and discuss specific behaviors that contribute to individual resident's risk for skin compromise. Effective 1/8/14, no splints or braces will be applied to a resident without collaboration between therapy and nursing and without a documented assessment to determine the safe use and appropriateness of the splint or brace.</p> <p>Monitoring</p> <p>The Skin Nurse or designee will follow all skin related issues as stated above and report monthly to the QA Committee beginning with the next QA meeting tentatively scheduled for 1/22/14. After 4 months, the QA Committee will determine if ongoing monitoring is still necessary.</p>	
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F 314	<p>Continued From page 11</p> <p>the admission evaluation helps define those initial care approaches.</p> <p>*Pressure Ulcer Treatment -Definitions and Descriptions Stage 2 Pressure Ulcer: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.</p> <p>1. Resident #3 was admitted to the facility on 12/27/2009 with diagnoses that included Alzheimer's dementia, post traumatic stress disorder, and aphasia. On 11/7/13 wheelchair dependence was added as a diagnosis.</p> <p>The Resident's Quarterly MDS, dated 9/3/13, recorded: *Cognitive Skills for Daily Decision Making- Severely Impaired-never/rarely made decisions. *Rejection of Cares- Behavior not exhibited. *Functional Limitation in Range of motion- Lower extremity- Impairment on one side. *Determination of Pressure Ulcer Risk- Is this resident at risk of developing pressure ulcers?--Yes. *Skin Conditions- Healed pressure ulcers-No. -Other Ulcers, Wounds and Skin Problems- none of the above were present. -Current number of Unhealed Pressure Ulcers at Each Stage- None were marked.</p> <p>*Monthly Summary signed by a LN, dated 11/16/13 documented:</p> <p>-Cognitive Patterns- "Inattention, Disorganized thinking, Severely impaired-never/rarely made</p>	F 314		

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F 314	<p>Continued From page 12 decision" -Skin Conditions- "None"</p> <p>Skin ("Braden Scale) Assessment--For Predicting Pressure Sore Risk documented: The Resident was low risk on 3/11/13, 6/7/13, 9/16/13.</p> <p>The resident's Care Plan, dated 12/27/09 "Origin" documented: *Problem: Impaired Skin Integrity (Risk for). -Related To: 1. Bowel/Bladder Incontinence. 2. Impaired safety Awareness. 3. Cognitive Impairment. 4. Weakness. 5. Communication Impairment. 6. (Decreased) bed mobility.</p> <p>Interventions: 2. "Assess resident awareness of the sensation of pressure." 3. "Provide special mattress for bed and or chair as needed." 4. "Braden assessment quarterly and with each SCSA." [Was not defined.] 6. "If skin open, monitor for S/SX (signs/symptoms) of Infection (i.e. redness Inc. warmth (Temp); pain, drainage or odor." 8. "Derma Saver Boots on while in bed (Blue) 11/21[13]." 9. "Q2HR(every 2 hour) turn schedule." 12. "Shin guards (velcro) to bilateral shins when up in w/c. Initiated 11/27/13, D/C'd(discontinued) 12/2/13." 13. "5 cm x 0.5 cm blister to (right)[marked out] (left) shin monitor (every) shift until resolved cover when opened 11/30[13]." 14. "Leave top strap of Blue boot (right)[marked</p>	F 314		
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F 314	<p>Continued From page 13 out] (left) side until blister heals 11/30/13." 15."OT (Occupational Therapy) placed new foot board behind calves to prevent legs from getting behind footrest (and) possibly causing skin break(down) 12/2/13."</p> <p>The Physician Order Flow Sheet TREAT-[sic], dated 11/1/13 documented:</p> <p>*"Monitor bruise on residents (right) lower legs (shin)" Day, Eve. [NOTE: This was initiated on 11/27/13]</p> <p>- The LN Signature form documented initials for both shifts from November 27th through November 30th. -The PRN (as needed)Notes form was not documented on related to the bruise.</p> <p>*"Shin splints (check) apply when resident is sitting up in his W/C." Days, Eve. [NOTE: This was initiated on 11/27/13]</p> <p>-The LN Signature form documented initials for both shifts from November 27th through November 30th. -The PRN Notes form did not provide notes related to the shin splints.[NOTE: There was no documentation of the skin related to the new usage of shin splints from when they were implemented on 11/27/[13] until the Stage 2 Pressure Ulcer was documented on 11/30/[13.]</p> <p>* "Monitor blister to (left) [(right)[had a line through it] shin (every) shift. Cover (with) DSD [dry sterile dressing] when opens until resolves." Day, Eve, Nocs, (nights). [NOTE: This was initiated on 11/30/13]</p>	F 314		

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F 314	<p>Continued From page 14</p> <p>-The LN Signature form documented the blister was not monitored on Day shift on 11/30.</p> <p>-The PRN Notes form documented on 11/30 Hour-"Day" and Medication/ Treatment "Blister intact." [NOTE: There was no documentation on this sheet for Eve and Noc shift. There was conflicting documentation with the Day shift monitoring on 11/30. One form documented the LN had not monitored the blister. The second form documented the blister. The LN initial was the same for both Day shift entries]</p> <p>Physicians Orders, dated 12/1/13 documented:</p> <p>*Monitor Bruise on (right) lower legs (shin) until resolved date of Origin 11/27/13</p> <p>*Shin Splints apply when sitting up in W/C date of Origin 11/27/13</p> <p>*Blue boots (bilateral) when (Resident) in bed (monitor) date of Origin 2/22/12</p> <p>Physician Order Flow Sheet TREAT-[sic] dated 12/1/13 documented:</p> <p>**Shin splints apply when sitting up in W/C" Days Eves</p> <p>-The LN signature form documented the shin splints were in place as ordered on both days and evening shifts on December 1st and 2nd and discontinued on December 3rd. [NOTE: The shin splints continued to be used on the day the blister was found and 2 more days after that.]</p> <p>**Monitor blister to (Left) shin and cover when open (with) DSD (every) shift until resolved." Day Eve Noc (nights)</p> <p>- The LN Signature form documented, on 12/1</p>	F 314		

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F 314	<p>Continued From page 15</p> <p>the blister was not monitored on Day and Evening shift. On 12/3 the blister was not monitored on Day shift.</p> <p>-The PRN Note form that was documented on Day shift for 12/1 and 12/3 was the same LN. The notes recorded were: Hour- "10:30"(both days) Medication/Treatment "Blister intact OTA (open to air)." [NOTE: There was conflicting documentation on day shift for 12/1 and 12/3. The one form stated the LN had not monitored the blister and the second form documented on the blister. The LN initial was the same on the forms for Day shift for the 2 days. There was not a note documenting why the blister was not monitored for the Evening shift of 12/1.]</p> <p>*Occupational Therapy Progress Notes documented:</p> <p>On 11/12/13 12:55 "Pt. treated for alternate w/c placement (with) front [sic] raised to highest setting to promote hip flexion (and) break up tone (extensor). Pt placed in high back tilt w/c standard seat width (and) depth (with) (bilateral) foot rests (and) foot board, antithrust seat cushion. ... Pt maintained posture throughout mealtime."</p> <p>On 11/13/13 12:35 "Pt seen for more w/c positioning (secondary) pt pushing flexible board (with) LE (lower extremity) ext. Footboard removed, footrests raised up to place pt's knees (and) hips at 90 (degree) flexion. ...Ordered sturdier footboard for behind calves, foot plates (with) clasps (and) antislidder belt (for) trial."</p> <p>On 11/20/13 12:55 "Pt seen for w/c positioning (and) caregiver education R/T (related to) positioning. Pt up at meal-time in w/c. ...Pt</p>	F 314		

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F 314	<p>Continued From page 16</p> <p>maintained upright neutral posture (without) scooting hips... Pt's foot on (left) side needed to be repositioned on foot pedal, pt will need footboard as already recommended. ...Waiting for equipment arrival to trial."</p> <p>On 11/21/13 10:55 "Pt (and) CNAs re-educated on importance of repositioning pt in w/c. Pt's feet observed to drop off w/c footrests esp. (especially) while pt asleep, requiring occasional repositioning. awaiting [sic] footboard to reduce risk of feet falling. Cont. to recommend pt be laid down when observed to be restless up in w/c as evidenced by frequent scooting fwd [forward]..."</p> <p>On 11/25/13 11:30 "Pt observed up in w/c (after) adjustments made. Pt voluntarily slides one or both feet off foot plates. Awaiting footboard... Reported need to reposition pt as needed when feet taken off foot plates or when scooted fwd. Cont. to monitor (and) educate as needed. ADD: [addendum] Pt placed on hold to await further equipment." [NOTE: Two days after this note Nursing implemented shin splints and 3 days after the shin splints were applied the Resident had a documented Stage 2 Pressure Ulcer.]</p> <p>On 12/2/13 09:30 "Pt was issued a curved headrest and footboard for posterior calves...."</p> <p>Interdisciplinary Progress Notes documented:</p> <p>On 11/27/13 at 15:00 "During AM cares CNA found a bruise on resident's (right) lower legs. when resident is sitting up in w/c he puts his legs behind his foot rests and rubs [sic] found of his legs. Shin splints purchase[sic] for him today. (Medical Doctor name) notified via fax and message left for (Residents wife name) on</p>	F 314		
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F 314	<p>Continued From page 17</p> <p>machine." [NOTE: This was the only Progress note related to the shin splints prior to the development of the Stage 2 Pressure Ulcer.]</p> <p>On 11/30/13 at 13:31 "During AM cares res was found to have a 5 x 0.5 cm (centimeter) fluid filled blister on his (left) shin MD faxed, wife notified. Will monitor (every) shift and cover with DSD when opens until resolved."</p> <p>On 12/1/13 at 10:38 "Res afebrile. Blister is still intact. will [sic] continue to monitor until resolved."</p> <p>On 12/3/13 at 17:50 "MD in Agreed (with) orders to monitor bruise to (right) lower leg until resolved and monitor blister to (left) shin and cover (with) DSD when opened."</p> <p>On 12/5/13 at 10:30 "Blister intact to (left) shin. Open to air." [NOTE: there was no assessment of the bruise or the Stage 2 pressure ulcer in the Progress note for 12/2, 12/3, 12/4.]</p> <p>Non- Pressure Skin Condition Report, dated 11/30/13 documented:</p> <p>*Date First Observed: "11/30/13"</p> <p>*Site/Location: (Indicate on body form) "(Right) [was marked out] (left) shin 5 cm x 0.5 cm water filled blister that is intact."</p> <p>*Other "sheer" [NOTE: The blister was not identified as a Stage 2 Pressure Ulcer, but a Non-Pressure Skin Condition Report was initiated. No other areas of the form were completed to include: Identifying the site on the body diagram provided on the form, Surrounding Skin Color, Surrounding Tissue/Wound Edges. There was no signature or initial on this form indicating who had completed it.]</p>	F 314		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/06/2013
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NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF SANDPOINT	STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH DIVISION SANDPOINT, ID 83864
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F 314	<p>Continued From page 18</p> <p>Memorandum for Record, dated 12/2/13, completed by the CCN (Corporate Compliance Nurse) documented:</p> <p>"Subject: (Resident's name) 11/27/13 Bruise Investigation"</p> <p>"On 11/27/13 at 7:30 am, the day shift CNA reported a new 3.0 x 3.0 cm bruise on (Resident's) right lower leg (lower shin area).... I agree this bruise was likely caused from bumping it on the footrest as the location of where they described the bruise to be in, matches with the height of the footrest. I could not see an obvious bruise today, however, (name) pointed out to me where it had been and based on that, it appears to match the footrest height if he were to put his right leg behind it.</p> <p>To prevent this from happening again, shin guards were purchased that day (11/27/13). ...On 11/13/13, it appears a sturdier footboard to place behind his calves was ordered. Today, OT placed this footboard and it appears to be doing it's job by not allowing the resident's leg to go behind the footrest..." [NOTE: This note dated 12/2/[13] is the first note in the chart describing the bruise since it was found on 11/27/[13]. The CCN did not see an obvious bruise. On 12/3/[13] the Interdisciplinary note documented "MD in Agreed (with) orders to monitor Bruise to (right) lower leg until resolved." No date of resolution of bruise was found in the record.]</p> <p>A second Memorandum for Record, dated 12/2/13, completed by the CCN documented:</p> <p>Subject: (Resident's name) 11/30/13 Blister</p>	F 314		
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F 314	<p>Continued From page 19 Investigation</p> <p>"On 11/30/13 at 7:00 am, the day shift CNA's reported a new blister to (Resident's name) left shin. According to the Incident Report it was initially felt that this blister may have been caused by the sheets d/t his constant movement. However, today I went and inspected this blister while he was lying in bed. Two of his primary care CNA's (Names of 2 CNA's) were also present. When I asked them what they felt may have caused this, they reported it may have been from the shin guards (purchased 11/27/13). Upon inspection of the shin guards, there are 2 strips of either neoprene or rubber on the inside. The diameter of one of these strips seem to match up perfectly with this blister and they are on the inside front of each guard (which appears to match up to where his blister is located---front shin.) I wondered if he may have even had a skin reaction from the material, although if that were the case, one would think it may be on the othe leg too or in 2 places on the left shin (since there are 2 strips inside the shin guard.) I feel it's very possible the blister was caused from not only the shin guard but (Resident's name) placing his feet behind the foot rest with the shin guard in place and rubbing his leg back and forth. He does move quite a bit and has spasms. Today, OT placed a footboard behind his calves. It was ordered in November. This should prevent him from being able to put his legs behind the footrests, which should prevent this from happening again. Due to this new footboard and the blister, I discontinued the shin guards today. There [sic] were not in place upon inspection today, however, he was in bed with his blue foot/heel protectors on." [NOTE the Physician Order Flow Sheet for December 1st and 2nd</p>	F 314		
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F 314	<p>Continued From page 20 documented on by the LN revealed the use of the shin splints after the blister was identified, not until the CCN investigated the blister were they discontinued.]</p> <p>On 12/3/13 at 9:41, 10:21, 10:45 am the Resident was observed in bed on his back, sleeping. Bilateral blue boots were on his feet. The Resident's feet and legs were directly on the bed.</p> <p>On 12/4/13 at 1:50 pm the Resident was observed up in his chair sitting in front of the Village Nurses Station. The right foot was positioned with the lateral side of the foot on the outer metal edge of the foot peg. [NOTE: The staff had not repositioned the foot as educated by OT for positioning while up in his W/C.]</p> <p>On 12/4/13 at 6:15 pm to 6:40 pm the Resident was observed up in his W/C in the Village RA (Restorative Dining) dining room. A footboard was in place behind the Resident's lower legs. The Resident's left foot was on the outer edge of the foot peg resting on the metal. [NOTE: The staff did not reposition the Resident's foot back onto the foot peg, as educated by OT for positioning while up in his W/C.]</p> <p>On 12/4/13 at 10:29 am while interviewing the DON and CCN about Skin conditions in the facility and skin protocols, the surveyor asked who decided to put the shin splint on the resident, and if it was an Interdisciplinary decision. Both the DON and the CCN stated they were "unsure" how the decision came about. When asked what they were calling the blister on the residents shin the DON was unsure and left to get the Skin care nurse. The CCN stated on December 2nd a new leg board was placed on the W/C. The only thing</p>	F 314		

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F 314	<p>Continued From page 21</p> <p>prior to this that was being used was the boots. When she had done the investigation "the splint was not being used after the observation of it (blister)." The surveyor was shown the splint that they had been using. The splint was a soft Neoprene type material with 2 hard black bars of rubber type substance running parallel to each other on the inside of the splint. The CCN stated, "in my investigating I found that the blister was the same width and length as the black bar."</p> <p>On 12/4/13 at 5:25 pm the DON was asked if the Skin nurse was tracking Residents that are high risk for pressure ulcers. The DON stated, "I think she does, I will check."</p> <p>On 12/4/13 at 2:58 pm the CCN provided to the Surveyor a "Staff or Witness Statement" from LN#3 WCC (Wound Care Coordinator) and LN#11 MDS (Minimum Data Set). The CCN stated, "They were written today. The two of them got together and decided amongst themselves that the brace would be used. the statements are their thought process for the use of it. It was not an Interdisciplinary decision."</p> <p>On 12/5/13 at 11:40 am the Administrator was asked if he would have expected OT to be involved in the assessment and use of the splint, he stated "No, because it is not something that would be used for mobility, restrictive or positioning." When asked if there was a possibility that something else could have been used, prior to the use of the shin splint being applied to the skin considering the risk of pressure ulcers. He stated, "I see what you are saying." When asked if he would expect his DON to have been consulted prior to the use of the splint, he stated "I empower my nurses to go with</p>	F 314		
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F 314	<p>Continued From page 22 it and do what the have decided to do, so not really."</p> <p>On 12/5 at the 1:10 pm the surveyor interviewed LN#3 WCC. When asked about her tracking system, she stated "I track them weekly. I track the new admits, surgical sites, any pressure areas, skin tears that are large." When asked about her process, she stated, "I have a skin book. The nurses will leave me a note in my mail box, then I would talk to the nurse. I would assess it, once I have assessed we have some protocols in place and if not then I would notify the MD. The skin protocols are at the desk. (Nurses Station). The protocols are used by all the nurses." When asked about the shin splints and the blister on the residents shin, she stated "I noticed him doing what he was doing and knew we had done shin guards in another facility, so we put them in place because they had worked there." Was asked if the shin splints used on the Resident were the same splints she had seen used in the other facility, she stated "No they were not the same." When asked what they were doing to treat the blister, she stated "A blister like that we are trying to keep it intact, open to air to dry." When asked what she was calling the blister and had she Staged it as a Pressure Ulcer. She stated, "At this point I have not called it a Stage 2. I have seen it every day since December 2nd. I would not necessarily call a blister a Stage 2, I haven't actually staged it" When asked why she had not staged the pressure ulcer, she stated "I don't know." She was then asked if anything else was tried prior to the shin guard being placed, she stated, "We tried moving the W/C legs differently, and was waiting for the pads (footboard) that are in place now." Was asked what was tried prior to the pads that are in place</p>	F 314		
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F 314	<p>Continued From page 23</p> <p>now, she stated, "Modifying the W/C, and repositioning him." She was then asked if she had checked the shin splint herself after the placement of them. She stated "No, I did not check them myself. I was gone for four days." The surveyor then asked if it was documented any where that the skin had been looked at after the application of the shin splint, she stated "I would have to check on that." When asked if there was an assessment anywhere that documented where the blister was at on the leg, she stated, "I need to get the nurses notes." When asked who does the assessments when she is gone, she stated "The nurses do that on skin sheets or in the nurse's notes."</p> <p>On 12/5/13 at 2:45 pm the Surveyor observed the Resident's blister with LN#3 WCC. Resident was observed in his bed, awake, fidgeting with his hands. The blister measured 4.6 cm x 1.2 cm with red spots surrounding the area. The skin over the blister was intact, loose and sagging, shiny to just the area of the blister, and gold in color. It was located on the mid lateral side of left leg. The WCC provided the "Non Pressure Skin Condition" assessment completed on 11/30/13 when the blister was found. When she was asked about the form being a non pressure form, she stated, "We have different ones. This is the one she started on it. (Name) started the report." WCC was asked if she had an assessment in her book completed by herself, she stated, "No." She was asked when she would complete the first assessment and she stated, "I should have done it." [Implying that her assessment should have already been done.] While observing the blister the WCC stated, "Leaving it open to air." When asked what was on the blistered area that was making the area shiny, she stated "I am not sure."</p>	F 314		
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F 314	<p>Continued From page 24</p> <p>When asked if they were using something from the skin protocol on the blister she stated, "I am not sure. They would be using lotion for most of these people." When asked if they would be using lotion directly on the blistered area, she made a gesture of shrugging her shoulders and stated "I am not sure."</p> <p>On 12/5/13 at 5:30 pm the Administrator, the CCN and the DON were advised of the findings and no additional information was provided.</p> <p>2. Federal guidance at F314 indicated, "...Pressure Ulcer - A pressure ulcer [PU] is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). Although friction & shear are not primary causes of PUs,</p>	F 314			

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F 314	<p>Continued From page 25</p> <p>friction & shear are important contributing factors to the development of PUs...Friction/Shearing, Friction is the mechanical force exerted on skin that is dragged across any surface. Shearing is the interaction of both gravity & [and] friction against the surface of the skin. Friction is always present when shear force is present. Shear occurs when layers of skin rub against each other or when the skin remains stationary & the underlying tissue moves & stretches & angulates or tears the underlying capillaries & blood vessels causing tissue damage."</p> <p>Resident #4 was admitted to the facility on 10/5/12 with multiple diagnoses including dementia, hallucinations, malposturing of neck, difficulty walking and wheelchair (wc) dependent.</p> <p>The resident's 10/6/12 Nursing Assessment form contained a section titled "Skin Assessment." This section documented the resident had a bruise on the back, dry skin rash on face, and 2 plus on lower extremities. There was no on the form that the resident had corns or skin on his coccyx or sacral areas on admission.</p> <p>The resident had 13 significant change MDS coded severely impaired cognitive skills, a minimum of two person extensive assistance for all ADLs, at risk for development of pressure ulcers (PUs), no unhealed or healed PUs, had Moisture Associated Skin Damage (MASD), pressure reducing device for chair and bed, turning/repositioning program, application of nonsurgical dressings and ointments/medications other than to feet. Section V documented the Pressure Ulcer Care Area triggered and was addressed in the care plan.</p>	F 314		
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F 314	Continued From page 26 The resident's 9/9/13 quarterly MDS coded severely impaired cognitive skills, a minimum of two person assistance for all ADLs, at risk for developing PUS, no unhealed or healed PUs, skin tears, had MASD, pressure reducing device for chair and bed, turning/repositioning program, application of nonsurgical dressings and ointments/medications other than to feet. The resident's "Skin ('Braden Scale') Assessment, dated 1/10/13 through 6/18/13, documented the resident's pressure sore risks ranged from 16 to 12 representing low to high risk. The resident was assessed on 8/22/13 with a score of 10 representing a high risk score. The resident's Care Plan (CP), printed 10/9/13, identified, in part: - Problem, at risk for/actual impairment in skin integrity, high risk, related to dementia, combative, resistive behaviors, incontinent of bowel and bladder, and severe cognitive impairment. -Exhibited by increased redness, abraded {sic} area sacral buttocks. -Interventions included, in part: monitor buttocks, roho cushion in wheelchair, visually inspect sacral area every shift, monitor that air mattress was functioning properly every shift, cleanse sacral wound with normal saline skin preparation to peri wound, silvadene cream to wound and dressing, change daily and as needed. The 12/1/13 Physician Order Report (recapitulation orders) contained, in part, the following: -Order date 6/18/13, monitor every hour (left) and right turn schedule (red sacral area)	F 314			

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F 314	<p>Continued From page 27</p> <ul style="list-style-type: none"> - Order date 2/2/13, Monitor buttocks/peri area due to very red, every shift until resolved - Order date, 10/23/13, Cleanse sacral wound with normal saline, skin preparation to peri wound, silvadene (silver sulfadiazine) cream to wound, cover with dressing as needed. <p>Review of the Physician Order Flow Sheets (Treatment Sheets) provided evidence the facility monitored the resident and cleansed the sacral wound as the physician ordered.</p> <p>The resident's "Behavior Care Progress Notes" documented, in part, "9/29/13 at (4:40 p.m.)...On 8/22 [2013], fax was sent to MD re: [resident's physician regarding] redness to [right] sacral area...On 8/28/ [2013], 2 [two] open areas were also noted on Res' [resident's] sacral area that remain under close observation & treatment..." The nurse's signature for this entry was not distinguishable.</p> <p>On 12/4/13 at 10:32 a.m., the surveyor asked LN #3 and DON about the resident's skin condition in August 2013. The surveyor referred the DON and LN #3 to the above identified entries, 2 open sacral areas (8/28/13), on the 9/29/13 4:40 p.m. Behavior Care Progress Note. The DON stated, "We will check into it."</p> <p>On 12/5/13 at 2:45 p.m., the resident's coccyx and buttocks were observed. Both the coccyx and buttocks were red and blanchable.</p> <p>On 12/5/13 at 3:20 p.m., the facility provided documentation related to the resident's skin condition in August 2013. LN #3, the Corporate Compliance Registered Nurse and survey team discussed the resident's "Non-Pressure Skin</p>	F 314		

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F 314	<p>Continued From page 28 Condition Report (NPSCR)" form dated from 8/22/13 through 10/7/13.</p> <p>The resident's NPSCR form documented, date first observed 8/22/13, right side sacral area, abrasion, "appears like friction." The form documented the resident's physician was notified of the resident's skin condition. LN #3 signed all the following entries. The following entries were documented on the form.</p> <p>- 8/28/13, 3 cm x 4 cm (3 centimeters by 4 cm), no depth, tunneling, odor or exudate type and amount. Pink/beefy red wound bed, surrounding skin color pink, and surrounding tissue/wound edges normal for skin. Progress and Treatment were "new." Plan of care updated. Comments: "Has what appears as a friction area on sacral Rt [right] side. Red and slow to blanch, [no] drainage...[no] and s/s [signs and symptoms] of discomfort."</p> <p>- 9/6/13, 2.8 cm x 3.5 cm, no depth or tunneling or odor. Exudate type and amount (serous and scant). Pink/beefy red wound bed, surrounding skin color bright red, and surrounding tissue/wound edges maceration. Improved progress and continue treatment. Plan of care updated. Comments: "Area remains with [increased] redness. Slow to blanch. Res [resident] continues to be resistive to cares. [No] s/s of infection."</p> <p>- 9/12/13, 2.5 cm x 3 cm, no depth, tunneling, or odor. Exudate type and amount (serous and scant). Granulation tissue wound bed, surrounding skin color bright red, and surrounding tissue/wound edges was blank.</p>	F 314		

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F 314	<p>Continued From page 29</p> <p>Improved progress and continue treatment. Plan of care updated.</p> <p>Comments: "Slight improvement. Decreasing in size wound bed [with] granulation tissue. Wound edge intact. Peri-wound [with increased] redness. [No] s/s of infection."</p> <p>- 9/17/13, 2 cm x 1.5 cm, no depth, tunneling, or odor. Exudate type and amount (serous and scant). Granulation tissue wound bed, surrounding skin color pink, and surrounding tissue/wound edges maceration.</p> <p>Improved progress and treatment changed. Plan of care updated.</p> <p>Comments: "Area smaller. Wound bed [with] granulated tissue wound edge intact peri wound red. Res continues to be resistive to care. [no] s/s of infection noted."</p> <p>- 9/24/13, 1 cm x 0.5 cm, no depth, tunneling, odor, exudate type or amount. Granulation tissue wound bed, surrounding skin color pink, and surrounding tissue/wound edges normal for skin. Improved progress and continue treatment. Plan of Care updated.</p> <p>Comments: "Area improved wound bed 100% granulation tissue. Wound edges intact. Peri wound [increased] pink blanchable. [no] /s of infection."</p> <p>- 9/26/13, 1.5 cm x 2 cm, "sf [superficial] depth." No tunneling, odor, or exudate type or amount. Wound bed normal for skin, surrounding skin color pink, and surrounding tissue/wound edges normal for skin. Improved progress and continue treatment. Plan of Care updated.</p>	F 314		

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F 314	<p>Continued From page 30</p> <p>- 10/3/13, 1.5 cm x 2.5 cm, sf depth. No tunneling, odor, or exudate type or amount. Wound bed, surround skin color and surrounding tissue/wound bed all were normal for skin. Improved progress and continue treatment. Plan of Care updated. Comments: "Area Improving. wound bed pink/new skin. Blanchable."</p> <p>- 10/7/13, 1.5 cm x 2.5 cm, sf depth. No tunneling, odor, or exudate type or amount. Wound bed, surrounding skin color, and surrounding tissue/wound edges all were normal for skin. Improved progress and continue treatment. Plan of Care updated was blank. Comments: "Area [with] new pink skin/blanchable. Surround tissue pink. [no] s/s of pain/discomfort."</p> <p>On 12/5/13 at 3:25 p.m., the survey team discussed the resident's skin condition as documented on the NPSCR with LN #3 and the Corporate Compliance Nurse. LN #3 said the resident had one open area to the right side sacral area as documented on the NPSCR, not two as documented in the 9/29/13 4:40 p.m. Behavior Care Progress Note.</p> <p>- The survey team reviewed the documentation and asked the LN if the right side sacral area was a closed reddened area or an open area. The LN stated, "The area was closed."</p> <p>- The survey team asked how the area could be closed when, on 9/12/13, the wound bed was "with granulation." The LN did not reply to the question.</p> <p>- The survey team asked how the area, identified as "appears like friction" was not a pressure ulcer/sore? At this time, the LN provided the surveyors with</p>	F 314		

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F 314	<p>Continued From page 31</p> <p>copies of information received from a Skin and Wound Management Seminar. The documentation included in part, "III. Extrinsic Factors A. Pressure is the compression or squeezing together of soft tissue (especially over bony prominences), caused by weight or tension. These forces cause blood vessels to collapse resulting in an ischemic response and, potentially, tissue necrosis. 1. Clinical Presentation a. Pressure ulcers have rounded, crater-like shapes with regular edges...B. Friction 1. The force of rubbing two surfaces against each other. 2. Friction without pressure causes damage to the epidermis and upper dermal layers only. (Partial thickness) AKA [also know as] sheet burn. 3. Friction accompanied with gravity causes shear."</p> <p>On 12/5/13 at 4:48 p.m., the Corporate Compliance Nurse (CCN) provided additional information related to the resident's resistance to cares and interventions. The surveyor informed the CCN, the documentation on the NPSCR provided a conflicting picture of what the resident's skin issue was, non-pressure versus pressure and whether the resident's right sacral area was closed or open. The CCN nodded her head in an up and down motion indicating acknowledgement.</p> <p>Note: Further review of the documentation, provided to the survey team on 12/5/13 at 3:20 p.m., was completed. The documentation contained Interdisciplinary Progress Notes (IPNs), dated 6/12/13 through 10/18/13. The IPNs were reviewed. The following entries were signed by LN #3 unless otherwise indicated below: -8/22/13 at 12:30 p.m., "...3 cm x 4 cm - on sacral area...appears as friction..." -8/28/13 at 6:30 a.m., "Skin [check] to Res sacral</p>	F 314		
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F 314	<p>Continued From page 32 area..."</p> <p>-9/5/13 at 6:30 a.m., "Tx [treatment] to Res buttocks this am..."</p> <p>-9/6/13 at 9:20 p.m., "Wound on coccyx..." This entry appeared signed by LN #12.</p> <p>-9/11/13 at 6:30 a.m., "...main wd [wound] now open..." The nurse's signature for this entry was not distinguishable.</p> <p>-9/12/13 at 8:50 p.m., "...coccyx wound improving..."</p> <p>-9/13/13 at 9:15 p.m., "...coccyx healing..."</p> <p>-9/17/13 at 8:55 p.m., "...coccyx wound..."</p> <p>-9/24/13 at 6:15 a.m., "...drsg [dressing change] to Res sacral area..."</p> <p>-9/26/13 at 7:30 a.m., "...drsg [change] to Res sacral area..."</p> <p>-10/3/13 at 6:30 a.m., "...drsg [change] to Res sacral area..."</p> <p>-10/7/13 at 7:00 a.m., "...drsg [change] to Res sacral area..."</p> <p>Note: On 9/29/13 at 4:40 p.m., nursing staff documented in the resident's Behavior Care Progress Notes the resident had 2 open sacral areas that developed on 8/28/13.</p> <p>Note: On 8/28/13, LN #3 documented on a Non-Pressure Skin Condition Record (NPSCR), the resident had one sacral area that was not open. During an interview with LN #3, the LN said the wound never opened. This interview conflicted with the nurse's Behavior Care Progress Note dated 9/29/13.</p> <p>Note: However on 9/12/13, the same sacral area wound bed had granulation tissue. This indicated the sacral area was open.</p> <p>Further review of the resident's IPNs provided evidence the resident received treatment to his</p>	F 314		

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F 314	Continued From page 33 buttocks, coccyx, and sacral areas. The resident's medical record contained conflicting information related to the resident's actual skin condition.	F 314			
F 323 SS=G	On 12/6/13 at 10:00 a.m., the Administrator and the DON were informed of the concerns. The facility did not provide any additional information that resolved the concern. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined the facility failed to provide an environment as free as possible from accident hazards, and failed to provide adequate supervision for a resident with a history of falls. This was true for 4 of 15 residents (#s 10, 12, 13, and 15) sampled for accident hazards and supervision. Resident #10 was harmed when she became entrapped in the bed rail as she fell from bed, and died as a result of her injuries. Resident #12's seatbelt was not assessed for safety. This practice created the potential for more than minimal harm should Resident #12 become entrapped by the seatbelt. Resident #s 13 and 15 had the potential for more than minimal harm	F 323	Corrective Action Resident #12 had a successful restraint reduction initiated on 12/6/13, and his seatbelt was discontinued on 12/9/13. The side rails were removed from resident #13's bed on 12/19/13. The CNA who failed to provide supervision to resident #15 per the care plan received written disciplinary action by the administrator on 11/13/13. Other Residents As this deficiency has the potential to affect multiple residents, Valley Vista Care – Sandpoint removed all side rails from resident beds after evaluation by physical and/or occupational therapy for less restrictive devices between 12/6/13 and 12/24/13. Valley Vista is now a side rail – free facility. All residents with seatbelts will have a thorough restraint reduction assessment completed by the DNS or an assigned nurse designee, with input from physical and/or occupational therapy, NLT 1/10/14.	1/10/14	

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F 323	<p>Continued From page 34</p> <p>when they were not provided supervision as directed in the care plan, or pertinent medical history was not included in a safety assessment for the use of bed rails. Findings included:</p> <p>The State Operations Manual, Guidance to Long Term Care Surveyors, Appendix PP, under F323, documented:</p> <p>"Regardless of the purpose for use, bed rails...and other bed accessories...while assisting with transfer and positioning, can increase resident safety risk. Bed rails include rails of various sizes (e.g., full length rails, half rails, quarter rails) that may be positioned in various locations on the bed. In 1995, the FDA [Food and Drug Administration] issued a Safety Alert entitled 'Entrapment Hazards with Hospital Bed Side Rails.' Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement...that may cause them to move about the bed or try to exit from the bed. The timeliness of toileting, appropriateness of positioning, and other care-related activities can contribute to the risk of entrapment."</p> <p>The guidance at F323 further documented:</p> <p>"The use of a specialty air-filled mattress or a therapeutic air-filled bed may also present an entrapment risk that is different from rail entrapment with a regular mattress. The high compressibility of an air-filled mattress compared to a regular conventional mattress requires appropriate precautions when used for a resident at risk for entrapment. An air-filled mattress compresses on the side to which a person</p>	F 323	<p>Facility Systems</p> <p>Valley Vista will remain a side rail free facility and utilize appropriate less restrictive devices such as lipped-mattresses, trapezes and transfer poles to assist residents with bed mobility and repositioning. On 12/17/13, the administrator and DNS in-serviced all licensed nurses on this policy change and advised them to obtain orders for physical and/or occupational therapy should a resident request side rails or require an assistive device for bed positioning or transfer assistance. The Administrator and DNS in-serviced all licensed nurses and CNA's on 12/17/13 and 12/18/13 regarding the importance of following the care plans to help ensure the safety of the residents.</p> <p>Effective 12/17/13, no restraints will be initiated at Valley Vista Care – Sandpoint without evaluation by a physical or occupational therapist to determine if less restrictive measures are available or appropriate. Licensed nurses were in-serviced on this protocol change by the administrator at the monthly licensed nurse meeting held on 12/17/13. Furthermore, nurses were instructed by the administrator on 12/17/13 to obtain orders for therapy to evaluate and treat the resident prior to requesting orders for a restraint from the physician. Only after the therapist has assessed the resident and deemed the restraint safe, appropriate and necessary will the nurse request orders for the restraint device.</p> <p>Effective 1/10/14, any resident with a restraint will have a restraint reduction assessment conducted by the MDS nurse at least quarterly in conjunction with that resident's next scheduled MDS assessment. On 12/17/13, the MDS nurses were in-serviced of this and were instructed to seek input from the appropriate physical and/or occupational therapist to help determine if any less restrictive devices were available or appropriate.</p>		

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F 323	<p>Continued From page 35</p> <p>moves, thus raising the center of the mattress and lowering the side. This may make it easier for a resident to slide off the mattress or against the rail. Mattress compression widens the space between the mattress and rail. When a resident is between the mattress and rail, the mattress can re-expand and press the chest, neck, or head against the rail. While using air therapy to prevent and treat pressure ulcers, facilities should also take precautions to reduce the risk of entrapment. Precautions may include following manufacturer equipment alerts and increasing supervision."</p> <p>The Administrator provided 2 copies of a document entitled, "Proper Use of Side Rails", dated 2001, revised October 2012. The administrator identified one copy as the facility's policy on siderails use before 6/1/13 [P1], and the second copy as the policy after 6/1/13 [P2]</p> <p>Both policies included:</p> <p>"Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents."</p> <p>"The use of side rails as an assistive device will be addressed in the resident care plan."</p> <p>"When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment."</p> <p>[NOTE: For this bullet point, P1 and P2 differed slightly after this sentence. P1 documented, "(the amount of safe space may vary, depending on the type of bed and mattress being used)." P2 documented, "The facility will also assess gaps within the bed system to be sure they are within the dimensions established by the FDA (Note: The review shall consider situations that could be caused by the resident's weight, movement, or body position.)"]</p>	F 323	<p>Monitoring</p> <p>As all side rails have been removed from the facility, no monitoring of side rail usage is necessary. Beginning in January 2014, an audit will be conducted monthly by the DNS, Administrator or nurse designee to ensure restraint usage compliance and compliance with attempts at reducing restraint usage. The results of these audits will be reviewed at the monthly Quality Assurance meeting, beginning with the next Quality Assurance meeting tentatively scheduled for 1/22/14. This audit will be conducted during each of the next 3 months, at which time the need for continued audits will be re-evaluated.</p> <p>CNA compliance with adhering to the care plan will be randomly audited on each shift biweekly for three months by the DNS, Administrator, charge nurse or designee beginning the first week in January 2014. Any staff member who fails to follow the care plan will receive an immediate on the spot correction and be reported to the Director of Nursing or Administrator for disciplinary action. All resident care plans and care guidelines will be audited by the Administrator, DNS, or designee monthly for the next 3 months, with the first audit completed NLT 1/10/14. The auditor will ensure that the care plans and care guidelines match and are accurate. The results of the audits will be shared by the administrator or DNS at the monthly QA meeting beginning with the next QA meeting tentatively scheduled for 1/22/13. After 3 months, the need for continued audits will be re-evaluated by the QA committee.</p>	
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F 323	<p>Continued From page 36</p> <p>1. R #10 was admitted to the facility on 12/11/12 with multiple diagnoses which included a fractured humerus, Stage III kidney disease, urosepsis, porphyria, generalized weakness, increased fatigue, and malaise.</p> <p>Resident #10's admission MDS assessment, dated 12/18/12, coded: *BIMS of 15, indicating the resident was cognitively intact. *Extensive assistance of two for bed mobility and transfers. *Physical assistance required for moving from a seated to a standing position, moving on and off the toilet, and surface-to-surface transfers.</p> <p>Resident # 10's Quarterly MDS assessment, dated 5/23/13, coded: *Unable to complete the BIMS, assessed by staff as having long-term and short-term memory loss and moderately impaired decision making skills. *Extensive assistance of two for bed mobility and toilet use. *Totally dependent on two for transfers, locomotion on and off the unit, and personal hygiene. *Extensive assistance of one for dressing and eating. *Did not ambulate.</p> <p>On 12/11/12, an "Evaluation for Use of Side Rails" form in R #10's record documented: *Side rail use was, "Family requested" to, "help her move." *Identified contributors to the resident's need for side rail use were documented as weakness and pain. There were spaces in this area of the form for cognitive and security considerations, both of</p>	F 323		

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F 323	<p>Continued From page 37</p> <p>which were blank.</p> <p>*The "Recommendations" area of the form offered the options of "Side Rails are recommended at this time...", "Side rails are not indicated at this time...", or "Further evaluation is required by", with boxes to select either PT, OT, or Other. The box next to "OT" had an "X" in it.</p> <p>*The "Recommended Type" of side rail was documented as, "Arco", with the boxes for "1/4 partial rails" for both the left and right checked. [NOTE: It was not clear from this assessment what an "Arco" rail was. On 12/5/13 at 9:00 AM, the Administrator identified it as a side rail which could be used in two different ways, either as a "bed cane" or as a "quarter rail."]</p> <p>*The "Recommended Use" area of the form, which offered options of using the side rails only at night, at all times when the resident is in bed, or only when the resident is ill, was blank.</p> <p>*The area of the form indicating whether side rail precautions had been discussed with either the resident, or the resident's family, was blank.</p> <p>*The area of the form indicating alternatives to side rail use had been discussed with either the resident, or the resident's family, was blank.</p> <p>*The area of the form indicating when the use of side rails should be reevaluated, was blank.</p> <p>*The area of the form indicating whether a physician's order for the side rails had been obtained, was blank.</p> <p>*The area of the form indicating whether the resident's care plan had been updated, was blank.</p> <p>*The "Comments" area of the form documented, "5/30/13. Reassessed [sic] for continued use of Arco rails - incontinent of B/B [bowel and bladder] - continues to remain appropriate for ongoing use of bilateral Arco rails [at] this time - Remains safe/appropriate." [NOTE: This was the only</p>	F 323		

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F 323	<p>Continued From page 38</p> <p>reevaluation documented regarding R #10's side rails since her admission in December 2012, even though the resident was documented with an ongoing decline, had been enrolled in hospice services, and had been placed on an air mattress. There was no documentation of how the side rails had been assessed as safe for this resident. Two days after this comment was added to the form, R #10 died when she fell from bed and became entrapped in her side rail.]</p> <p>Resident #10's Interdisciplinary Progress Notes documented: *12/11/12, 3:30 PM, from OT, "OT orders to eval[uate] and [treat] [received]. Chart reviewed Attempted to initiate eval, [patient] in bed sleeping, opened eyes to command but then closed again; shook head. Will do eval on 12/12/12." [NOTE: This note did not include evidence the OT conducted an assessment for the need for side rails.] *12/12/12 at 4:20 PM, from the Physical Therapist. "Requested Arco rails for bed to assist rolling and supine to sit." [NOTE: These were the only two progress notes the facility provided from OT or PT discussing the use of side rails. There was no evidence either OT or PT had reevaluated the need for side rails as the resident's health and strength began to decline.]</p> <p>On 12/11/12, a "Consent for Use of Side Rails" form in R #10's chart documented family consent for the use of "Arco" 1/4 partial side rails on the left and right upper portions of her bed. The form was signed by Resident #10's daughter, rather than by Resident #10. [NOTE: At the time, the resident had been assessed as cognitively intact. There was no explanation as to why the resident herself did not sign the consent.]</p>	F 323		

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F 323	<p>Continued From page 39</p> <p>Resident #10's Physician's progress notes documented: *1/8/13. "Cannot speak properly...Aggravating factors include situational stress. Relieving factors include nothing...Positive for fatigue, weight loss, anxiety, dizziness, gait disturbance, dyspnea...patient is oriented to time, place, person, and situation...has normal insight. Exhibits normal judgement, demonstrates appropriate mood and affect..." *2/19/13. "Weight loss...risk factors...include anxiety, history of stroke, Porphyria...positive for anxiety, depression, extremity weakness, gait disturbance, memory impairment, numbness in extremities...level of distress is lethargic. Nourishment type is thin...the patient is not oriented to time, place, person, or situation...has poor insight...does not demonstrate the appropriate mood or affect...she has become despondent...she has not responded to therapy to recover her lost function. This has prompted a referral to Hospice..." [NOTE: The facility did not reassess the need for side rails for this resident at this time, even though the physician had noted a number of areas of decline for the resident.] *3/14/13. "Failure to thrive...the symptoms began three months ago...reported as being incapacitating...the symptoms are uncontrolled...positive for extremity weakness, gait disturbance, memory impairment, numbness in extremities...her orientation cannot be evaluated due to her expressive aphasia. Today I did not see recognition of me in her eyes..." *4/20/13. "Failure to thrive...reported as being severe...has been unable to speak coherently and has been difficult to feed...now on Hospice care...positive for dizziness, extremity weakness,</p>	F 323		

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F 323	<p>Continued From page 40</p> <p>gait disturbance, memory impairment...level of distress is anxious...not oriented to time, place, person, or situation...poor insight...exhibits poor judgement...does not demonstrate the appropriate mood or affect..."</p> <p>*5/18/13. "Failure to thrive...Aggravating factors include change in routine...the symptoms are uncontrolled...has been admitted to hospice care...swelling...occurred 1 week ago. The severity is moderate and has worsened...The swelling is associated with appetite change, blistering, decreased mobility, generalized weakness and malaise...the left leg has started weeping...the patient is not oriented to time, place, person, or situation...has poor insight. Exhibits poor judgement..."</p> <p>Resident #10's Physician Order Report (Recapitulation Orders) for May 2013 documented, "Monitor air bed for proper inflation every shift." Initiated 3/2/13.</p> <p>Resident #10's Monthly Nursing Summary forms documented under the area of, "P. Restraints", the use of bed rails, right side up and left side down, for safety in bed, on 1/17/13, 2/27/13, 4/21/13, and 5/9/13.</p> <p>Resident #10's care plan documented, under the problem area, "Potential for Injury: Falls... Related to...narcotic use...CHF...weakness/fatigue...poor safety awareness...[change] in physical condition...impaired communication..." initiated 12/11/12, the following interventions: *"New fall 1/20/13 and 1/25/13." [NOTE: There was no date documented as to when this intervention was added. The resident was also noted with falls on 1/31/13, 3/3/13, and 3/30/13, which were not mentioned on her care plan.]</p>	F 323		

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F 323	<p>Continued From page 41</p> <p>**"Set up to self propel from nurse station to res room [after] meals as res allows." Initiated 1/21/13, discontinued 5/30/13.</p> <p>**"[Every] 15 minute [checks]." [NOTE: This intervention was highlighted in yellow, indicating it had been discontinued. The date 1/28/13 was hand-written next to this intervention, with no signature or initials to indicate who had written that date. It was unclear whether 1/28/13 was the date this intervention was initiated, or the date it was discontinued.]</p> <p>**"Arco rails bilat[erally] while in bed." Date initiated 5/30/13. [NOTE: Resident #10's assessment for the use of side rails, and consent to use them, was completed on 12/11/12. The monthly nursing summaries referenced above indicated one 1/4 side rail up on each summary.]</p> <p>**"High/low bed in low position while in bed." Date initiated 5/30/13.</p> <p>On 5/8/13, the resident's Hospice Recertification form documented, "She is sleeping more with more agitation when awake..."</p> <p>Resident #10's Interdisciplinary Progress Notes (PNs) documented: 5/23/13 at 11:00 AM. "Care conference held. Daughter present. [Social Services], Activities, Dietary, Hospice Nurse [and Social Services]. Daughter voices she does not want discussion of death or hospice." 5/25/13 at 10:00 PM. "During [bedtime] cares CNA found a skin tear on resident's [right] knee 1.0 cm [centimeter] [long]..." 6/1/13 at 4:20 PM. "Res found with out signs and symptoms of life per RN."</p> <p>Resident #10's record included documents entitled, "Memorandum for Record." Six of these</p>	F 323		
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F 323	<p>Continued From page 42</p> <p>documents were related to falls for the resident. Documentation on these forms included:</p> <p>*1/20/13. "On...1/20/13 at [11:52 PM] [R #10] was found on the floor next to her bed...had been incontinent of BM [bowel movement]...she will attempt to transfer herself if no one is available to assist...[R #10] has a unique condition called Intermittent Porphyria. This presents with symptoms such as sudden increased energy and activity for on [sic] average of 3 days followed by 2-3 days if extreme fatigue with increased weakness." The facility's conclusion was documented as, "Found on floor; likely a fall while trying to respond to bowel urgency." The facility's plan was included, "Provide [every] 15 minute checks to monitor need for toileting assistance following the initiation of bowel protocol", and "Monitor signs and symptoms of Intermittent Porphyria."</p> <p>*1/25/13. "On Sunday 1/27/13 [NOTE: The date of the memorandum may have been made in error, as it was two days before the event.] at [3:40 PM] [R #10] was found on the floor perpendicular to her bed, lying on her back...wheelchair was next to the bed where she had been sitting prior to the event...it was noted that since lunch she had refused all cares and assistance with getting into bed...last checked at [3:30 PM]...will attempt to self-transfer if no one is available to assist." The facility's conclusion was, "Found on floor; likely a fall while try [sic] to self-transfer from wheelchair to bed." The facility's plan included, "Provide [every] 15 minute checks while resident is in her room..."</p> <p>*2/4/13. "On 1/31/13 at 11:10 AM, [R #10] was found sitting on her wheelchair pedals at the</p>	F 323		

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F 323	<p>Continued From page 43</p> <p>North Nurse's station...She is able to self propel her [wheelchair] short distances with cueing. She is most successful in doing this on her way back to her room. However she will attempt to transfer herself if no one is available to assist." The facility's conclusion was, "Found sitting on wheel chair pedals, probably due to attempt to self transfer due to confusion, weakness and poor impulse control." The facility's plan included, "Provide [every] 15 minute checks - one to one [as needed]."</p> <p>*3/4/13. "On 3/3/13 at 11:55 PM, [Resident #10] was found on her knees on the floor and her upper torso on her bed...prior to the event it was noted that [R #10] was in bed and appeared to be sleeping. On the CNA's last round at [10:20 PM] [R #10] was incontinent of urine and had been changed and repositioned." [NOTE: 1 hour, 35 minutes had elapsed between the time documented by the facility as "last rounds" for R #10, and the time the resident was discovered with her legs out of the bed but her torso in the bed. When R #10 last fell on 1/31/13, the facility's plan was to implement 15 minute checks.] The facility's conclusion was, "Found with knees on floor and upper torso on her bed, probably due to attempt to self transfer or roll out of bed due to confusion, weakness, and immobility." The facility's plan included, "Provide [every] 15 minute checks - one to one [as needed]."</p> <p>4/1/13. "On 3/30/13 at [3:05 AM], [R #10] was found on the floor lying next to her lo-bed by [CNA]...On the CNA's last round at [2:00 AM] [R #10] was incontinent of urine and had been changed and repositioned. ..." [NOTE: One hour and 5 minutes had elapsed between the last rounds on R #10 and the time of the fall, even</p>	F 323		
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F 323 Continued From page 44
though one of the interventions for the 2 previous falls had been every 15 minute checks.] The facility's conclusion was, "Found on floor, probably due to attempt to self transfer or roll out of bed." Again, the facility's plan documented, "Provide [every] 15 minute checks - one to one [as needed]."

*6/5/13. "On 6/1/13, [R # 10] was found partially on the floor by [CNA] as she was passing [R #10's] room. According to the report, [CNA] was walking past the room and saw that [R 10's] feet were on the floor. Upon further inspection, she noted that [R # 10's] upper body was not on the floor. [NOTE: This describes a similar circumstance as R #10's fall on 3/4/13.] [R #10's] left arm was between the side rail posts closest to the door, and [R #10's] head was resting on her arm. The right lateral aspect of [R # 10's] neck was against the side rail surface of the mattress...she had a pulse but did not appear to be breathing. [R #10] had a nasal cannula on at the time and [LN #6] turned to oxygen flow all the way on the O2 concentrator to provide higher O2 flow. Together with 2 CNA's, she lifted [R #10] back into bed. At that point, she no longer was able to find a pulse or respirations. A purple, approximately 2 cm X 8 cm bruise was noted to be present on the right lateral aspect of [R # 10's] neck where it had made contact with the 1/4 rail...CNA reports that she last went into the room and checked on [R # 10] to see if she needed a gown sometime around [3:00 PM]. At that time, [CNA #7] observed that [R # 10] was still on her right side and asleep...The alternating air mattress...was operational and appeared to be working effectively...The mattress manufacturer's recommendation advise [sic] that 'it is preferred that the rails be used in the raised position

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F 323	<p>Continued From page 45</p> <p>whenever a resident is in bed'...The bed is a standard size with a platform width of 35 inches..." [NOTE: Even though the reports from the three previous falls had documented every 15 minute checks for R #10, there were no staff statements ascertaining her whereabouts or positioning between 3:00 PM, and the time she was observed entrapped in her side rail at 4:05 PM.] The facility's conclusion was documented as, "On 6/5/13, the county coroner called me [Administrator] and stated that autopsy determined the preliminary cause of death was 'neck compression by bed rail and mattress.' It appears likely that [R #10] rolled over or repositioned herself in bed. At that point, her legs apparently slid off of the bed, her arm threaded between the side rail posts, and her neck became pinned against the side rail." The facility's plan to prevent reoccurrence included:</p> <ul style="list-style-type: none"> -Side rail assessments conducted on 100% of facility residents using side rails. -All staff in-serviced on safe side rail usage with air beds. -Bolster mattress overlays were ordered for all air mattresses in use. [NOTE: Bolster overlays are a non-side rail alternative to promote safety with air mattress use.] -Nursing staff in-serviced on proper assessment and use of rails, use and installation of an air mattress, and risk factors for entrapment. [NOTE: Please see example #2 below regarding side rail evaluation completed after this event.] <p>Resident #10's death certificate documented: **Date of Death, June 1, 2013." **Time of Death, 16:20 [4:20 PM]." **Cause of Death: Asphyxiation due to neck compression due to hanging." **Describe how injury occurred..." was</p>	F 323		
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F 323	<p>Continued From page 46</p> <p>documented as, "Found with legs and body out of bed, left arm in siderail, head between mattress and side rail."</p> <p>On 12/5/13, the Administrator, Corporate Compliance Nurse (CCN), and LN #2 were interviewed regarding Resident #10, and her fatal fall on 6/1/13. The Administrator stated on the day Resident #10 expired, he received a phone call from the RN on duty. The Administrator stated once the RN described the circumstance, he immediately came to the facility, and ensured the coroner and police were called, as well as notified the state agency hotline of the event. The Administrator stated the facility launched an investigation to determine what had caused the event, and identify ways such an event could be avoided in the future. Regarding Resident #10, the surveyor's interview on 12/5/13 revealed:</p> <p>*The facility was unsure if one 1/4 side rail was in use, as indicated on the monthly nursing summary forms, or both 1/4 side rails, as indicated on the resident's side rail assessment.</p> <p>*It was unknown how or when additional risk factors which developed after the date of the original side rail assessment, such as the failure to thrive diagnosis, weakness, anxiety, and decreased insight and judgement, were reevaluated to determine if ongoing side rail use continued to be appropriate for the resident.</p> <p>[NOTE: The only dates documented in Resident #10's record for side rail assessments are 12/11/12 (the date of her admission to the facility), and 5/30/13 (two days before she died due to a fall and entrapment in her side rail).]</p> <p>*The Administrator agreed the facility had initiated 15 minute checks after one of Resident #10's falls, but he could not recall which fall. He stated as the resident's health declined, the checks were</p>	F 323		
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F 323	<p>Continued From page 47</p> <p>discontinued because she was not attempting to self-transfer, and had been removed from the resident's care plan. The Administrator did not believe the 15 minute checks were in place at the time of Resident #10's final fall. [NOTE: Per the facility's documentation cited above, 15 minute checks were listed as fall interventions following Resident #10's falls on 1/31/13, 3/3/13, and 3/30/13.]</p> <p>*Regarding the 15 minute checks on Resident #10's care plan, the Administrator stated the facility CNAs used "Resident Care Guidelines" more frequently, and if they initialed that document, it meant any item listed on it had been carried out. The Administrator stated he believed the 15 minute checks for Resident #10 were still on her Resident Care Guidelines at the time of her fall. The Administrator did state the resident's care plan and the Resident Care Guide should match one another.</p> <p>*The Administrator could not confirm exactly what time Resident #10 fell, as compared to when she was discovered by staff. [NOTE: Staff statements indicate Resident #10 was seen on rounds at 3:00 PM, then found half on the floor with her arm entrapped in her side rail at 4:05 PM on 6/1/13. Therefore, even if 15 minute checks were listed on Resident #10's Resident Care Guidelines, the checks were not carried out.]</p> <p>*The Administrator, CCN, and LN #2 were unable to clearly indicate whether the 1/4 side rails for Resident #10 were used for mobility, as documented in her side rail assessment; or for safety, as documented on her monthly nursing summaries. They were unable to report whether lesser restrictive alternatives were considered for Resident #10. The Administrator stated the side rail could have been in place due to the air mattress. The Administrator stated he did not</p>	F 323		

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F 323	<p>Continued From page 48</p> <p>know for sure if the manufacturer's recommendations for side rails up meant a 1/4 rail would be sufficient to meet that requirement. The Administrator stated the facility had not questioned that before the fall, because the air mattress had been provided by Hospice and it was up to Hospice to make sure it was safe. Additionally, the Administrator stated the both the air mattress and the side rails were made by the same company, so it could be presumed they were safe to use together.</p> <p>*LN #2 stated initially, the family had requested the use of a side rail for R #10 to help with mobility.</p> <p>*LN #2 stated with the initial assessment of the side rail, the resident would have to show she could use it appropriately to reposition, her head would not fit through it, and it was securely attached to the bed. LN #2 stated from that perspective, the assessment had been accurate because ultimately it was the resident's arm which was trapped in the side rail, not her head.</p> <p>*The Administrator stated the side rail assessment should be repeated at least quarterly, and with any change of condition. The Administrator was unable to explain why the side rail assessment for Resident #10 had not been updated between 12/11/12 and 5/30/13. The Administrator stated following the fatal event for Resident #10 the facility had done extensive education to ensure assessments were being updated regularly.</p> <p>*The Administrator stated he did not believe there would be a physician's order for the use of the side rail, as the facility did not require a physician's order to use such a device.</p> <p>On 12/5/13 at 1:45 PM, the Administrator provided the following additional documentation</p>	F 323		

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F 323	<p>Continued From page 49 for Resident #10: *The manufacturer's recommendations for safe use of the air mattress for Resident #10. Following the statement cited above the facility's report of the event, the recommendations documented, "Health care professionals assigned to each case should make the final determination whether side or assist rails are warranted after assessing patient risks of entrapment and falls..." *A 5/22/13 order from the hospice agency involved in R #10's care, which documented, "DME [Durable Medical Equipment] as needed", along with a facility care plan for an air bed, initiated 3/1/13. [NOTE: The physician's order did not specify an air mattress or side rail should be used for R #10. The care plan for the air mattress pre-dated the physician's order by 82 days.] *R #10's Resident Care Guidelines for May 2013. The care guidelines included 15 minute checks for the entire month. [NOTE: When R #10 fell on 6/1/13, staff statements documented a period of an hour and 5 minutes since she was last seen.] The care guidelines also documented the addition of bilateral Arco side rails on 5/30/13.</p> <p>Resident #10 was harmed when the facility did not assess the continued use of side rails as her medical condition and equipment in use changed, did not consider lesser restrictive measures which could have been used for safety, and did not monitor the resident per her plan of care. R #10 ultimately became entrapped in her side rail, and died as a result of her injuries.</p> <p>On 12/5/13 at 5:30 PM, the Administrator, DNS, and CCN were informed of the surveyor's findings. The facility offered no further information to resolve the concern.</p>	F 323			

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F 323	Continued From page 50 2. Resident #13 was admitted to the facility on 4/1/2011 with diagnoses that included: Seizure Disorder, Dementia with Behavioral Disturbance, CVA, (Cerebrovascular Accident Current/Ischemic), Muscle weakness (Generalized), Aphasia. * On November 9th, 2010 the Resident completed paperwork assigning her husband as her DPOA [Durable Power of Attorney for Health Care]. * Quarterly MDS dated 9/16/2013 documented: -Bed Mobility: Extensive assistance- 1 person physical assist -Functional Limitation in Range of Motion: A. Upper extremity- Impairment on one side B. Lower extremity- Impairment on one side. *Current MD orders dated 12/1/2013 documented that the Resident was receiving a medication for seizures: -"Keppra 500 mg 1 by mouth twice a day (Seizures) Notes: Monitor for seizures and document on seizure log" *Social Services Initial Resident History Assessment dated 4-1-11 documented: "Has had 2 seizures." *Resident's Care Plan dated "Origin 04/01/11" documented: -Impaired Physical Mobility -Related To:	F 323			

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F 323	<p>Continued From page 51</p> <ol style="list-style-type: none"> 1. CVA 2. Hemiparesis/hemiplegia 3. Weakness <p>-Interventions:</p> <p>5. "1/2 side rails [(L/R For)-this area was yellowed out as discontinued] Increased Mobility/Positioning upper, Bilat (bilateral) 11/20/13"</p> <p>*Consent for Use of Side Rails dated 7/20/12 and signed by DPOA documented:</p> <p>-Recommendations-"1/4 partial rail- Left: Upper-Right: Upper"</p> <p>-Frequency- "Side rail(s) are recommended at all times when resident is in bed."</p> <p>-Purpose- "(Increase) mobility (Increase) repositioning"</p> <p>*Evaluation for Use of Side Rails dated 6/7/13 documented:</p> <p>-Why is the use of a side rail(s) being considered? Checked was "Resident requested-Other (Increased) mobility"</p> <p>-Identify all that contribute to the resident's need to use side rail(s): Checked was "Physical: Weakness"</p> <p>-Additional Considerations included: Medications that require increased safety measures (diuretics, psychotropic, orthostatic medications) "Yes, list: see MAR(Medication Administration Record)" Will the side rail(s) impede resident's freedom of movement? "Yes"</p> <p>-Recommendations- "Side rail(s) is/are recommended at this time due to: (Increased)</p>	F 323		
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F 323	<p>Continued From page 52</p> <p>mobility</p> <p>-Recommended Type: "1/2 partial rail- Left: Upper Right: Upper" [NOTE: DPOA had signed consent for 1/4 rails. A new consent explaining to the DPOA why 1/2 side rails were being used was not found.]</p> <p>-Recommended Use: "Side rail(s) are recommended at all times when resident is in bed."</p> <p>-"Side rail precautions have been discussed with: "Resident Family/Resident representative"</p> <p>-Alternatives to side rails have been discussed with: "Resident Family/Resident representative" [Note alternatives discussed were not documented on the Evaluation]</p> <p>-Comments section: Dated 9/27/13 "(Resident) demonstrates safe & appropriate use of 1/2 rails for bed mobility and transfers. Then remains safe & appropriate for ongoing use."</p> <p>-Physician order has been obtained, including medical symptom/ condition [NOTE this area was not checked and an order was not found in the record for the use of the side rails.]</p> <p>-Plan of care updated [NOTE this area was not checked and the care plan was noted to have not been updated until 11/20/13.]</p> <p>*Side Rail Assessment Addendum dated 6/7/13 documented "Yes" to:</p> <ol style="list-style-type: none"> 1. Are bars within the bed rails closely spaced to prevent the patient's head from passing through the openings and becoming entrapped? 2. Will the mattress to bed rail interface prevent an individual from falling between the mattress and bed rails and possibly smothering? 5. Is the mattress appropriately sized for the selected bed frame? 	F 323		

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F 323	<p>Continued From page 53</p> <p>6. Is the space between the bed rails and the mattress and the headboard and the mattress filled either with an added firm inlay or mattress that creates an interface with the bed rail that prevents an individual from falling between the mattress and bed rails?</p> <p>7. Are the latches securing the bed rails stable so that the rails will not fall when shaken?</p> <p>The Assessment documented "No" to:</p> <p>3. Inspect the mattress to ensure it has not shrunk (related to time and cleaning). Such shrinkage increases the potential space between the rails and the mattress. Any concerns with mattress shrinkage?</p> <p>4. Check for compression of the mattress outside perimeter since easily compressed perimeters can increase the gaps between the mattress and the bed rail. Any concerns with the outside mattress perimeter?</p> <p>[NOTE: Each section had an area for comments- no comments were found]</p> <p>The Assessment also documented:</p> <p>9. Type of Mattress: "Therarest"</p> <p>10. Type, number, and location of side rail(s) assessed: "2 1/2 upper with control (no entrapment"</p> <p>Summary of Findings: Dated 9/27/13 "Rails [sic] snug to mattress (Resident) Demonstrates ability to use them safely. These are safe & appropriate"</p> <p>On 12/2/13 at 4:40 pm while on the Initial Tour of the facility, the surveyor observed the resident had 2 1/2 upper side rails positioned up on the bed. The resident was not in the room. LN#1 stated the resident used the rails "for positioning."</p>	F 323			

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F 323	<p>Continued From page 54</p> <p>On 12/4/13 at 4:40 pm both upper half side rails were observed to be up on the resident's bed. There was a bed side table positioned across the foot of the bed. The resident was not in the room. The side rails did not have padding on them.</p> <p>On 12/5/13 at 8:20 am the resident was observed to be in her W/C (wheelchair) in her room. The resident was observed to use her left arm/hand to get a brief out of her dresser drawer and put it in the bathroom. Then Resident was observed to go back to the dresser drawer and get her TV (television) control out of the top drawer of her dresser and turn on the TV, using the left hand. The Resident's right hand was observed to be flaccid. The bilateral side rails did not have padding on them.</p> <p>On 12/5/13 at 11:00 am the Resident was observed to be asleep in her w/c beside her bed. The 2 1/2 side rails were in the upright position on the bed. The bilateral side rails did not have padding on them.</p> <p>On 12/5/13 at 9:00 am during an interview with the Administrator, CCN(Corporate Compliance Nurse), and LN#2 when asked if there was a history of Seizures in a Resident would there be any special considerations for the side rail. The CCN stated "It would definitely be considered." She then asked the Administrator if there was anyone with seizures and side rails. The Administrator stated "Yes (name) and he has padded side rails." When asked how they were determining 1/4 and 1/2 side rails for the Residents, the CCN stated "the assessment will tell what they will use. If I was doing the assessment I would use the rail that is the least restrictive for the Resident." [NOTE: Resident #13</p>	F 323		

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had a diagnosis of Seizures and the side rails used were not observed to be padded. The Evaluation of Use of Side Rails documented "yes" to the side rails will impede the resident's freedom.]

On 12/5/2013 at 3:40 pm during an interview with LN #2 when asked to tell the surveyor the story of the side rails she stated, they were placed in June of 2013. The past DON had done the assessment and addendum on 6/7/13 and wrote an Interdisciplinary note. The DON did not explain why the side rails went from 1/4 to 1/2, and a new consent was not done at that time. LN#2 then stated "It was her (Resident) request to go to the 1/2 side rail instead of the 1/4. The week of 6/5 the CCN went in and talked to her (Resident) about the rails. We had removed them for I think 2 hours. She yelled and screamed. (Resident) was offered a trapeze and she declined." Then the facility placed the 1/2 side rail "that were manufactured for the bed. It is a Hill ROM bed." The surveyor asked if the facility had other Hill ROM beds in the building. LN #2 stated "Yes, and they do not have rails on them." The surveyor then asked if the rail on the bed was the only rail that fit that bed. She stated, "yes it is." LN#2 was asked if they had documentation that the Resident was unhappy with the rails that were on the bed before. She stated "I do not have any documentation that she was unhappy with the rails before." When asked if the Resident can have any other type of bed that is in the facility. LN#2 stated "I don't see why she can't have any bed."

On 12/5/13 at 4:00 pm the Administrator spoke with the Surveyor and LN#2 was present. The Administrator stated he wanted to clarify the

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F 323	<p>Continued From page 56</p> <p>information about the previous side rails. He stated "(Resident) did have 1/2 side rails prior to the change of the side rails. The DON at that time was calling 1/2 side rails 1/4 because it was a 1/4 of the bed." [NOTE: The surveyor requested documentation of this and none was provided.]</p> <p>On 12/5/13 at 5:30 pm the Administrator, CCN and DON were informed of the findings. No additional information was provided.</p> <p>3. Resident #15 was admitted to the facility on 4/27/13 with multiple diagnoses which included dementia, diabetes, and urosepsis.</p> <p>The most recent quarterly MDS assessment for Resident #15, dated 10/2/13, documented in part:</p> <ul style="list-style-type: none"> * Moderately impaired cognition with a BIMS score of 4; * Extensive assistance with 1 person for bed mobility, transfers, locomotion on and off unit, dressing, toilet use, personal hygiene, and bathing; * Limited assistance with 1 person for walking in room and corridor; * Not steady, only able to stabilize with assistance for moving from seated to standing position, walking, moving on and off the toilet, and surface to surface transfers; and, * Frequently incontinent of bladder. <p>Resident #15's Care Plan, with a print date of 10/21/13, documented in part:</p> <ul style="list-style-type: none"> * Problem - Potential for Injury: Falls, Related to: 	F 323		

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F 323	<p>Continued From page 57</p> <p>Use of psychotropic medications, weakness, impaired balance during transitions, impaired safety awareness, and use of diuretics; and, * Interventions - Extensive assist times 1 with transfers, frequent reminders to use call light and ask for assistance with transfers, shoes or non-slip socks, falling star program (dated 11/7/13), do not leave unattended in bathroom, resident with attempt to self transfer, start 15 minute checks (dated 11/9/13).</p> <p>A Resident Incident Report for Resident #15, dated 9/20/13 at 5:00 p.m., documented in part: * Describe exactly what happened - "Resident self transferred [and] sat on floor in front of toilet [and] bumped her [right] knee," and, "Bruising starting [and] some redness. Denies hitting head. Staff did not know resident would get up."</p> <p>A Memorandum for Record for Resident #15, dated 9/26/13, documented in part: * Subject: [Resident's name] Found on Floor Investigation: "[Resident's name] was found on the floor of her bathroom. She was found sitting on her buttock directly in front of the toilet. Her wheelchair was directly to her left;" * Conclusion/Root Cause: "Found on floor; likely a fall related [to] an attempted self-transfer and being left alone in close proximity to the toilet with a need to void, d/t [due to] increased need to void and urgency r/t [related to] UTI [urinary tract infection];" * Plan: "1. Continue Falling star program 2. Vital sign and neurological checks per protocol 3. Monitor injuries until resolved 4. Continue with previously implemented interventions 5. Do not leave unattended in close proximity to the toilet as [resident's name] will attempt to self-transfers 6. Promptly treat and assist requests and need to</p>	F 323			

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F 323	<p>Continued From page 58</p> <p>use the bathroom or to lay down 7. Continue with RA [Restorative Assistance] programs 8. Assess UTI has resolved after completion of ABX [antibiotics] 9. Staff training on leaving residents alone in high risk fall situations."</p> <p>A Resident Incident Report for Resident #15, dated 11/9/13 at 9:55 a.m., documented in part: * Describe exactly what happened - "Res[ident] found on the floor in her room. Res[ident] was self transferring from toilet to wheelchair. Wheelchair breaks were not on. Res[ident] fell on to her back and got a bruise/abrasion on the back of her head that has become a lump."</p> <p>A Memorandum for Record for Resident #15, dated 11/13/13, documented in part: * Subject: [Resident's name] Found on Floor Investigation. "On Saturday 11/9/13 at 0955 [9:55 a.m.] hours, [resident's name] was found on the floor of her bathroom. She was found by [CNA's name] on her back with her head near the room door and her feet near the bathroom door. Her wheelchair was upright, near her feet and the brakes were not locked. When staff asked [resident's name] was happened she stated she was attempting to get back into her wheelchair...Approximately 10 minutes before this occurrence [CNA's name] reported she assisted [resident's name] onto the toilet per [resident's name] request. She then instructed [resident's name] to use the call light to notify staff when she was done and [resident's name] was in agreement. She placed the wheelchair outside of the bathroom and closed the bathroom door. She then left the room and closed the room door...Staff report [resident's name] does ambulate to and from the bathroom but she is unsafe and unable to do so independently;"</p>	F 323		
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F 323	<p>Continued From page 59</p> <p>* Conclusion: "Found on floor; likely a fall related [to] attempted to transfer, weakness;"</p> <p>* Plan: "1. Continue Falling Star program 2. Monitor and treat injuries as MD orders until resolved 3. Notify MD of abnormal vital signs 4. Place on QD [every day] orthostatic blood pressure [times] 1 week and then weekly thereafter 5. Continue to not leave alone in bathroom 6. Not to be left alone, while in wheel chair in [resident's name] room 7. Staff education on review of CP [care plan]/RCG [resident care guide] as appropriate."</p> <p>Note: The resident was left alone in the bathroom with the bathroom door closed as well as the bedroom door closed, despite care plan instruction. The result was a fall in which the resident sustained a bruise and an abrasion to the back of her head.</p> <p>On 12/5/13 at 3:52 p.m., the RAC (Resident Assessment Coordinator) was interviewed about the aforementioned falls for Resident #15. The RAC stated, "She was never to be left alone [in the bathroom] and she was," and added that the staff member involved was educated and disciplined.</p> <p>On 12/5/13 at 5:30 p.m., the Administrator and DON were informed of the fall issue with Resident #15. No further information or documentation was provided which resolved the issue.</p> <p>4. Resident #12 was admitted to the facility on 10/17/13 with multiple diagnoses including decreased functional status and muscle</p>	F 323		
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F 323	<p>Continued From page 60 weakness.</p> <p>The resident's 10/25/13 admission MDS coded severely impaired cognition, upper extremity one sided functional limitation in ROM, lower extremity functional limitation in ROM on both sides, and one person extensive assistance for all ADLs.</p> <p>The resident's 10/17/13 health service report from a local provider documented in part, "Weakness...severity...mild-moderate...problem...worsening...occurs persistently...location includes generalized...has never been told...had a stroke...cannot open...left hand...admitted to skilled care now."</p> <p>The resident's medical record contained a 10/30/13 facility form that documented, "OT [occupational therapy] has assessed it [seatbelt] to be safe. Can we have an order for a seat belt when resident is up in his w/c [wheelchair]..." The Reply/Response/Comment section of the form contained a handwritten entry, "...Seat belt in wc for safety." The entry appeared signed by the resident's physician on 10/31/13.</p> <p>The resident's care plan, printed 10/17/13, identified, in part, the following: - Problem: Potential for Injury: Falls, One of the problem interventions was, "Seat belt in w/c for safety - 10-31-13"</p> <p>On 12/3/13 at 1:35 p.m., the resident was sitting in a wheelchair (wc) near the 200 hall nurses station. There was a fastened seat belt laying across the resident's lap. CNA #4 stated, "[Resident #12] tends to scoot forward in the chair so it [the seatbelt] keeps him from falling out [of</p>	F 323		

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F 323

Continued From page 61 the wc]."

On 12/5/13 at 8:46 a.m., the resident was sitting in a wc near the 200 hall nurses station. There was a fastened seatbelt laying across the resident's lap. The resident was asked if he could open the clasp of the belt laying across his lap. The resident said no. The surveyor asked the resident if he knew why the seatbelt was on his lap. The resident said no.

On 12/6/13 at 9:50 a.m., the Director of Therapy provided a copy of a 10/30/13 OT Progress Note. The Note documented, "Pt [patient] seen for self releasing seat belt trial. Pt unable to follow 1 step command to lift hand to notice/attend to seatbelt button. Multiple trials attempted. Pt has been observed to stay within limits of wc seat, however at times slowly 'wiggles' forward in seat...Recommending use of a seatbelt...to reduce risk of fall from wc..." The survey team then discussed the use of the seat belt with the DON, the Administrator, Director of Therapy, OT #8, and the Corporate Compliance Registered Nurse. The survey team asked the OT if other seating systems were ruled out before using the seat belt. The OT stated, "I did not rule out other seating systems. The seat belt was not assessed for safety just assessed to see if he could self-release."

On 10/30/13 the facility requested and on 10/31/13 the physician ordered the use of a seatbelt for the resident. However, an assessment was not completed to ensure the seatbelt did not pose a safety risk for the resident.

On 12/6/12 at 10:00 a.m., the Administrator, DON, and Corporate Compliance Nurse were

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F 323 F 325 SS=D	<p>Continued From page 62 informed of the survey team's above identified concerns related to the use of the seat belt for Resident #12.</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to: 1) ensure a resident's weight (wt) loss was assessed to determine possible causes when the wt loss was severe, and 2) ensure the resident's nutritional care plan was individualized with facility interventions and resident preferences. This affected 1 of 3 (#5) residents sampled for weight status. This practice created the potential for the resident to experience a compromised nutrition status. Findings included:</p> <p>Resident #5 was admitted to the facility on 3/22/13 with multiple diagnoses including fall with multiple fractured ribs, gastroesophageal reflux (GERD), depression, tobacco abuse, and decreased functional activities.</p>	F 323 F 325	<p>Corrective Action The consultant dietician assessed resident #5's chart, weight loss and dietary patterns on 12/3/13. The subsequent recommendations were care planned, and the care plan was reviewed for accuracy by the Dietary Manager on 12/4/13. The resident's weight loss occurred in May 2013, and there has been no further substantial weight loss since then.</p> <p>Other Residents As this deficiency has the potential to affect other residents, the Dietary Manager reviewed the monthly weights for all residents facility-wide on 12/10/13. All residents who triggered for a significant weight loss (5% at 30 days, 7.5% at 90 days and 10% at 180 days) were referred to and evaluated by the registered dietician during her visit on 12/10/13. Additionally, all of the aforementioned residents had their care plans reviewed and updated by the Dietary Manager by 12/13/13.</p>	1/10/14

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F 325	<p>Continued From page 63</p> <p>The resident's 3/29/13 admission MDS coded moderately impaired cognitive skills, ate independently with set up help, height 64 inches, and weight 131# (pounds). Section V did not trigger for nutritional status.</p> <p>The resident's 9/10/13 quarterly MDS coded intact cognition, ate independently with set up help, height 64 inches and weight 117#.</p> <p>The resident's care plan, print date 10/7/13, documented, "Problem: Potential for alteration in nutrition .origin date 3/22/13 related to fractured rib... depression, GERD .tobacco abuse, Anxiety 11/12/13, and Inattention at meals 11/18/13." Exhibited by: Decreased appetite Goals: 1 No significant wt change ie <2% x 1 wk, <5% x 1 mo, <7.5% x 3 mo [sic], <10% x 6 mo [for example, less than 2 percent in one week, <5% in one month, <7.5% in 3 months, and <10% in six months] during next 90 days "</p> <p>Interventions included, "...fortified cereal and fortified mashed potatoes, cue and encouragement with meals, offer planned snack 3 x daily " These three interventions were not dated, therefore the intervention dates were not evident</p> <p>On 12/4/13 at 3.20 p.m., the surveyor met with the facility's RD and Dietary Manager (DM) about the resident's severe wt loss. The RD provided numerous documents related to the resident's nutrition status. The documentation, included, in part, "...5/9/13 131#. .5/13/13 125#, 5/20/13 122#, 5/27/13 121#..."</p> <p>Federal guidance at F325 indicated, "...Suggested parameters for evaluating</p>	F 325	<p>Facility Systems Effective 12/11/13, all residents will continue to be weighed weekly and the weights will be reviewed weekly by the dietary manager or designee. Any resident who triggers for a 5% weight loss within a 30 day period or less, 7.5% weight loss within a 90 day period, or 10% weight loss within a 180 day period will be added to the weekly Resident at Risk meeting so that they can be reviewed by the team in an attempt to avoid a significant weight loss. Any resident on that list will remain on the program until their weight stabilizes. These residents will also be referred to the dietician for evaluation. The Dietary Manager or designee will be responsible for calculating and identifying the weight loss percent and notifying the dietician in writing of the need for an evaluation. Additionally, all residents in the Resident at Risk program will have their care plans reviewed weekly by the Resident at Risk committee for accuracy and effectiveness beginning 12/26/13.</p> <p>Monitoring Beginning on 12/11/13, the Dietary Manager will perform an audit following each visit by the Registered Dietician to ensure that all residents requiring her evaluation have been seen, recommendations have been care planned, and the evaluation has been appropriately documented in the IDT notes. The Dietary Manager will present the results of her audits to the QA Committee monthly, beginning with the next QA meeting tentatively scheduled for 1/22/14. Monthly audits will continue for 3 months at which time the need for continued audits will be evaluated.</p>	
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F 325	<p>Continued From page 64</p> <p>significance of...wt loss are:...Severe:...1 month...Greater than 5%...3 months...Greater than 7.5%..." The following formula determined percentage of weight loss: "% of body weight loss = (usual weight - actual weight)/ [divided by] (usual weight) x [multiplied by] 100."</p> <p>Note: The resident sustained a wt loss of 10 pounds in 18 days. Using the above federal guidance, the resident's wt loss was evaluated. One hundred and thirty-one# minus 121# equaled 10# wt loss. Ten# wt loss divided by 131# equaled 0.076, 0.076 multiplied by 100 equaled a 7.6% wt loss in an 18 day timeframe, 5/9/13 to 5/27/13.</p> <p>On 12/4/13 at 3:30 p.m., the surveyor informed the RD in 18 days the resident sustained a 10# wt loss and the wt loss according to the federal guidance was severe, in excess of 7.5%. The RD stated, "I review weights on a weekly basis. The resident was picked up in our "Resident At Risk (RAR)" meeting on 6/11/13. On 6/19/13, I did an assessment of the resident's wt loss." The surveyor asked and the RD confirmed, the resident's weights were reviewed, "once a week." The surveyor informed the RD, the 6/19/13 assessment was completed 23 days after the resident sustained the severe wt loss.</p> <p>- At 3:35 p.m., the surveyor, RD, and DM evaluated the resident's body mass index at 20.1, normal weight.</p> <p>- At 3:40 p.m., the DM stated, "The family once said the resident liked to snack while smoking. We could make that an intervention to see if that helps her intake." The surveyor asked both the RD and the DM for a care plan intervention identifying the resident liked to eat snacks while smoking and if facility staff were aware of the</p>	F 325		
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F 325	<p>Continued From page 65</p> <p>resident's preference to snack while smoking. Both the RD and the DM indicated the care plan was not updated with the resident's preference of snacks while smoking.</p> <p>Note: Review of the resident's care plan did not provide evidence of the resident's preference of snacks while smoking.</p> <p>The RD's 6/19/13 assessment documented in part, "...moved to the cottage on 5/1/13...started on Ativan on 4/28[13] prn but only used 2x [times] in May - can affect appetite...Staff report she picks at her meals. She has a smoking schedule that is followed. She asks frequently when the next time is. Staff have not observed any problems chewing/swallowing. Intakes past week; ...55%, 3 meals refused. Snacks 31%...weight [decrease] may be r/t [related to] several factors; room change, UTI & ATB [urinary tract infection and antibiotic therapy], or being anxious to smoke and not eating well. Plan; 1) Health shake at noon, 2) continue snacks..."</p> <p>The documentation provided by the RD on 12/4/13 at 3:20 p.m., also included, in part: * Forms titled, "Immediate Dietary Card Changes." The forms documented the following: "6-20-2013, Health shake at noon" "7-04-2013, Trial-serve sandwich and soup MWF [Monday, Wednesday, Friday] at lunch/can be set up with prep cook" "7-12-2013, Fortify cereal and give fortified potatoes at meals d/c [discontinue] health shake at lunch" * A previous nutrition care plan, printed 3/22/13, with the same goals as the care plan printed 10/7/13, contained handwritten entries as follows, in part: "Health shake with noon meal"</p>	F 325		

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F 325	<p>Continued From page 66</p> <p>6-25-13... Cue and encouragement with meals, 6-27-13... Restorative dining for breakfast & lunch 6-27-13, dc 7/1/13, and offer planned snax [snacks] 3x daily, 7-2-13."</p> <p>On 12/4/13 at 4:20 p.m., the surveyor informed the DON of the concern about the resident's 10 pound weight loss in 18 days and the RD did not assess the weight loss until 6/19/13. The DON stated, "I'll check into it."</p> <p>On 12/5/13 at 11:02 a.m., the RD spoke with the surveyor about the assessment of the resident's severe wt loss. The RD stated, "An assessment was done on 6/19/13." The surveyor informed the RD, on 5/27/13 at the severe wt loss point, the resident was not assessed and the care plan was not updated or individualized for the resident.</p> <p>The RD did not evaluate the wt loss until 23 days after the wt loss was severe. Additional interventions were not implemented until after the RD's assessment on 6/19/13. The facility did not explore resident preferences that may have had a positive affect on the resident's nutritional intake.</p> <p>On 12/6/13 at 10:15 a.m., the Administrator was informed of the finding. The facility did not provide any additional information.</p>	F 325		
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of</p>	F 329	<p>Corrective Action Clarification orders were requested for resident #1 and resident #2 regarding the diagnosis and reason for use of the antipsychotic medication. Appropriate diagnoses were received for each resident from their physicians on 12/6/13 and 12/24/13 respectively.</p>	1/10/14

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adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs

This REQUIREMENT is not met as evidenced by

Based on observation, record review and staff interviews, it was determined the facility failed to ensure unnecessary medications were not administered to a resident without adequate indications for use. This was true for 2 of 5 sampled residents (#s 1 and 2) reviewed for antipsychotic medication use. This deficient practice created the potential for more than minimal harm to residents as unnecessary medications can lead to adverse reactions and health decline. Findings included.

1. Resident #2 was admitted to the facility on 1/9/13 with multiple diagnoses which included TBI (Traumatic Brain Injury), torticollis (an asymmetrical head or neck position), manic depression, dementia, and dysphasia

F 329

Other Residents
As this deficiency has the potential to affect all residents in the facility who have orders for psychotropic medications, an audit was completed 12/23/13 by the DNS on residents with orders for antipsychotic medications to ensure the diagnosis is appropriate. The DNS subsequently sent faxes to the physicians of the residents whose orders were unclear or inappropriate with a request to clarify the diagnosis or discontinue the medication.

Facility Systems
The DNS provided all nurses with a list of appropriate diagnosis for antipsychotic medication usage at the monthly licensed nurse meeting on 12/17/13. Effective 1/9/14, no antipsychotic medications will be initiated without first being reviewed by the Director of Nursing, Behavior Nurse or designee to ensure that the resident's diagnosis is appropriate for the medication ordered, and ensure that any necessary non-pharmaceutical interventions have been attempted. After hours and on weekends, the floor nurse will contact the Administrator, DNS, behavior nurse or administrative nurse on call and have the antipsychotic medication reviewed prior to the initiation of the medication. All VVC nurses received a memorandum explaining this procedure on 1/9/14.

Monitoring
The behavior care nurse or designee will conduct a monthly audit of all residents with antipsychotic medications to ensure the diagnosis is appropriate for the use of the medication prescribed. The results of this audit will be reviewed at the monthly QA meeting beginning with the next meeting tentatively scheduled for 1/22/14. The QA audit will be conducted for 3 months, at which time the need for continued audits will be reviewed.

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F 329	<p>Continued From page 68</p> <p>Resident #2's most recent quarterly MDS assessment, dated 9/18/13, documented in part:</p> <ul style="list-style-type: none"> * Unable to interview; * Unclear speech; * Sometimes understood; * Daily occurrence of physical behavioral symptoms directed toward others; * Daily occurrence of verbal behavioral symptoms directed toward others; * No hallucinations or delusions; * Total dependence with the assistance of 2 or more people for transfers, toilet use, and bathing; * Total dependence with the assistance of 1 person for locomotion on and off the unit and dressing; * Extensive assistance of 2 or more people for bed mobility; * Extensive assistance of 1 person for eating and personal hygiene; and, * Received an antipsychotic daily in the past 7 days. <p>The Care Plan for Resident #2, printed 10/3/13, documented in part:</p> <ul style="list-style-type: none"> * Problem - Behavior, Related to: TBI and Dementia with Behavioral Disturbance; * Interventions - Monitor behavior on flow sheets; monitor for effectiveness/side effects of psychotropic medication; * Problem - Behavior Monitoring System: For Reference Only; and, * Interventions - Targeted Behaviors: physical aggression, resistance to cares, inappropriate sexual behaviors, attempting to self transfer, and verbal aggression. <p>Resident #2's Care Plan Flow Sheet for the month of December 2013 documented in part:</p>	F 329		

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F 329	<p>Continued From page 69</p> <ul style="list-style-type: none"> * Targeted Behaviors: Physical Aggression - No boxes were marked for occurrence of behavior; * Targeted Behaviors: Resistance to Cares - No boxes were marked for occurrence of behavior; * Targeted Behaviors: Inappropriate Sexual Behaviors - No boxes were marked for occurrence of behavior; * Targeted Behaviors: Attempting to Self Transfer - No boxes were marked for occurrence of behavior; and, * Targeted Behaviors: Verbal Aggression - For 12/2/13 and 12/4/13 the boxes had a check mark for the occurrence of the behavior on the day shift, and 12/3/13 had a check mark for the occurrence of behavior on the evening shift. <p>A December 2013 Physician Order Report (recapitulation orders) for Resident #2 documented in part:</p> <ul style="list-style-type: none"> * "Quetiapine (Seroquel) 100 MG 1tablet [no space between 1 and tablet] By Mouth Twice daily (Dementia with Behaviors and Paranoia)" with a Origin date of 9/24/13. <p>Resident #2's 12/2013 MAR documented nursing staff administered Seroquel as ordered by the resident's physician.</p> <p>A Report of Consultation for Resident #2, dated 7/29/13, documented in part:</p> <ul style="list-style-type: none"> * "Seroquel has been discontinued "Her biggest issue here is trying to get out of her wheelchair. She has good days and bad days [and] the only other problematic behavior is her yelling. Staff has no concerns regarding her need for a change in her psychotropic meds [medications];" * "We made this horrible mistake of [decreasing] her Seroquel [and] Namenda and she had constant agitation. We brought the namenda 	F 329		
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F 329	<p>Continued From page 70</p> <p>back [without] change, then Seroquel up to 100 MG bid [twice daily] [and] treating a U.T.I . which restored her previous adjustment," dated 11/27 [year not documented].</p> <p>On 12/4/13 at 11:45 a.m., the DON was asked how the Resident #2's paranoia manifested itself. The DON said she would look into it.</p> <p>On 12/4/13 at 1:19 p.m., the DON summoned the surveyor to discuss Resident #2's paranoia and behaviors. The DON said the resident would accuse staff of hurting her when there was no staff around, and was in a constant state of distress. The DON added the resident, "Always tried to get out of [her] chair" and would not reposition or follow direction.</p> <p>On 12/4/13 at 2:32 p.m., the DON again summoned the surveyor to further discuss the resident's paranoia and stated there was, "Nothing on paranoia. Nothing we've ever documented." When asked if Resident #2 experienced hallucinations, the DON said the resident was hard to understand and was unable to tell if the resident saw something not there.</p> <p>On 12/4/13 at 2:45 p.m., CNA #9 was asked of she was aware of Resident #2 having hallucinations. The CNA said the resident was lucid most of the time and may have seen a family member, but it was hard to tell. When asked if the resident had any paranoia, the CNA stated, "No."</p> <p>On 12/4/13 at 2:50 p.m., RN #10 was asked if Resident #2 experienced any hallucinations or paranoia. The RN said she hadn't noticed anything, and the resident was hard to</p>	F 329			

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F 329	<p>Continued From page 71</p> <p>understand. The RN added the resident had a UTI (urinary tract infection) and had some behaviors, but did not see anything not there. RN #10 continued that the resident liked to have someone around and might get upset if the staff left her side.</p> <p>Note: There was no evidence in Resident #2's medical record that the resident had hallucinations or paranoia. Additionally, the facility did not assess the resident's behaviors prior to initiating Seroquel, as being attributed to a medical condition or problem, environmental stressors, psychological stressors, or persistent in occurrence as indicated in the Federal Guidance under F 329.</p> <p>2. Resident #1 was originally admitted to the facility on 5/15/13, readmitted on 8/3/13, with multiple diagnoses including multiple sclerosis, altered mental state, anxiety, tobacco abuse, and speech disturbance.</p> <p>The resident's 8/12/13 admission MDS coded: -moderately impaired cognitive skills, minimal depression, no delirium or hallucinations or delusions, -rejection of care occurred 4 to 6 days but less than daily, -physical behavioral symptoms directed towards others and other behavioral symptoms not directed towards others occurred 1 to 3 days, -verbal behavioral symptoms directed towards others occurred 4 - 6 days but less than daily,</p>	F 329		

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F 329	<p>Continued From page 72</p> <p>-behavioral symptoms put the resident and others at significant risk for physical illness or injury, and -administered anti-anxiety medication one day in 7-day look-back period. -Section V of the MDS documented Psychosocial Well-Being, Behavioral Symptoms, and Psychotropic Drug Use Care Areas triggered and were addressed in the care plan.</p> <p>The resident's 11/11/13 quarterly MDS coded: -moderately impaired cognitive skills, severe depression, no delirium, no change in mental status, no hallucinations or delusions, -rejection of cares occurred daily, -physical behavioral symptoms directed towards others and other behavioral symptoms not directed towards others occurred 1 to 3 days, -verbal behavioral symptoms directed toward others occurred daily, and -administered anti-anxiety and anti-psychotic medications 7 days in the 7-day look-back period.</p> <p>The resident's care plan, printed 11/27/13, identified the Problems: -Behavior, exhibited by verbal aggression, resistance to cares, yelling out, physical aggression and throwing objects. One intervention included monitoring psychotropic drug use. -Behavior Monitoring system: Note: Review of the care plan revealed targeted behaviors had interventions. Review of the medical record revealed the facility monitored the frequency of the identified behaviors. -Psychosocial Well-Being, exhibited by agitation, verbal aggression, resistance to cares, history of suicidal ideations, and labile emotions. Note: Merriam-Webster dictionary defined labile as readily or frequently changing, continually</p>	F 329		
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F 329	<p>Continued From page 73</p> <p>undergoing chemical, physical, or biological change or breakdown, or emotionally unstable.</p> <p>The resident's 12/13 Physician Order Report (recapitulation) contained the following: -Order date 8/4/13, Lorazepam 0.5 milligram (mg) by mouth (po) every 6 hours as needed (Agitation/Sleep) -Order date 11/3/13, Seroquel 300 mg po twice daily (Behaviors/Agitation)</p> <p>The resident's 11/13 and 12/13 MARs documented nursing staff administered Seroquel as ordered by the resident's physician.</p> <p>On 12/4/13 at 10:44 a.m., the surveyor and the facility's Licensed Clinical Social Worker (LCSW) discussed the use of Seroquel for the resident. The surveyor informed the LCSW, the federal guidance at F329 for the use of anti-psychotic medications specified "indications for use for conditions other than Dementia." The guidance identified diagnoses for the use of an anti-psychotic medication. The diagnosis of "Behaviors/Agitation" did not meet the criteria specified at F329. In addition, the 2014 Nursing Drug Handbook did not include Behaviors/Agitation as an indication for use. The LCSW stated, "I will have to get back to you on that."</p> <p>On 12/4/13 at 1:34 p.m., the surveyor discussed the diagnosis of "Behavior/Agitation" for the use of the anti-psychotic medication Seroquel with the DON and the LCSW. The DON said I will see what I can find out about this.</p> <p>On 12/5/13 at approximately 3:00 p.m., the DON provided a copy of a fax from the resident's</p>	F 329		
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F 329	<p>Continued From page 74</p> <p>physician, dated 10/16/13, that documented the following.</p> <ul style="list-style-type: none"> - The "Notes/Comments/Questions" section, "As per our conversation, please review attached med [medication] list & consider reverting to resident's original med list, in an attempt to help [decrease] agitation & aggression & determine if [increased] behaviors are related to side effects of new medication." - The "Reply/Response/Comment" section contained, in part, a handwritten entry, "In 1 [one] week begin Seroquel 50 mg day one for depression, 100 mg day two, 300 mg day three po qd [by mouth every day]." The handwritten entry appeared signed by the resident's physician on 10/17/13. The surveyor informed the DON, the diagnosis of depression did not meet the criteria for use of an anti-psychotic at F329. <p>On 12/5/13 at approximately 4:00 p.m., the DON provided the surveyor with a copy of a 11/18/13 letter sent to the resident's physician titled, "Note To Attending Physician/Prescriber" about the use of the anti-psychotic Seroquel. The DON stated, "After the pharmacy review on 11/18/13, the pharmacist prepared and we forwarded this letter to the resident's physician."</p> <p>Review of the letter revealed the pharmacist identified, "This resident is receiving Seroquel 300 mg bid [2 times a day] for 'behaviors/agitation.' Nursing home regulations indicate that an antipsychotic medication should generally be used only for the following conditions/diagnoses. Please update the indication for this resident." The letter also included the ten diagnoses listed under "Indications for use for conditions other than Dementia" at F329. The letter also contained a</p>	F 329		
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F 329	Continued From page 75 "Physician/Prescriber Response" section, this section was, "blank." On 12/6/13 at 10:00 a.m., the Administrator, DON, and Corporate Compliance Nurse were informed of the findings. The facility did not provide any additional information related to the findings.	F 329			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	Corrective Action Resident #16's care plan was updated on 12/13/13 instructing nursing staff to apply a leg bag when the resident is in his wheelchair to prevent his catheter tubing from contacting the ground. The Administrator showed the infection control nurse where the 2013 CDC list of reportable diseases could be found on 12/17/13. This list is located in the facility's Infection Control Manual, and a copy of it was given to the surveyor on 12/6/13 by the Corporate Compliance Nurse. Other Residents On 12/13/13, the infection control nurse visually inspected all other residents in the facility that have catheters. Any resident whose catheter tubing appeared to be in danger of touching the ground was care-planned to have a leg bag applied when up in the wheelchair. As mentioned above, the 2013 CDC list of reportable diseases is current and located in the facility's Infection Control Manual.	1/10/14	

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F 441	<p>Continued From page 76</p> <p>hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, the facility failed to ensure that: *The Infection Control Nurse was educated on the Current Guidelines for the CDC [Center of Disease Control], *The environment was maintained to help prevent the development and transmission of disease and infection.</p> <p>This deficient practice had the potential to affect nearly all residents in the facility including 13 of 15 sampled residents, (#1-9 #12-15), and 1 random resident (#16.) There was potential for more than minimal harm when the Infection Control Nurse did not know what, or when to report Communicable Diseases, per CDC Guidelines; and when Resident #16 was observed to have his foley catheter tubing dragging on the floor while in his W/C in the hallways. Findings included:</p> <p>*The facility's Infection Control Policy and Procedure Manual documented in part, *Reporting Communicable Diseases</p>	F 441	<p>Facility Systems On 12/17/13 and 12/18/13 at the monthly nurse and CNA meetings, the administrator in-serviced all nursing staff on the importance of preventing catheter tubing from contacting the floor. Nurses were advised to consider assessing residents for appropriateness of a leg bag if the catheter tubing was in danger of contacting the floor and if the resident frequently transferred independently. The infection control nurse will monitor the CDC reportable diseases and conditions lists monthly beginning in January 2014 and update the infection control manual accordingly.</p> <p>Monitoring The infection control nurse will conduct a weekly audit of residents with indwelling catheters x 4 weeks and then monthly x 2 months beginning the first week in January 2014. The results of the audit will be shared at the monthly QA meeting beginning with the next QA meeting tentatively scheduled for 1/22/14. After 3 months, the need for continued auditing will be reviewed.</p>	

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F 441	<p>Continued From page 77</p> <p>-General Guidelines:</p> <p>2. The Infection Preventionist is responsible for notifying the local, district, or state health department of confirmed cases of state-specific reportable diseases.</p> <p>3. Diseases that are included in state lists of reportable diseases may also include diseases that must be reported to the CDC (Nationally Notifiable Diseases.)</p> <p>5. When a disease has been reported to the local, district, or states health department. the Infection Preventionist is responsible for maintaining an in -house report of such action, including the date and time of the report.</p> <p>1. On 12/5/13 at 4:15 pm LN#3 was interviewed by the surveyor. LN#3 was identified by the facility as the Infection Control Nurse. The interview was concerning the Infection Control program at the facility. When asked what has to be reported to the CDC, who updates the list and when it is to be reported, LN#3 provided a CDC-2007 CDC Guidelines for Isolation book. The LN#3 had gone out to the Valley Nurses Station and obtained it. When asked if this manual had been updated from the 2007 guidelines she stated "I took over this job in May and am not sure if the last person kept it up." She did not know whether the manual was a newer one or not and stated she had not updated it since May when she took over. When asked what infections were reportable, she made a gesture of shrugging her shoulder and did not know. At one point in the conversation LN#3 stated, "I would go to the Administrator."</p> <p>On 12/5/13 at 4:45 pm the surveyor spoke with</p>	F 441		
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F 441	<p>Continued From page 78</p> <p>the CCN and explained the concerns that the Infection Control Nurse was not aware of the infectious diseases to be reported, where to find out the information and when to report it. No comment was offered.</p> <p>On 12/6/13 at 10:30 am after the Exit conference the Administrator provided the surveyor the "Reporting Communicable Diseases" policy for the facility. He stated since the Infection Control Nurse is new to the position and also the WCC, he keeps track of the reportable diseases. The facility had not had a reportable disease for a long time and the last one was an active Tuberculosis resident. When the Administrator was asked if it would also be important for the Infection Control Nurse to be aware of what to report, when to report and how to report an infection. The Administrator stated, "I see what you are saying." [NOTE: The Infection Control Nurse had been in the position for approximately 7 months, from May 2013 until present date of 12/6/13.]</p> <p>On 12/6/13 at 10:30 am the Administrator, CCN, and DON were notified of the findings. No additional information was provided.</p> <p>2. Resident #16 was observed self-propelling his wheelchair throughout the 300 hall of the facility. There was a catheter privacy bag suspended beneath the seat of his wheelchair. Tubing from the catheter bag was observed dragging on the floor during the survey, on the following occasions: *12/3/13 at 10:30 AM. During this observation, the tubing was noted to contain a cloudy, thick</p>	F 441		
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F 441	<p>Continued From page 79</p> <p>substance with the appearance of crystallized ginger.</p> <p>*12/3/13 at 10:35 AM, and 1:35 PM, and 3:45 PM.</p> <p>*12/5/13 at 8:35 AM and 3:00 PM.</p> <p>On 12/5/13 at 3:00 PM, the surveyor informed the CCN of the observations, and concern with infection control. The CCN stated, "I understand."</p> <p>On 12/5/13 at 5:30 PM, the Administrator, CCN, and DNS were informed of the surveyor's findings. The facility offered no further information.</p>	F 441		

Bureau of Facility Standards

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the annual State licensure and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Karen Marshall, MS, RD, LD Team Coordinator Lauren Hoard, BSN, RN Susan Gollobit, RN Nina Sanderson, BSW, LSW</p> <p>The survey team entered the facility on Monday, 12/2/13 and exited the facility on Friday, 12/6/13.</p> <p>Survey Definitions:</p>	C 000	<p>Preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because the provisions of federal and state law require it.</p> <p style="text-align: center;">RECEIVED DEC 30 2013 FACILITY STANDARDS</p>	
C 268	<p>02.107.01 DIETARY SERVICE</p> <p>107. DIETARY SERVICE.</p> <p>01. Dietary Supervision. A qualified food service supervisor shall be designated by the administrator to be in charge of the dietary department. This person shall:</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not ensure the Dietary Manager (DM) completed a State approved course or program for Food Service Supervision. This had the potential to affect 13 of 13 (#s 1-9 & 12-15) sampled residents and all other residents who resided in the facility. Findings included:</p>	C 268	<p>Corrective Action</p> <p>The dietary manager is currently enrolled in a state approved food service supervisor's course. She is ¾ of the way through the course and is expected to graduate and become certified in March 2014.</p> <p>Facility Systems</p> <p>Valley Vista's contracted registered dietician has been conducting weekly visits since the summer of 2013 to provide oversight and supervision, and will continue to make weekly visits at least until the dietary manager completes her course and receives her certification.</p>	1/10/14

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Don Kennel

TITLE

NHA

(X6) DATE

12/27/13

Bureau of Facility Standards

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C 268	<p>Continued From page 1</p> <p>The Idaho Administrative Code, Department of Health and Welfare, IDAPA (Idaho Administrative Procedures Act) 16.03.02 - Rules and Minimum Standards for Skilled Nursing & Intermediate Care Facilities, sub-section 002.13.a,b,c, & d, defined a Food Service Supervisor as a person who:</p> <p>"a. Is a qualified dietitian; or b. Has a baccalaureate degree with major studies in food and nutrition or food service management; or c. Is a graduate of a state approved Food Service Supervisor's (Dietetic Assistant) course, classroom or correspondence; or d. Has training and experience in food service management in military service equivalent in content to program in paragraph c."</p> <p>On 12/2/13 at 5:00 p.m., the person in charge of the facility's dietary department, the DM stated, "I am currently enrolled in a DM course and should complete the course next year, 2014."</p> <p>On 12/2/13 at 5:35 p.m., the Administrator was informed of the finding. The Administrator shook his head in an up and down motion indicating acknowledgement. The facility did not provide any additional information.</p>	C 268	<p>Monitoring The administrator will continue to follow the progression of the dietary manager towards completion of her certification beginning 1/10/14 with the anticipation that she complete the course and become certified in March 2014.</p>	
C 409	<p>02.120,05,i Required Room Closet Space</p> <p>i. Closet space in each sleeping room shall be twenty inches by twenty-two inches (20" x 22") per patient/resident. Common closets utilized by two (2) or more patients/residents shall be provided with substantial dividers for</p>	C 409	<p>Request Continuation of a Waiver</p>	1/10/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001540	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/06/2013
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF SANDPOINT		STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH DIVISION SANDPOINT, ID 83864		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 409	Continued From page 2 separation of each patient's/resident's clothing for prevention of cross contamination. All closets shall be equipped with doors. Freestanding closets shall be deducted from the square footage in the sleeping room. This Rule is not met as evidenced by: Based on the Waivers in Effect form review and Administrator interview, it was determined the facility did not provide the required personal closet space for residents in rooms 102, 108, 109, and 304. Findings included: The facility was granted a waiver of this requirement on 10/25/12. On 12/2/13 at 6:45 p.m., the Administrator stated, "We [the facility] plan to continue to request a waiver for closet spaces in rooms 102, 108, 109 on the 100 hall and room 304 on the 300 hall." During the interview, the Administrator confirmed the dimensions of the closet spaces remained unchanged. This reduction in required closet size created a potential for residents to have insufficient space to store clothing and personal items.	C 409		
C 422	02.120,05,p,vii Capacity Requirements for Toilets/Bath Areas vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds.	C 422	Request Continuation of a Waiver	1/10/14

Bureau of Facility Standards

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C 422	<p>Continued From page 3</p> <p>Tubs, showers, and lavatories shall be connected to hot and cold running water.</p> <p>This Rule is not met as evidenced by: Based on Waivers In Effect form review, Resident Group interview, family and individual interviews, and Administrator interview, it was determined the facility did not provide 1 tub or shower for every 12 licensed beds. This had the potential to affect all residents who resided in the facility. Findings included:</p> <p>The facility was granted a waiver of this requirement on 10/25/12.</p> <p>On 12/2/13 at 6:45 p.m., the Administrator stated, "We [the facility] plan to continue to request a waiver for the number of bathing facilities." During the interview, the Administrator confirmed the number of five bathing facilities remained unchanged from the last annual survey.</p> <p>On 12/3/13 at 3:00 p.m., six residents attended the Resident Group interview. The residents were asked about the bathing schedule in the facility. The residents did not voice any concerns about the frequency of bathing or the time of day the residents were bathed.</p> <p>In addition, interviews with resident family members and individual residents did not reveal any concerns with the frequency of bathing or the time of day the residents were bathed.</p> <p>Based on the facility licensed for 73 beds, the facility would be required to have a minimum of at least 7 tubs/showers available for resident use.</p>	C 422		

Bureau of Facility Standards

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C 670	Continued From page 4	C 670		
C 670	02.150,03,a Aseptic/Isolation Techniques a. Applied aseptic or isolation techniques by staff. This Rule is not met as evidenced by: Please refer to Tag F441 as it relates to CDC reporting Guidelines	C 670	Refer to F441	1/10/14
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 related to the use of an abductor wedge and abductor strap without obtaining a physician's order and not including the use of the wedge and strap on the resident's care plan.	C 784	Refer to F309	1/10/14
C 787	02.200,03,b,iii Fluid/Nutritional Intake iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Please refer to F325 as it related to severe weight loss, RD assessment of the severe weight loss, and nutrition care plan interventions	C 787	Refer to F325	1/10/14
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by:	C 790	Refer to F323	1/10/14

Bureau of Facility Standards

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C 790	Continued From page 5 Please see F 323 as it pertains to accident hazards and supervision.	C 790		
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Refer to F329 as it relates to having a correlating diagnosis for each medication.	C 798	Refer to F 329	1/10/14



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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December 27, 2013

Daniel K. Kennick, Administrator
Valley Vista Care Center of Sandpoint
220 South Division
Sandpoint, ID 83864-1759

FILE COPY

Provider #: 135055

Dear Mr. Kennick:

On **December 6, 2013**, a Complaint Investigation survey was conducted at Valley Vista Care Center of Sandpoint. Karen Marshall, R.D., Lauren Hoard, R.N., Nina Sanderson, L.S.W. and Susan Gollobit, R.N. conducted the complaint investigation. This complaint was investigated in conjunction with another complaint investigation and with the facility's annual Recertification and State Licensure survey.

Observations:

- Dietary Services' dry storage area;
- Snacks intended for resident consumption that were distributed from Dietary Services to the different units in the facility; and
- Three reach-in freezers for temperature control.

Documents reviewed:

- Facility's Registered Dietitian's (RDs) monthly inspection of the Dietary Service's dry storage room;
- Resident Council Meeting minutes from September 1, 2013 through December 6, 2013;
- Grievances dated September 1, 2013 through December 6, 2013; and
- Refrigerator and Freezer Temperature logs from April 1, 2013 through June 30, 2013.

Daniel K. Kennick, Administrator

December 27, 2013

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Interviews conducted:

- Six residents who attended the Resident Group interview;
- One resident family member;
- The facility's Dietary Manager;
- Two different Dietary Service employees;
- One Dietary Service Cook; and
- The Environmental Director.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006088

ALLEGATION #1:

The complainant stated the facility's Dietary Service had outdated snacks, specifically various types of crackers. According to the complainant, the Assistant Dietary Manager was told about the outdated snacks, and the Assistant Dietary Manager said to serve the outdated snacks anyway.

The complainant stated that so far there have been no negative outcomes due to the practice of serving outdated snacks.

FINDINGS:

During the survey process and complaint investigation, the survey team learned that the person in charge of Dietary Services, the Dietary Manager, had been working in that position for approximately four months. Prior to becoming the Dietary Manager, the Dietary Manager was the assistant Dietary Manager.

The Dietary Services' dry storage areas did not contain any snacks including crackers that were outdated or exceeded the manufacturer's expiration date.

Review of the dry storage area revealed those snacks without a use-by-date contained handwritten dates on the packaging. The handwritten dates were written legibly with what appeared to be black magic marker.

None of the snacks, including crackers, distributed from Dietary Services to the different units in the facility were outdated or exceeded the manufacturer's expiration date.

The RD's May and June 2013 monthly review of the dry storage area did not provide evidence

that snacks including crackers were outdated.

Review of the Resident Council Meeting minutes did not provide evidence residents were concerned about receiving outdated snacks from Dietary Services.

Residents who attended the Resident Group interview were asked if the facility provided outdated snacks. The residents in the Group interview said the facility did not and none of the residents had noticed outdated snacks.

Review of the facility Grievances did not provide evidence residents or family members were concerned about Dietary Services providing outdated snacks including crackers.

The Dietary Manager said no one had voiced a concern about the dates on snacks including crackers.

Three other Dietary Service employees were interviewed about outdated snacks, including crackers. All three employees said should a snack have an outdated use-by-date, the snack would be tossed in the trash. The employees were asked if anyone ever told them to use an outdated snack. All three employees replied that no one ever told them to use outdated snacks including crackers.

A resident's family member was asked about the facility providing outdated snacks. The family member said the facility did not provide outdated snacks to the resident who was part of the family.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the facility's Dietary Service had a main walk-in freezer that reached the temperature of thirty degrees. The walk-in freezer went for three days this way before a repairperson could fix it. The same freezer had issues like this in the past and was dying.

FINDINGS:

The facility did not have a walk-in freezer. All the freezers in the facility were free standing, reach-in type.

The Dietary Service Refrigerator and Freezer Temperature logs for April, May and June 2013 were reviewed. The logs revealed staff evaluated the temperature of all freezers a minimum of

Daniel K. Kennick, Administrator
December 27, 2013
Page 4 of 4

two times a day.

Review of the logs revealed there were several days in June 2013 when freezer number three was out of service. The log contained the initials of a Dietary Services cook.

The cook was interviewed and asked for an account of freezer number three during the several days in June 2013. The cook remembered when the freezer did not maintain the required temperature of zero degrees Fahrenheit. The cook explained the frozen foods items were placed in the other two freezers to prevent the foods from thawing. The cook went on to say the concern with the freezer was reported to the Environmental Director, and as much as she could recall, eventually, the freezer was repaired.

The Environmental Director said he remembered a couple times in the past year when Dietary Service employees contacted him with concerns about their refrigeration units or freezers. He said he could not remember specifically what happened in June 2013, but he did remember one time when he could not repair the equipment, and he had to call professional refrigeration specialists to evaluate the equipment. The Environmental Director later provided an invoice from a refrigeration company. According to the invoice, the local company repaired the condenser of one of the three freezers on May 21, 2013.

Two other Dietary Service employees were interviewed and asked what the procedures would be if a freezer or a refrigerator did not maintain the required temperatures. Both employees said they would contact the supervisor, place frozen items in other freezers and not use the unit in question until told to do so by their supervisor.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



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

EKK/dmj



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Dear Mr. Kennick:

On **December 6, 2013**, a Complaint Investigation survey was conducted at Valley Vista Care Center of Sandpoint. Karen Marshall, R.D., Lauren Hoard, R.N., Nina Sanderson, L.S.W. and Susan Gollobit, R.N. conducted the complaint investigation. This complaint was investigated in conjunction with another complaint investigation and with the facility's annual Recertification and State Licensure survey.

The investigation included:

Review of the identified resident's records from the acute care hospital just prior to her admission to the facility; as well as, the resident's record while in the facility; photos of the resident supplied by both the complainant and the facility and interviews with Adult Protection Services (APS), the facility's Administrator and nursing staff who had cared for the identified resident during her stay.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006219

ALLEGATION #1:

The complainant stated an identified resident sustained a bruise to the right side of the forehead above the right eye. A physician's visit was requested to evaluate the bruise but it never

Daniel K. Kennick, Administrator
December 27, 2013
Page 2 of 3

occurred. The complainant stated an investigation was requested regarding the origin of the bruise but was never provided.

FINDINGS:

Hospital records documented the identified resident was receiving three anti-coagulant medications while hospitalized, one of which was continued when the resident was transferred to the nursing facility.

Hospital progress notes documented a bruise to the right side of the resident's face, which they were monitoring.

The physician in the hospital documented that despite the potential for bruising; anti-coagulation was a priority for this resident due to the nature of resident's illness.

Photos of the resident taken upon admission to the facility showed bruising to the right side of the resident's face and a large discolored area on the right side of the forehead.

A grainy black and white photo of the resident provided by the complainant showed a discolored area on the right side of the forehead similar in size and shape of the facility's photo with a small-darkened area inside it. NOTE: A hand-written note on this photo documented it was taken on July 22, 2013. A computer-generated date on the lower right hand corner of the photo documented July 31, 2013, at 2:38 p.m.

Interviews with the Administrator and direct care staff indicated the discolored area was similar in nature to a birthmark and essentially remained the same throughout the resident's stay in the facility with the exception that it may become darker when the resident was hot. The darkened area in the center did develop in the facility but was not a bruise. The area was identified as a patch of dry skin, which became more irritated when the resident "picked" at it. The area did not open, was identified by the facility on July 24, 2013, and was treated with the application of lotion. Prescription treatment was not required.

The facility did not investigate the development of this area in terms of generating an incident report, stating dry skin frequently develops in the elderly and usually the application of non-prescription lotion is sufficient.

There is no documentation indicating that the resident's responsible party reported concern to the facility regarding the discolored area on the resident's forehead or requested a physician's evaluation of the area. NOTE: The resident discharged from the facility against medical advice (AMA) before a physician's visit would have been required by regulation.

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Page 3 of 3

APS visited the resident in the home approximately three and a half weeks after discharge. The APS worker reported at the time that a bruise to the right cheek was present but seemed to be healing. No other bruising was noted. There was no notation of the discolored area above the forehead.

The facility conducted an investigation of the incident after being alerted by APS of concerns regarding this situation. The facility was unable to substantiate the presence of new bruising or injury for the resident while in the facility aside from the patch of dry skin on the forehead.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

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

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

LKK/dmj