



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 1970

December 23, 2013

Arthur F. Gulden, Administrator
Bingham Memorial Skilled Nursing & Rehabilitation Center
98 Poplar Street
Blackfoot, ID 83221-1758

Provider #: 135007

Dear Mr. Gulden:

On **December 9, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Bingham Memorial Skilled Nursing & Rehabilitation Center by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 6, 2014**. Failure to submit an acceptable PoC by **January 6, 2014**, may result in the imposition of civil monetary penalties by **January 27, 2014**.

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

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

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

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

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

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

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 9, 2014**, if substantial compliance is not achieved by that time.

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

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

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

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

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

- BFS Letters (06/30/11)

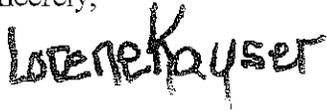
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2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **January 6, 2014**. If your request for informal dispute resolution is received after **January 6, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and slanted.

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

LKK/dmj
Enclosures

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

PRINTED: 12/23/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/09/2013
NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual recertification, state licensure, and complaint investigation survey of your facility. The survey team entered the facility on Monday, 12/2/13 and exited the facility on Monday, 12/9/13.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Arnold Rosling, RN, BSN, QMRP</p> <p>Definitions: CAA = Care Area Assessment CNA = Certified Nursing Assistant DC'd = Discontinued DNS/DON = Director of Nursing Services d/t = due to IDT = Interdisciplinary Team LLE = Left Lower Extremity LPN = Licensed Practical Nurse LSW = Licensed Social Worker MDS = Minimum Data Set NWB = Non Weight Bearing ORIF = Open Reduction Internal Fixation OT = Occupational Therapist OOB = Out of bed POC = Plan Of Care PRN = As needed RLE = Right Lower Extremity ROM = Range of Motion RN = Registered Nurse r/t or R/T = related to SRAB = Self Releasing Alarm Belt TIA = Transient ischemic Attacks w/c = wheel chair</p>	F 000	<p>The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).</p> <p style="text-align: center;">RECEIVED MAR 06 2014 FACILITY STANDARDS</p>		
F 151 SS=E	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL	F 151			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE **Administrator** (X6) DATE **3/5/14**

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 151	<p>Continued From page 1</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, the facility failed to provide an environment where long term residents did not feel they were discriminated against because of their payer source. This practice potentially affected 11 of 12 (#s 1, 2, 3, 4, 5, 6, 8, 9, 10, 11, & 12) sampled resident and three random (#s 15, 16 & 17) residents. There was a potential for psychological harm when a resident was treated in a manner in which they got the feeling they were not as "good" as another individual. Findings include: On 12/4/13 at 9:00 a.m. a group interview was conducted with residents. There were four long term care residents, including the president of the resident council, in attendance. When the group was asked about rules, resident rights, dignity, activities and dining experience there was total agreement there were problems within the facility.</p> <p>Residents were concerned about their rights as a citizen and a resident. There were recent elections in the previous months and they were not given the opportunity to vote nor did they know there were elections.</p> <p>The group was not aware who the ombudsman</p>	F 151	<p><u>F 151</u></p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Met with residents 12 and 17 to discuss their wishes and plan shower schedule</p> <p>Resident 15 discharged from facility</p> <p>All residents, including residents 1-11, received a letter on 12/30 and had the opportunity to attend a resident council meeting addressing the issues of shower schedule and frequency, the ombudsman contact information, grievance process, dining room procedures, meal menus and substitutions, perceptions of preferential treatment, activities, care plan meetings, snacks, and other resident rights.</p> <p>For residents' voting, the elections were already passed but a new system is in place. The voting process was discussed with the resident council president. He agreed to the following- the opportunity to vote in both primary and general elections will be discussed at the resident council meeting the month prior to any election. Activities will coordinate voting for those residents who have a desire to do so by visiting each of them to ask if they want to vote. Further, the local precinct will send representative to our facility so our residents can vote here.</p> <p>Corrective action for residents that may be affected by this deficiency:</p> <p>All residents have the potential to be affected by these identified concerns.</p> <p>Administrator will meet with Resident Council on 12/30 to discuss showers, dining room procedures, menu, and residents rights overall.</p>		

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F 151	<p>Continued From page 2</p> <p>was and all indicated there was interest in filing complaints in the past. There was no grievance process to file a complaint through. See F 166 which was cited because of the lack of grievance process.</p> <p>There was discussion about the long term residents being treated differently than the residents who were short term (rehabilitation). The short term residents had a special dining room, were served first, and got to order their meals off of individualized menus. One resident commented that it was "because the facility gets more money" for those residents so the facility caters to them. Resident #12 stated if the rehabilitation residents "want a special meal, they write it on the menu and can get it. We don't get a menu." The dietitian was interviewed on 12/5/13 at 2:30 p.m. She stated that there was a perception the short term residents got preferential treatment. She stated there was a time when the "Restorative" dining area residents were served on silver platters and used china dishes for meals. She stated she had been trying to improve the dining experience of the long term residents. The residents still felt there was a difference in the way they were treated.</p> <p>The residents when asked about any other issues brought up there was a differential treatment with bathing. Resident #12, #15, and #17 all wanted to have more than two baths a week. They indicated that the "short term" residents could have a bath more often than twice a week. See F 242 for more information on bathing choices.</p> <p>Staff interviews confirmed there was a problem with the short term residents getting preferential treatment with bathing. CNA #5 was interviewed</p>	F 151	<p>Letter will be presented to all residents who do or do not attend this meeting addressing these highlighted concerns.</p> <p>In-service will be provided to activities, social services, and nursing staff by administrator concerning resident rights on 1/2/14</p> <p>Letter that was given out to residents on 12/30 as well as grievance/concern procedure is provided to residents or family with their admission packet and paperwork.</p> <p>Letter provided to residents on 12/30 will be re-distributed at least quarterly to all residents.</p> <p>Opportunity to vote in both primary and general elections will be discussed at the resident council meeting the month prior to any election. Activities will coordinate voting for those residents who have a desire to do so by visiting each of them to ask if they want to vote and local precinct representatives will come to the facility so residents can vote.</p> <p>All residents upon admission are asked shower preferences throughout the week.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Administrator will interview 5 residents weekly for a period of at least 12 weeks starting the week of 1/5 to ensure residents are exercising their rights and to discover any issues of concern. Any issues will be reported to the QA committee.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p>	

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F 151	Continued From page 3 12/4/13 at 10:15 a.m. and LN#2 was interviewed 12/6/13 at 12 noon. Both interviewees indicated the short term residents are asked every day if they want a bath and if they do then they go to the top of the bath list for the day. The CNAs felt this practice made it hard to do all the baths they were required to do and sometimes long term residents did not get their scheduled baths. When asked why the short term residents got preferential treatment, LN#2 stated, it was about money. She further stated the preferential treatment for the rehabilitation residents "came down from the towers." [Indicating upper management] LN #2 indicated this practice had been going on for a very long time.	F 151	The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. Additionally, QA committee will review facility progress on resident rights, including resident grievance forms, at least quarterly on an on-going basis to aid in monitoring compliance.		
F 166 SS=E	On 12/6/13 at 1:00 pm the administrator was informed a about the preferential treatment and he stated he was not aware of the residents' feelings. No further information was provided. 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and review of the grievance process, the facility failed to provide a process residents could use to voice grievances and get a resolution to their issue. This had the potential to affect all residents in the facility including 12 of 12 (#s 1 - 12) sampled residents and random Resident #16. Findings	F 166	F 166 Corrective action for residents found to have been affected by this deficiency: Concern forms were filled out for residents 8 and 16 All residents received a letter on 12/30 and had the opportunity to attend a resident council meeting addressing the grievance process, and other resident rights. Corrective action for residents that may be affected by this deficiency: All residents have the potential to be affected by these identified concerns.	1/10/14	

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F 166	<p>Continued From page 4 include:</p> <p>During the group interview on 12/4/13 at 9:00 a.m. when asked if there were any unresolved issues, the residents in attendance stated there were issues mostly with lost clothing. They had told staff about the lost clothing but nothing had been done about it. Resident #16 became upset when talking about the clothes she had lost, because a deceased relative had given them to her and she had seen another resident wearing the item.</p> <p>During an interview on 12/4/13 at 5:50 p.m. with Resident #8's family member, she had complaints about lost clothing. She indicated that she had talked with staff but there had never been a resolution. She was not aware there was a grievance process.</p> <p>The facility provided the surveyor with five grievances, none were of the ones the residents and family members stated they had told staff about, missing clothing.</p> <p>On 12/4/13 at 11:00 a.m. the administrator was interviewed about the grievance process. He stated a process the facility, he and the social worker had used in the past. The Administrator was asked for a procedure to verify there was a systematic process for residents and family to use. The administrator said he would get the surveyor one. On 12/4/13 at 1:00 p.m. the administrator provided a written Procedure named, "Resident and Family Concerns." He stated at the time, he had just typed the process up, put it on letter head and had [ward clerks name] at the front desk pass it out to all residents.</p>	F 166	<p>Administrator will meet with Resident Council on 12/30 to discuss grievance process. Letter will be presented to all residents who do or do not attend this meeting addressing grievances. Letter highlights and designates social services or administrator to assist in the process.</p> <p>In-service will be provided to activities, social services, and nursing staff by administrator concerning the grievance process on 1/2/14</p> <p>Grievance forms will be kept in the hallway of the main entrance with a sign highlighting their purpose</p> <p>Letter that was given out to residents on 12/30 as well as grievance/concern procedure is provided to residents or family with their admission packet and paperwork. Letter provided to residents on 12/30 will be re-distributed at least quarterly to all residents.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Administrator will interview 5 residents weekly for a period of at least 12 weeks starting the week of 1/5 to ensure residents understand the grievance process and to discover any specific issues of resident concern. Administrator will also audit to ensure grievance forms are in place weekly for the same period of at least 12 weeks starting the week of 1/5. Any issues will be reported to the QA committee.</p> <p>Grievance forms will be kept in the hallway of the main entrance with a sign highlighting their purpose. Social services is available to assist any patients with the grievance process. All staff was inserviced on the grievance process.</p>		

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F 166	Continued From page 5 The surveyor informed the administrator on 12/4/13 at 11:00 a.m. the grievance forms for residents to file a grievance could not be located. The administrator's response was, they were in the computer and staff had access to them. The surveyor informed the administrator the residents need to have access to the forms so they could file grievances if they had one. At 12/4/13 at 1:00 p.m. the administrator stated, he placed forms next to the nurses station so the residents would have access to them. No other information was provided.	F 166	Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. Additionally, QA committee will review facility progress on the grievance process by reviewing grievances at least quarterly on an on-going basis to aid in monitoring compliance.		
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, it was determined the facility used physical restraints on residents without identified medical conditions which required the use of the restraints. Additionally, the facility failed to evaluate the use of less restrictive devices/restraints, other than seatbelts or lap buddies for cognitively impaired residents. This affected 4 of 12 (#1, 2, 8, & 9) residents sampled for the use of physical restraints. This practice created the potential for more than minimal harm should the resident experience contractures, decreased mobility or the development of pressure sores. Findings include:	F 221	F 221 Corrective action for residents found to have been affected by this deficiency: Restraint assessment tool established and put in place to be used for any resident either where restraints may be medically appropriate or requested by resident/legal representative. Assessment tool is used by nursing and/or therapy to assess patient. Assessments then reviewed by nursing and therapy. Resident 1 was assessed, restraint was removed, and documentation completed. Resident 2 was assessed, restraint was removed, and documentation completed. Resident 8 was assessed, restraint was kept in place initially due to medical need, restraint was later taken off on trial basis due to therapy recommendation in order to try a least restrictive measure. Resident 9 was assessed, restraint was removed, and documentation completed.	1/10/14	

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F 221	<p>Continued From page 6</p> <p>1. Resident #1 was admitted with multiple diagnoses to include, anxiety disorder, depression, senile delusions, hearing loss, and blindness related to macular degeneration.</p> <p>Resident #1's Annual MDS, dated 06/18/13, and Quarterly MDS dated 9/12/13, coded the following:</p> <ul style="list-style-type: none"> - Problems with short term and long term memory, - Daily decision making skills severely impaired, - Extensive assist of one person for transfers, bed mobility, and toileting. - Had a trunk restraint in use. <p>Note: The Residents Physical Restraint CAA referred to the Fall Risk CAA for the narrative.</p> <p>The Residents CAA Narrative, under falls, dated 06/18/13, documented the following, "The [Resident's name] is at risk to fall r/t blindness, dementia and the need for assist with transfers. A self release seat belt is used when [Resident's name] is up in her chair r/t her fall risk. This [self releasing seat belt] has been assessed and found to be the least restrictive for her. She [Resident] cannot remove it on demand so it is released per protocol."</p> <p>The Resident's Falls/Restraint Care Plan, initiated on 9/24/12 documented: * Problem - Resident is at risk for injuries R/T falls due to, history of falls, poor vision, impaired judgment, hallucinations, and dementia.</p> <p>* Approaches - Date: 8/26/11, Self-release alarm belt (SRAB) in w/c. Check restraints Q (every) 30 minutes, release Q (every) 2 hrs and PRN for 15 minutes to provide care and reposition.</p>	F 221	<p>Other residents with restraints were assessed, documented, care planned, medical necessity identified or risk/consequence form put in place, and consents signed.</p> <p>Corrective action for residents that may be affected by this deficiency:</p> <p>All residents have the potential to be affected by these identified concerns.</p> <p>Restraint assessment tool established and put in place to be used for any resident either where restraints may be medically appropriate or requested by resident/legal representative. Assessment tool is used by nursing and/or therapy to assess patient. Assessments then reviewed by nursing and therapy. If recommendation includes application of restraint family is contacted for consent and physician is consulted.</p> <p>Restraint committee will follow up with restraint assessments a minimum of every 90 days and as needed by completing the physical assessment form and reviewing it with nursing and therapy.</p> <p>Care plans will be updated related to any changes in restraints for residents.</p> <p>In-service will be provided to nursing staff by DON concerning proper procedures for restraints on 1/2/14</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Director of Nursing will audit 4 residents weekly for a period of at least 12 weeks starting the week of 1/5 to ensure residents have been properly assessed and necessary documentation is in place. Any issues will be reported to the QA committee.</p>		

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F 221	<p>Continued From page 7</p> <p>NOTE: The date the Fall/Restraint Care Plan Problem area was initiated did not match the date the Approaches were initiated and it could not be determined if the SRAB had been reviewed or revised after 8/26/11.</p> <p>Resident #1 was observed to have the SRAB on, while up in her wheel chair during the survey on 12/3/13 at 10:05 a.m., 12/4/13 at 11:00 a.m., and 12/5/13 at 10:45 a.m. On 12/4/13 at 11:05 a.m. CNA #8 was asked by the surveyor why Resident #7 had a SRAB on her wheel chair and if the resident was able to release the seat belt on her own. CNA #8 stated the resident was not able to release the seat belt on her own and the SRAB was put on the resident's wheel chair, "To keep her in her chair." The CNA stated the resident will try to stand up by herself sometimes even with the seat belt on.</p> <p>Note: Resident #1's IDT Clinical Team Meeting notes were reviewed by the surveyor for 1/9/13 through 10/31/13 and did not include documentation the SRAB had been reviewed, less restrictive devices had been tried, or that a plan for reduction of the restraint had been attempted.</p> <p>On 12/5/13 at 11:15 a.m., LPN #9 was asked about the SRAB. The LPN stated, "The SRAB was applied to the resident's wheel chair because she kept trying to get up and fell. The SRAB keeps the resident in her wheel chair."</p> <p>On 12/5/13 at 5:45 p.m., the DNS and RN #3 were asked about the resident's SRAB. RN #3 stated the SRAB was applied to the residents wheel chair for safety. No additional information</p>	F 221	<p>Restraint committee chaired by DON and consisting of at least nursing representative and therapy representative, usually Director of Rehab, meets at least every other week and as needed to review restraint information and assessments.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. Additionally, QA committee will review facility progress on restraints at least quarterly on an on-going basis to aid in monitoring compliance.</p>	1/10/14	

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F 221	<p>Continued From page 8 was provided.</p> <p>2. Resident #2 was admitted to the facility on 5/12/10 with multiple diagnoses to include, chronic pain, history of falls, vertigo, and depression.</p> <p>Resident #2's Significant Change MDS, dated 2/18/13, coded the following:</p> <ul style="list-style-type: none"> - Short Term and Long Term memory impairment. - Daily decision making skills moderately impaired - Total dependence of one person for bed mobility, transfers, and toileting. - Had a trunk restraint in use. <p>The Resident's CAA Narrative, under restraints, dated 2/22/13, documented the following, "A lap buddy was added to her POC for fall risk on 2/7/13 d/t a slide out of her w/c. This was with her 1/1. It is thight that thus [sic] (It is thought that this) may be a behavior as she is positioned well in her chair but requires someone with her at all times d/t impulsive behaviors. Will proceed with a POC for restraint use."</p> <p>The Resident's Fall/Restraint Care Plan, initiated on 9/24/13, documented:</p> <ul style="list-style-type: none"> * Problem - Resident is at risk for injuries R/T falls due to history of falls, decrease in strength with poor balance, and impaired judgment. * Approaches - Lap buddy in w/c dated 1/28/12 and DC'd on 10/1/12. Seat belt in reclining w/c dated 10/28/13. The Fall/Restraint Care Plan had a box under the Approach column to check restraint Q 30 minutes, release Q 2 hrs and PRN for 15 minutes to provide care and reposition, however, this box was not marked by staff as part of the approach related to the SRAB. 	F 221			

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F 221	<p>Continued From page 9</p> <p>Resident #2 was observed to have the SRAB on, while up in her wheel chair during the survey on 12/3/13 at 10:05 a.m., 12/4/13 at 9:30 a.m., and 12/5/13 at 11:05 a.m. On 12/5/13 at 11:15 a.m., LPN #9 was asked by the surveyor if the resident was able to release the seat belt on her own. The LPN stated she did not know if the resident able to release it on her own because the LPN has never asked the resident to unbuckle it. CNA #6 was asked by the surveyor why Resident #2 had a SRAB on her wheel chair. The CNA stated the SRAB was attached to the resident's chair to keep her in her chair.</p> <p>Note: Resident #2's IDT Clinical Team Meeting notes were reviewed by the surveyor for 1/9/13 through 11/12/13 and did not include documentation the SRAB had been reviewed, less restrictive devices had been tried, or that a plan for reduction of the restraint had been attempted.</p> <p>On 12/5/13 at 5:45 p.m., the DNS and RN #3 were asked about the resident's SRAB. RN #3 stated Resident #2's regular w/c was changed to a recline back wheel chair and the SRAB was attached to the chair and had not been reassessed for need.</p> <p>3. Resident #9 was admitted to the facility on 11/24/13 with the following diagnoses, Left shoulder injury, left humerus fracture, and dementia.</p> <p>Resident #9 did not have any MDS information to review.</p> <p>The Resident's Falls/Restraint Care Plan, initiated on 12/6/13, documented in part:</p>	F 221			

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F 221	<p>Continued From page 10</p> <p>* Problem - [Resident's name] is at risk for injuries R/T falls due to, history of falls, decline in strength with poor balance, impaired judgment, dementia, and poor safety awareness.</p> <p>* Approaches - Evaluate/assess need for safety equipment. Restraints, obtain appropriate doctors order. Instruct resident and family on risks and benefits and sign consent. Lap buddy while in wheel chair. Assess for increased agitation and reassure client that restraint is for protection. Check client every 30 minutes. Release restraint every 2 hours and PRN. Re-evaluate for restraint reduction/elimination 30 days and PRN. Re-evaluate need for lap buddy on/by 1/3/13. Release lap buddy during supervised activity, meals, or 1/1 visits...</p> <p>Note: The facility did not identify a medical condition which required the use of the lap buddy prior to use nor did the facility attempt the use of a less restrictive device first. Additionally, there was no documentation to indicate the lap buddy had been assessed for safety prior to use.</p> <p>The Resident's Telephone Orders (Physician) dated 12/5/13, documented the following order, "Lap buddy, tab alarm, safety."</p> <p>The Resident's Consent for Physical Restraint, dated 12/5/13, documented the following for the use of the lap buddy and tab alarm, "Lap Buddy and tab alarm may be used when needed for the following reasons: to help prevent falls from w/c or help notify staff of moms attempt to get up on her own."</p> <p>Note: The consent contained the following statement, "I understand that less restrictive measures have been considered and tried, and</p>	F 221			

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F 221	<p>Continued From page 11</p> <p>that the use of the restraint has been explained, and that the use of the restraint will enable and promote greater functional independence." There was no documentation in the resident's record to indicate less restrictive measures had been attempted. Additionally, the restraint did not, "enable and promote greater functional independence" to the resident as she was observed by the surveyor to be confined to her w/c.</p> <p>The resident was observed on 12/4/13 at 11:30 a.m. and 12/15/13 at 9:00 a.m. of the survey to have a lap buddy restraint in place most of the time the resident was in her w/c. The lap buddy was removed by staff during meals and the resident was able to stand and transfer with the assistance of 1 staff member.</p> <p>On 12/5/13 at 5:45 p.m., the DNS and RN #3 were asked about the resident's lap buddy. The facility was unable to provide documentation the lap buddy had been assessed for safety or that less restrictive devices had been tried first.</p> <p>4. Resident #8 was admitted to the facility on 1/12/12 with diagnoses of Parkinson, diabetes mellitus type II, and dementia.</p> <p>The most recent annual MDS assessment, dated 10/20/13, documented the resident:</p> <ul style="list-style-type: none"> - had short and long term memory problems, - had severely impaired decision making skills, - had verbal and physical behavior symptoms 4 to 6 days a week, - required extensive assistance for bed mobility, transfers, dressing, personal hygiene and 	F 221			

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F 221	<p>Continued From page 12</p> <p>bathing, - had a trunk restraint.</p> <p>The resident's Falls/Restraint Care Plan, initiated on 9/24/12, documented a problem of, "Resident is at risk for injuries [related to] falls due to: history of falls, decline in strength with poor balance, and impaired judgement, diagnoses of Dementia with Lewy Bodies." There were multiple interventions, one of which was, "Check restraint [every] 30 minutes, release [every] 2 hours and PRN for 15 minutes to provide care and reposition." There were no other interventions for restraints on the resident's care plan.</p> <p>The resident was observed on:</p> <ul style="list-style-type: none"> - 12/2/13 at 8:00 a.m. in the dining room with the lap buddy in place. - 12/2/13 at 8:50 in his room with the lap buddy in place waiting to go to bed. - 12/3/13 at 1:30 p.m. in the common area with his daughter had lap buddy in place. - 12/4/13 at 12 noon, in the dining room with the lap buddy in place. - 12/4/13 at 5:30 p.m., in the dining room with the lap buddy in place. <p>Most of the time during the survey the resident spent time in bed the lap buddy was used when he got up.</p> <p>The medical record was reviewed and the following noted:</p> <ul style="list-style-type: none"> - The nursing notes documented the resident had the lap buddy on while up in the wheelchair. - The physician wrote an order on 3/21/12 for, "Lap Buddy in wheelchair." - The resident's power of attorney signed, on 5/3/11, a "consent to use physical restraint" form. - The resident was assessed on 4/22/13 to be at 	F 221			

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F 221	Continued From page 13 high risk for falls, - The 10/20/13 CAA documented, "Lap Buddy to prevent slipping out of wheelchair. [Resident #8] has poor safety awareness and is at risk to fall. Someone is usually always with him when he is up. Restraint released per protocol. Will continue with restraint POC [Plan of Care]." The facility failed to: - identify the medical necessity for the restraint, - provide documentation of less restrictive means used prior to the lap buddy, - provide any assessments for initiating the restraint, - provide documentation of a plan for reduction of the restraint. The DON and Unit Manager were interviewed about the Lap buddy on 12/5/13 at 3:25 p.m. The unit manager said the resident had one to one staff for awhile due to his falls, the physician ordered the lap buddy and he has done better. The resident refused the restorative program which would have aided in his strengthening. No other information was obtained.	F 221			
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced	F 242	<u>F 242</u> Corrective action for residents found to have been affected by this deficiency: Met with residents 12 and 17 to discuss their wishes and plan shower schedule Resident 15 discharged from facility All residents, including residents 1-11 received a letter on 12/30 and had the opportunity to attend a resident council meeting addressing the issues of shower frequency, feelings of preferential treatment, and other resident rights. Corrective action for residents that may be affected by this deficiency:		

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F 242	<p>Continued From page 14</p> <p>by: Based on staff and resident interview, the facility failed to provide for choices for 1 of 12 (# 12) sampled residents and 2 (#s 15 & 17) random residents who stated a preference in more frequent bathing times. There was a potential for psychological harm when residents were not allowed to make significant choices in their daily activities. Findings include:</p> <p>On 12/4/13 at 9:00 a.m. during the group interview, Residents #12, #15 and #17 were interviewed and when the "right to choose" was brought up for discussion, the residents expressed concerns about their bathing preferences, stating that some residents in the facility were allowed to have a bath more often than twice a week.</p> <p>a) Resident #12 would like to have a bath more often the twice a week. She stated she had a colostomy and twice a week was not enough.</p> <p>b) Resident #15 would like to have a bath at least five days a week. She indicated she had COPD [chronic obstructive pulmonary disease] and perspired a lot and felt two days a week was not enough.</p> <p>c) Resident #17 indicated he would prefer a bath three days a week but was not upset with only getting a bath two days a week.</p> <p>After the meeting, interviews were conducted with multiple CNA's and LN#2. During the interviews with the CNAs, CNA #5 stated on 12/4/13 at 10:15 a.m. residents that reside on the rehabilitation unit could get a bath more than two days a week. The residents are asked every day</p>	F 242	<p>All residents have the potential to be affected by these identified concerns.</p> <p>Administrator will meet with Resident Council on 12/30 to discuss shower schedule and frequency. Letter will be presented to all residents who do or do not attend this meeting addressing this issue.</p> <p>It is not facility policy or practice to provide preferential treatment to any residents at all including shower schedule.</p> <p>In-service will be provided nursing staff by administrator concerning shower schedule, frequency, and residents' right to choose on 1/2/14</p> <p>Letter that was given out to residents on 12/30 addressing shower frequency is provided to residents or family with their admission packet and paperwork.</p> <p>Letter provided to residents on 12/30 will be re-distributed at least quarterly to all residents.</p> <p>All residents upon admission as part of the admission assessment are asked for input on shower preferences throughout the week. Shower preference sheet then kept in chart and CNA information sheets updated to include shower schedule for residents. CNA information sheets are provided each shift to nursing staff.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Administrator will interview 5 residents weekly for a period of at least 12 weeks starting the week of 1/5 to ensure residents are being showered enough and according to their desires. Any issues will be reported to the QA committee</p>		

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F 242	Continued From page 15 if they prefer a bath and if they did, their name was put on the top of the bathing list for the day. LN#2 was interviewed on 12/6/13 at 12 noon and confirmed the practice of asking the residents in the rehabilitation unit if they prefer a bath and then putting them at the top of the list. On 12/6/13 at 1:00 p.m. the administrator was informed about the bathing issue no further information was provided.	F 242	Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. Additionally, QA committee will review facility progress on resident rights at least quarterly on an on-going basis to aid in monitoring compliance.	1/10/14
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, group interview and staff interview, it was determined the facility failed to provide individualized activities for each resident that matched the resident's hobbies, skills, abilities, and preferences and make changes to each resident's Activity Care Plan as needed if/when the resident's interests, abilities, and/or preferences changed. In addition, the facility failed to ensure the development of a calendar of activities with resident input for evening and weekend activities. This was true for 5 of 12 (#s 3, 4, 6, 8, & 11) sampled residents and 4 of 4 individuals in the group meeting. Failure to provide an ongoing program of activities to meet resident needs	F 248	F 248 Corrective action for residents found to have been affected by this deficiency: Activity care plans updated for residents 3, 4, 6, 8, and 11. Activities reviewed and assessed patients related to interests and activities in order to create the best plan for each resident. Activities designed specifically for patients with dementia will be planned and cognitively impaired residents will be invited to participate. Resident council will be consulted to create evening and additional weekend activities. Corrective action for residents that may be affected by this deficiency: All residents have the potential to be affected by these identified concerns. Administrator will meet with Resident Council on 12/30 to discuss activities schedule. Activity schedule for January will be discussed and altered as necessary. Letter will be presented to all residents who do or do not attend this meeting addressing activities schedule and asking for suggestions on things they would like to do.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/09/2013
NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
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F 248	<p>Continued From page 16</p> <p>created a potential for depression, boredom, and an increase in negative behaviors, resulting psychological harm. Findings include:</p> <p>1. Resident #3 was admitted to the facility 4/22/11 with diagnoses of dysthymic disorder (severe depression), episodic mood disorder, diabetes mellitus type II and psychiatric disorder with delusions.</p> <p>The annual MDS assessment, dated 10/22/12, documented the resident was moderately cognitively impaired, required extensive assistance with ADLs and the assessment triggered a CAA for activities. However, a CAA was not completed and no evaluation was conducted to determine the resident's need for activities.</p> <p>The 10/22/12 MDS assessment identified the following preferences as "important" or "somewhat important": having books, newspapers, and magazines to read; listen to music; do things with groups of people, do favorite activities, go outside in good weather and practice religious activities.</p> <p>The resident's care plan for activities, with a start date of 6/7/13 documented approaches of:</p> <ul style="list-style-type: none"> ** Provide with a monthly calendar. * Provide with a good morning greeting and daily activity reminder. * Invite to resident council once each month. * Provide local news in the lobby. * Invite to exercise as scheduled. * Invite to beauty shop weekly or as needed. * Invite to arts and crafts as scheduled. * Invite to social and special events. * Invite to movies as scheduled. 	F 248	<p>Activities will meet with and complete activity assessment on new admits to determine interests and desires related to activities to coordinate appropriate plan of care. If family is available, they will be consulted as needed in this process.</p> <p>In-service will be provided to activities staff by administrator and DON concerning care plans, activity schedule, and individualized activities on 1/2/14</p> <p>Activities designed specifically for patients with dementia will be planned and cognitively impaired residents will be invited to participate. These activities designed more for dementia patients will often be one on one or small group type things and be reviewed at least quarterly to assess effectiveness.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Administrator will meet with activities at least monthly to cover additional training, activity care plans, effectiveness of activities meeting the needs of residents, and additional improvement for residents as necessary.</p> <p>Activities will present at least quarterly to the QA committee to review calendar and needs of residents. QA committee will make recommendations as necessary.</p> <p>Administrator will meet with resident council at least quarterly (approved by resident council president) to discuss wishes of residents in relation to activities. Additionally, letter presented to residents on 12/30 will be redistributed to residents quarterly asking for suggestions to activities.</p>	

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F 248	<p>Continued From page 17</p> <ul style="list-style-type: none"> * Invite to outdoor activities as weather permits. * Invite to food activities as scheduled. * Invite to game activities as scheduled. * Invite to [specific] church activities and church services as scheduled. * Invite to musical activities/programs as scheduled. * Invite to bingo 3 x a week. * Invite to play cards as scheduled. * Encourage families to bring in items to personalize rooms. * Assist resident to use phone to contact family and friends as appropriate. * Respect the right to refuse. * Encourage to attend and participate in activities of choice and ones she may be successful at doing. * Encourage family members to attend activities with resident if this is helpful to promote participation. * Encourage resident to assist with helping other residents at activities if this improves participation or makes feel useful." <p>The resident's Daily Activity Participation Record for November 2013 documented a total 21 activities that were offered on approximately a weekly basis. Of the 21 activities, the resident was not offered an opportunity and/or refused to participate in 13 of the activities including Arts and Crafts, Exercise, Games/Cards, Manicures/Nails, Mail, Movies, Outside activities, Resident council, Reading the news, Room visits/one to ones, Sensory stimulation , and Stop & Shop. Of the other identified activities listed, the only one she participated in more than once was Religious Services, TV and Visitors. Bingo was offered and refused on 10 occasions.</p>	F 248	<p>Administrator will monitor 3 activities, interview 3 residents, and audit 3 resident care plans weekly for a period of at least 12 weeks starting the week of 1/5 to ensure activities are meeting needs of residents and care plans are appropriate for resident needs and desires. Any issues will be reported to the QA committee.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. Additionally, QA committee will review facility progress on activities at least quarterly on an on-going basis to aid in monitoring compliance.</p>	1/10/14	

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F 248	<p>Continued From page 18</p> <p>The Daily Activity Participation Records for October and September 2013 were similar to the findings in the November 2013 records.</p> <p>The Activity Director (AD) was interviewed on 12/6/13 at 8:15 a.m. She said the activity care plan was done the way she had been told to do it many years ago. The AD said Resident #3 used to participate in more activities in the past but has not done so recently. The AD said she did not offer many activities for residents with cognitive impairment such as sensory stimulation or one-to-one activities.</p> <p>2. Resident #8 was admitted to the facility on 1/12/12 with diagnoses of Parkinson's disease, diabetes mellitus type II and dementia.</p> <p>The most recent annual MDS assessment, dated 10/20/13, documented the resident had short and long term memory problems, had severely impaired decision making skills, had verbal and physical behaviors 4 to 6 days a week, required extensive assistance for bed mobility, transfers, dressing, personal hygiene and bathing, and triggered a CAA for activities. A CAA was not completed on the resident and no evaluation was conducted to determine the resident's need for activities.</p> <p>The 10/20/13 MDS documented the resident had a preference for doing things with groups of people.</p> <p>The resident's care plan for activities, with a start date of 10/20/13 documented almost the exact same approaches as those documented for Resident #3 above.</p>	F 248			

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F 248	<p>Continued From page 19</p> <p>The resident's Daily Activity Participation Record for November 2013 documented a total 21 activities that were offered on approximately a weekly basis. Of the 21 activities, the resident was not offered an opportunity and/or refused to participate in 18 of the activities including Arts and Crafts, Beauty/Barber, Bingo, Exercise, Entertainment, Evening Activity, Games/Cards, Manicures/Nails, Mail, Movies, Outside activities, Resident council, Reading the news, Room visits/one to ones, Sensory stimulation, Snack/Juice and Stop & Shop. Of the other identified activities listed, the resident participated in Music/Singing one time and TV and Visitors on several occasions.</p> <p>The resident's Daily Activity Participation Record for October 2013 documented similar findings as for November 2013 with slightly more participation from 10/22 -31/13. The September 2013 Participation Record was similar to the October and November 2013 records.</p> <p>The AD was interviewed on 12/6/13 at 8:15 a.m. She said the activity care plan was done the way she had been told to do it many years ago. She said Resident #8 did not participate in activities because the CNAs put him in bed right after meals, so he does not get to the activities that may interest him. There was discussion about residents with limited cognition and the lack of programs. The AD did say sensory stimulation was offered sometimes but nothing consistent was scheduled. She indicated there was not enough time to do everything that needed to be done.</p> <p>3. Resident #11 was admitted to the facility 2/22/13 with diagnoses of dementia with</p>	F 248			

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F 248	<p>Continued From page 20</p> <p>psychosis, history of TIA [transient ischemic attacks] and stroke without residual affects.</p> <p>The admission MDS assessment, dated 3/1/13, documented the resident had moderate cognitive impairment, required extensive assistance for bed mobility, transfers, dressing, personal hygiene and bathing, and triggered a CAA for activities. A CAA was not completed on the resident and no evaluation was conducted to determine the resident's need for activities..</p> <p>The 3/1/13 MDS documented the resident had the following preferences: having a book, newspapers and magazines to read; listening to music; keeping up with the news; doing things with groups of people and doing favorite activities; and go outside when the weather was good.</p> <p>The resident's care plan for activities with a start date of 3/1/13 documented approaches similar to those of Resident's #3 and #8 above.</p> <p>The resident's Daily Activity Participation Record for November 2013 documented a total 21 activities that were offered on approximately a weekly basis. Of the 21 activities, the resident was not offered an opportunity and/or refused to participate in 15 of the activities including Arts and Crafts, Beauty/Barber, Bingo, Exercise, Entertainment, Evening Activity, Games/Cards, Mail, Movies, Music/Singing, Resident council, Reading the news, Room visits/one to ones, and Sensory stimulation. Of the other identified activities listed, the resident participated in Manicures/Nails twice, Outside activities, Stop & Shop, Snack/Juice one time each and TV on several occasions. There were no documented Visitors.</p>	F 248		

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F 248	<p>Continued From page 21</p> <p>The resident's Daily Activity Participation Record for September and October 2013 documented similar participation as that noted in November 2013.</p> <p>The AD was interviewed on 12/6/13 at 8:15 a.m. She said Resident #11 did not receive activities since he refuses to go to them. No further information was obtained.</p> <p>4. Resident #6 was readmitted to the facility on 11/26/13 with diagnoses of diabetes mellitus type II, sacral pressure sore, and end stage renal failure.</p> <p>The resident did not have an MDS assessment completed at the time of the survey.</p> <p>The resident was on bed rest due to a pressure sore on his sacrum. The resident received in room hemodialysis three days a week. As a result, the resident spent all of his time in his room.</p> <p>The admission care plan for activities dated 11/26/13 documented the following goal, "Resident will be invited to and attend 4 activities per week through the next review." There were no approaches identified for this goal.</p> <p>The resident was observed on 12/3, 12/4 and 12/5/13. The resident was confined to the Clinitron bed in his room. On 12/3 and 12/5 the resident received 4 hours of in room hemodialysis. The rest of the observations the resident was sleeping. There was a television in the room and it was not always on for stimulation.</p>	F 248			

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F 248	<p>Continued From page 22</p> <p>The AD was interviewed on 12/6/13 at 8:15 a.m. because no care plan information was provided for the resident.</p> <p>5. The Activity Calendars were reviewed for October, November and December 2013. The calendars lacked variety. Bingo was offered three times a week and all three calendars were almost a mirror of each other. The holidays of Halloween, Thanksgiving and Christmas included some different activities. There were no activities scheduled after 4:30 p.m. each day on any of the 3 calendars.</p> <p>On Saturdays there was a 9:30 a.m. activity of exercise, a 10:30 a.m. activity of Bingo and an 11:30 a.m. activity of "mealtime social." There were no scheduled afternoon activities.</p> <p>The AD was interviewed on 12/6/13 at 8:15 a.m. The interview did not maintain a focus around the calendar, but the interview migrated to there was not enough time in the day for the AD to complete the requirements of her job. She indicated she had two volunteers but was not able to get her work completed as needed. The calendar issue was never resolved.</p> <p>Note: During a telephone call on 12/20/13 at 11:10 a.m., the administrator stated that all 3 activities staff were paid staff.</p> <p>6. Resident #4 was admitted to the facility with multiple diagnoses to include, heart failure, CVA (cerebrovascular accident), hemiparesis, seizure disorder, and cerebral aneurysm.</p> <p>Resident #4's Admission MDS, dated 8/23/13, coded the following under Activity Preferences: - "Somewhat important," to have books,</p>	F 248			

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F 248.	<p>Continued From page 23</p> <p>newspapers, and magazines to read, to listen to music, do things with groups of people, participate in favorite activities, go outside to get fresh air when the weather is good, and participate in religious activities.</p> <p>Resident #4's Activity CAA Narrative, dated 8/23/13, documented, "[Resident's name] care area triggered due to PH resident mood interview. However [Resident's name] stated that he would like to attend activities of interest during his stay."</p> <p>The resident's Activity Care Plan dated, 8/23/13, was a generalized care plan identical to the above plans for Resident #s 3, 8, & 11 and did not include Resident #4's personal interests, hobbies, and preferences.</p> <p>The resident's Initial Activity Assessment, Activity Pursuit Patterns, dated 8/22/13, documented the following: * Current interests - playing cards, listening to music, reading, using the computer, taking trips, watching TV, and repairing guitars. * Favorite time of year - fall, "because it is hunting season."</p> <p>Resident #4's Daily Activity Participation Record for August, September, October, and November 2013, was a generalized participation record with generalized programs identical to the participation records for Resident #s 3, 5, & 11. The programs identified on the participation record were not resident specific to identify Resident #4's personal interests, hobbies, and preferences.</p> <p>7. On 12/4/13 at 9:00 a.m. a Group Interview was conducted and 4 residents were present. The residents stated the last activity during the</p>	F 248			

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F 248	Continued From page 24 weekdays is at 4:30 p.m. and once in awhile they will have an activity after dinner. The residents indicated December is a good month for activities because of Christmas. Additionally, the residents stated there is only one activity on Saturday, Bingo, in the morning, and the only activity on Sunday is a church service by the LDS church. The residents stated they have talked to the facility about having more activities on the weekend and in the evenings and were told, "We will try." On 12/6/13 at 8:15 a.m. the AD was interviewed related to Activity Care Plans not being resident specific. The AD stated she was told by the previous MDS Coordinator the Activity Care Plans need to be the same for every resident. The AD stated she was unaware there was a specific requirement for developing resident specific care plans. The AD stated she only has two volunteers and does not have time to get everything done that she needs to.	F 248			
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns;	F 272	<u>F272</u> Corrective action for residents found to have been affected by this deficiency: Care Plan meetings established with resident and family invited to participate for residents 1, 2, 3, 4, 5, 8. Care plans reviewed during these meetings and updated as necessary. CNA information sheets created to provide nursing staff with information about residents. Information sheets updated by charge nurses with any care plan changes so that nursing staff learns of these changes in report and from the information tool. Corrective action for residents that may be affected by this deficiency:		

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F 272	Continued From page 25 Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not ensure the CAA areas of residents' comprehensive assessments included input from residents or their legal representatives as part of the care planning decision process. This was true for 6 of 12 residents (#s 1, 2, 3, 4, 5, & 8) sampled for CAA completion. The deficient practice had the potential to cause more than minimal harm when care plans were developed without recognition of residents' perceptions of their situation and care. Findings included:	F 272	All residents have the potential to be affected by these identified concerns. Care plan meetings will be held at least quarterly for each patient and family will be invited to attend. Care plans will be reviewed during these meetings, discussed with resident and/or family, and updated as necessary. CNA information sheets created to provide nursing staff with information about residents. Information sheets updated by charge nurses with any care plan changes so that nursing staff learns of these changes in report and from the information tool. New physician orders reviewed by DON and/or charge nurse to ensure care planning is updated if necessary. MDS nurse will receive information related to care plan meetings and completed CAA resource papers from IDT members related to triggered areas. MDS nurse will ensure appropriate and accurate information is included in the MDS and ensure that the needs of each resident are addressed in appropriate care plans. Administrator will meet with Resident Council on 12/30 to discuss residents involvement in care planning. Letter will be presented to all residents who do or do not attend this meeting addressing this issue. In-service will be provided to nursing management, social services, and nursing staff by administrator concerning care planning on 1/2/14 Measures that will be put into place to ensure that this deficiency does not recur:		

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F 272	Continued From page 26 1. Resident #1 was admitted to the facility on 1/13/12 with multiple diagnoses to include, anxiety disorder, depression, senile delusions, hearing loss, and blindness related to macular degeneration. The Resident's most recent Annual MDS dated 6/18/13, documented the following triggered areas; Cognitive Loss, Visual Function, Communication, Urinary Incontinence, Psychosocial Well Being, Activities, Falls, Nutritional Status, Dental Care, Pressure Ulcers, Psychotropic Drug Use, and Physical Restraints. The Resident's most recent CAA Narrative dated 6/18/13, documented information was received from nursing staff, LSW, MDS Coordinator, and the Dietitian, however, it did not include input from the resident or the resident's legal representative. 2. Resident #2 was admitted to the facility on 5/12/10 with multiple diagnoses to include, chronic pain, history of falls, vertigo, and depression. The Resident's most recent Significant Change MDS dated 2/18/13, documented the following triggered areas; Cognitive Loss, Visual Function, Communication, ADL Function/Rehab Potential, Urinary Incontinence, Activities, Falls, Nutritional Status, Dental Care, Pressure Ulcers, Psychotropic Drug Use, Physical Restraints, and Pain. The Resident's most recent CAA Narrative dated 2/18/13, documented information was received from the LSW, MDS Coordinator, Activities, and the Dietitian; however it did not include input from	F 272	MDS nurse will provide monthly MDS calendar to IDT. Social services will schedule care plan meetings with resident and/or family in conjunction with MDS calendar as much as possible but at least quarterly. Administrator or DON will review and audit up to 3 care plan mtgs weekly and CAAs to ensure resident or family involvement for a period of at least 12 weeks starting the week of 1/5 to ensure residents are exercising their rights and to discover any issues of concern. Any issues will be reported to the QA committee. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. Additionally, QA committee will review facility progress on CAA and care planning at least quarterly on an on-going basis to aid in monitoring compliance.	11/10/14	

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F 272	<p>Continued From page 27 the resident or the residents legal representative.</p> <p>3. Resident #4 was admitted to the facility on 8/16/13 with multiple diagnoses to include, diabetes mellitus, CVA (Cerebrovascular Accident), hemiplegia, seizure disorder, and cerebral aneurysm.</p> <p>The Resident's Admission MDS dated 8/23/13, documented the following triggered areas; Visual Function, Communication, ADL Function, Urinary Incontinence, Psychosocial Well Being, Activities, Falls, Nutritional Status, Dental Care, Pressure Ulcers, Psychotropic Drug Use, Physical Restraints, and Return to Community References.</p> <p>The Resident's most recent CAA Narrative dated, 8/23/13, documented information was received from the MDS Coordinator and the LSW; however it did not include input from the resident or the residents legal representative.</p> <p>On 12/5/13 at 4:30 p.m., the DNS and the MDS Coordinator were interviewed about the lack of input for Residents #1, 2, and 4 from the resident or the resident's legal representative. The MDS Coordinator and DNS did not have an explanation but stated going forward the facility would be sure to ask and incorporate input from the resident and/or the resident's legal guardian.</p> <p>4. Resident #3 was admitted to the facility on 4/22/11 with diagnoses of Dysthymic disorder, episodic mood disorder, psychiatric disorder with delusions and diabetes mellitus type II without complications.</p>	F 272		
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F 272	Continued From page 28 The 10/22/12 Annual MDS assessment documented the resident was moderately cognitively impaired, did not have behavioral symptoms and was moderately depressed. The resident required extensive assistance with bed mobility, transfers, dressing, personal hygiene and bathing. The assessment triggered the areas of: Cognitive Loss, Visual Function, Communication, ADL function, Urinary incontinence, Psychosocial Well Being, Mood State, Activities, Falls, Nutritional Status, Pressure Ulcers, Psychotropic Drug use, and Physical Restraint. Review of the documentation for the triggered CAAs revealed there was no CAA for Activities. The October 2013 RAI manual documented on page 4-6 the following, "CAA documentation. CAA documentation helps to explain the basis for the care plan by showing how the IDT determined that the underlying causes, contributing factors, and risk factors were related to the care area condition for a specific resident; for example, the documentation should indicate the basis for these decisions, why the finding(s) require(s) an intervention, and the rationale(s) for selecting specific interventions. Based on the review of the comprehensive assessment, the IDT and the resident and/or the resident's representative determine the areas that require care plan intervention(s) and develop, revise, or continue the individualized care plan." The triggered items for Resident #3 did not have an evaluation of the triggers, no documentation whether the resident and family were involved in the assessment and whether the facility should or should not proceed to care planning.	F 272			

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F 272	<p>Continued From page 29</p> <p>The MDS LPN was interviewed on 12/5/13 at 4:30 p.m. and indicated that the CAAs were not complete for Resident #3. No further information was provided.</p> <p>5. Resident #5 was admitted to the facility on 1/13/12 with diagnoses of bipolar with psychosis and Alzheimer's dementia.</p> <p>The most recent annual MDS assessment, dated 10/7/13, documented the resident was moderately cognitively impaired, was minimally depressed, required limited to no assistance with bed mobility, transfers, dressing and personal hygiene.</p> <p>The assessment triggered the areas of, "Cognitive Loss, ADL Function, Psychosocial Well Being, Activities, Falls and Psychotropic Drugs. Review of the documentation for the triggered CAAs revealed there was no CAA for ADL function.</p> <p>The October 2013 RAI manual documented on page 4-6 the following, "CAA documentation helps to explain the basis for the care plan by showing how the IDT determined that the underlying causes, contributing factors, and risk factors were related to the care area condition for a specific resident; for example, the documentation should indicate the basis for these decisions, why the finding(s) require(s) an intervention, and the rationale(s) for selecting specific interventions. Based on the review of the comprehensive assessment, the IDT and the resident and/or the resident's representative determine the areas that require care plan intervention(s) and develop, revise, or continue the individualized care plan." The triggered items</p>	F 272			

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F 272	<p>Continued From page 30</p> <p>for Resident #5 did not have an evaluation of the triggers, no documentation whether the resident and family were involved in the assessment and whether the facility should or should not proceed to care planning.</p> <p>The MDS LPN was interviewed on 12/5/13 at 4:30 p.m. and indicated the CAAs were not complete for Resident #5. No further information was provided.</p> <p>6. Resident #8 was admitted to the facility on 1/12/12 with diagnoses of Parkinson, diabetes mellitus type II, dementia.</p> <p>The most recent annual MDS assessment, dated 10/20/13, documented the resident had short and long term memory problems, had severely impaired decision making skills, had verbal and physical behaviors 4 to 6 days a week, required extensive assistance for bed mobility, transfers, dressing, personal hygiene and bathing.</p> <p>The assessment triggered the areas of: Cognitive Loss, Communication, ADL function, Urinary incontinence, Psychosocial Well Being, Activities, Falls, Nutritional Status, Dental Care, Pressure Ulcers, Physical Restraints and Pain.</p> <p>The October 2013 RAI manual documented on page 4-6 the following, "CAA documentation. CAA documentation helps to explain the basis for the care plan by showing how the IDT determined that the underlying causes, contributing factors, and risk factors were related to the care area condition for a specific resident; for example, the documentation should indicate the basis for these decisions, why the finding(s) require(s) an intervention, and the rationale(s) for selecting</p>	F 272			

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F 272	Continued From page 31 specific interventions. Based on the review of the comprehensive assessment, the IDT and the resident and/or the resident's representative determine the areas that require care plan intervention(s) and develop, revise, or continue the individualized care plan." The triggered items for Resident #8 did not have an evaluation of the triggers, no documentation whether the resident and family were involved in the assessment and whether the facility should or should not proceed to care planning.	F 272		
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on assessment review and staff interview, the facility failed to ensure that there was an annual assessment completed within 366 days from the last full assessment. This was true for 1 of 12 (# 3) sampled residents. Not completing an annual assessment created a potential for harm as the care area assessments and revisions to the care plan were not done. This could potentially cause the resident's clinical condition to decline. Findings include: Resident #3 was admitted to the facility on	F 275	<u>F275</u> Corrective action for residents found to have been affected by this deficiency: Annual MDS assessment completed for resident 3 Corrective action for residents that may be affected by this deficiency: All residents have the potential to be affected by these identified concerns. MDS nurse will create monthly MDS calendar to highlight quarterly or annual assessments. MDS nurse will provide this calendar to IDT at least monthly. Additional part-time MDS nurse will be hired to aide in the completion and accuracy of MDS assessments.	

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F 275	Continued From page 32 4/22/11 with diagnoses of Dysthymic disorder, episodic mood disorder, psychiatric disorder with delusions and Diabetes Mellitus type II without complications. Upon review of the resident's MDS assessments it was found that the last comprehensive assessment was an annual assessment dated 10/22/12. After that assessment there were 5 quarterly assessments. These were dated, 1/20/13, 4/21/13, 6/7/13, 8/27/13 and 11/25/13. The MDS LPN that completed the assessments was interviewed on 12/4/13 at 4:30 p.m. and did not have comment, but confirmed that she missed the assessment.	F 275	In-service will be provided to nursing management and nursing staff by administrator concerning MDS assessments on 1/2/14. MDS nurse involved in establishing information for in-service and will be present at in-service to both learn and interject any necessary points. Measures that will be put into place to ensure that this deficiency does not recur: MDS nurse will create monthly MDS calendar to highlight quarterly or annual assessments. MDS nurse will provide this calendar to EDT at least monthly. Administrator will monitor up to 3 annual MDSs and completion of MDS calendar weekly for a period of at least 12 weeks starting the week of 1/5 to ensure proper completion and to discover any issues of concern. Any issues will be reported to the QA committee.		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and	F 278	Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. Additionally, QA committee will review facility progress on MDS assessments at least quarterly on an on-going basis to aid in monitoring compliance. <u>F278</u> Corrective action for residents found to have been affected by this deficiency: MDS assessments corrected on residents 1, 2, 3, 5, and 11	1/10/14	

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F 278	<p>Continued From page 33</p> <p>false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the MDS assessments were accurately documented. This was true for 5 of 12 (#s 1, 2, 3, 5 and 11) sampled residents. Inaccurate assessments can lead to potential harm when the area that was inaccurate did not trigger a potential problem for further assessment and care planning. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 4/22/11 with diagnoses of dysthymic disorder, episodic mood disorder and diabetes mellitus type II without complications.</p> <p>The 11/25/13 quarterly MDS assessment Section C for "Cognitive Patterns" was not completed. The section has two parts. One is an interview portion and if the resident was not able to be interviewed the staff who care for the resident were to be interviewed. This assessment had dashes (-) in both parts. As a result the assessment did not accurately reflect the resident's cognitive status.</p>	F 278	<p>Corrective action for residents that may be affected by this deficiency:</p> <p>All residents have the potential to be affected by these identified concerns.</p> <p>Additional part-time MDS nurse will be hired to aide in the completion and accuracy of MDS assessments.</p> <p>No dashes will be used on the MDS. Skips may be used when appropriate if there is no supporting documentation for the MDS section being completed.</p> <p>In-service will be provided to activities, social services, nursing management, and nursing staff by administrator concerning MDS accuracy on 1/2/14. MDS nurse involved in establishing information for in-service and will be present at nursing in-service to both learn and interject any necessary points.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Administrator will audit 4 completed MDSs weekly for a period of at least 12 weeks starting the week of 1/5 to ensure MDS accuracy and to discover any issues of concern. Any issues will be reported to the QA committee.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. Additionally, QA committee will review facility progress on MDS accuracy at least quarterly on an on-going basis to aid in monitoring compliance.</p>		

1/10/14

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F 278	<p>Continued From page 34</p> <p>The MDS nurse was interviewed on 12/5/13 at 4:30 p.m. She indicated the section was not completed correctly.</p> <p>2. Resident #5 was admitted to the facility on 1/13/2012 with diagnoses of Alzheimers dementia, depression, and bipolar with psychosis.</p> <p>The 7/7/13 quarterly MDS assessment Section P Health Conditions was not accurate. Item number "J 1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment, whichever is more recent" documented the resident had a fall. The coder was to document the number of falls in J 1900. There was an "0" in each box which created an inaccurate depiction of the resident's fall status.</p> <p>The MDS nurse was interviewed on 12/5/13 at 4:30 p.m. She indicated the section was not completed correctly.</p> <p>3. Resident #11 was admitted to the facility on 2/22/13 with diagnoses of dementia without psychosis and TIA/stroke without residual.</p> <p>The 8/28/13 quarterly MDS assessment Section P Health Conditions was not accurate. Item number "J 1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment, whichever is more recent" documented the resident had a fall. The coder was to document the number of falls in J 1900. There was an "0" in each box which created an inaccurate depiction of the resident fall status.</p> <p>The MDS nurse was interviewed on 12/5/13 at 4:30 p.m. She indicated the section was not completed correctly.</p>	F 278			

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F 278	Continued From page 35	F 278		
F 280 SS=E	<p>4. For Residents #1 and #2 the MDS had sections that had dashes (-) and were not completed.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview it was determined the facility failed to ensure care plans were periodically reviewed and revised for 5 of 12 sampled residents (#s 2, 3, 5, 8, & 11). This had the potential to result in harm if residents did not receive appropriate care due to lack of direction from the care plans. Findings</p>	F 280	<p><u>F280</u></p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Care plan for resident 2 revised and updated as necessary, met with resident and/or family representative for care plan meeting and reviewed care plan at meeting.</p> <p>Care plan for resident 3 revised and updated as necessary, met with resident and/or family representative for care plan meeting and reviewed care plan at meeting.</p> <p>Care plan for resident 5 revised and updated as necessary, met with resident and/or family representative for care plan meeting and reviewed care plan at meeting.</p> <p>Care plan for resident 8 revised and updated as necessary, met with resident and/or family representative for care plan meeting and reviewed care plan at meeting.</p>	

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F 280	Continued From page 36 include: 1. Resident #2 was admitted with multiple diagnoses to include, anxiety disorder, depression, senile delusions, hearing loss, and blindness related to macular degeneration. The resident's Comprehensive Care Plan failed to have the following revisions completed when changes were made, for example: * The Fall Care Plan last updated on 11/15/13, documented the resident was to to have, "1:1 Supervision at all times." The resident was no longer on 1:1 Supervision and had not been since 11/7/13. * The Visual Care Plan last updated on 11/15/13, documented, "Encourage the resident to wear eye glasses..." On 12/3/13 at 10:05 a.m. and 12/4/13 at 10:45 a.m. the resident was observed sitting in her room without her glasses, and on 12/5/13 at 11:15 a.m. the resident was observed in the dining room without her glasses, * The Restorative Care Plan in place for eating or swallowing, last updated 8/5/13 documented, "Restorative dining 3 meals daily/7x/wk. (daily 7 times a week). On 12/3/13, 12/4/13, and 12/5/13 at 8:30 a.m. the resident was observed to eat in the main dining room and required extensive assist to total dependence with meals. * The Anticoagulation Therapy/Coumadin Care Plan last updated 8/15/13, documented, "Oxygen per nasal cannula." On On 12/3/13 at 10:05 a.m., 12/4/13 at 10:45 a.m., and on 12/5/13 at 11:15 a.m. the resident was observed sitting in her room without her her oxygen on. * The Restorative Care Plan, last updated 8/15/13 and 10/28/13, in place for ROM (range of motion), Bed mobility, Transfers, and Walking, last updated 8/15/13, documented, "Supine (to	F 280	Care plan for resident 11 revised and updated as necessary, met with resident and/or family representative for care plan meeting and reviewed care plan at meeting. Corrective action for residents that may be affected by this deficiency: All residents have the potential to be affected by these identified concerns. Resident care plans were reviewed and updated as necessary. Social services will schedule care plan meetings with residents and families to review care plans and update them as needed. Care plans will be updated at least quarterly in conjunction with care plan mtgs and MDS calendar, and as necessary. In-service will be provided to activities, social services, nursing administration, and nursing staff by administrator concerning care planning and care plan process on 1/2/14 Measures that will be put into place to ensure that this deficiency does not recur: Social services will schedule care plan meetings with residents and/or families at least quarterly and as needed where care plan is reviewed and revised as necessary. Administrator or DON will monitor 5 care plans weekly for a period of at least 12 weeks starting the week of 1/5 to ensure care plan are being accurately updated at least quarterly. Any issues will be reported to the QA committee. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not		

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F 280	<p>Continued From page 37</p> <p>Sit and Sit (to) Supine in bed x (times) 3 reps 6x (times) wk (week), straight leg raises as ordered, and ambulate as ordered." The resident's most recent Quarterly MDS, dated 11/17/13, coded, the resident requires extensive assist of one person for bed mobility and transfers. Additionally, the MDS coded, "activity did not occur" related to walking in room or corridor.</p> <p>On 12/5/13 at 5:45 p.m., the DNS and RN #3 were interviewed related to the above findings. The DNS and RN #3 indicated the care plans should have been reviewed and revised when changes were made. RN #3 said, "I will have to search her room for the glasses. I don't know if she even has any (glasses). RN #3 stated the resident does not use oxygen and she (RN #3) did not know why it was on her care plan. Additionally, the DNS and RN #3 indicated the resident was no longer able to perform the activities identified on her Restorative care plan.</p> <p>2. Resident #3 was admitted to the facility on 4/22/11 with diagnoses of Dysthymic disorder (depression), episodic mood disorder, psychiatric disorder with delusions and diabetes mellitus type II without complications.</p> <p>The resident's comprehensive care plan failed to have revisions completed when changes were made. Some examples were:</p> <ul style="list-style-type: none"> - The ADL/Rehab Potential care plan last updated 9/11/13 documented an approach of "RNA as Ordered." The resident was no longer receiving RNA services. - The Falls/restraint care plan last updated 9/11/13 documented an approach of, "Fall prevention/restraints: Falling Star Program." The DON stated, the resident was no longer in the 	F 280	<p>The QA committee will review any issues uncovered by weekly audits, make recommendations, and after the initial 12 weeks make a determination related to changing the frequency of those audits. Additionally, QA committee will review facility progress on care planning at least quarterly on an on-going basis to aid in monitoring compliance.</p>	1/10/14

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F 280	<p>Continued From page 38 falling star program.</p> <p>The Unit Manager and DON were interviewed on 12/5/13 at 3:25 p.m. about revising of resident care plans and indicated they should have been revised when changes were made.</p> <p>3. Resident #5 was admitted to the facility on 1/13/12 with diagnoses of Alzheimer's dementia, depression and Bipolar with psychosis.</p> <p>The resident's comprehensive care plan failed to have revisions completed when changes were made. Some examples were: - The Falls care plan last updated 5/4/13 documented an approach of, "Falling star program." The DON stated the resident was no longer in the falling star program. - The ADL/Rehab potential care plan last updated on 7/3/13 documented an approach of, "ROM with ADL cares and PRN." The DON stated, the resident no longer needed the approach and it should have been discontinued. - The Cognition Care Plan last updated 7/3/13 documented an approach of, "Code alert to Wanderguard." The DON stated, the resident no longer used a wander guard. - The Fall/Restraint care plan last updated 7/3/13 documented an approach of, "Falling star program." The DON stated, the resident was no longer on the falling star program.</p> <p>The Unit manager and DON were interviewed on 12/5/13 at 3:25 p.m. about revising of resident care plans and indicated they should have been revised when changes were made.</p> <p>4. Resident #8 was admitted to the facility on 1/12/12 with diagnoses of Parkinson's disease,</p>	F 280			

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F 280	<p>Continued From page 39 diabetes mellitus type II, and dementia.</p> <p>The resident's comprehensive care plan failed to have revisions completed when changes were made. Some examples were:</p> <ul style="list-style-type: none"> - The ADL/rehab potential care plan last updated 10/31/13 documented an approach of, "ROM with ADL care and PRN." The DON stated, the resident was no longer doing ROM. - The Skin integrity care plan last updated 10/31/13, documented an approach of, "Restorative Program." The DON stated, the resident was no longer in the restorative program. - The Skin integrity care plan last updated 10/31/13, documented an approach of, "Left Knee Brace." The DON stated, the resident no longer wore a knee brace. <p>The Unit manager and DON were interviewed on 12/5/13 at 3:25 p.m. about revising of resident care plans and indicated they should have been revised when changes were made.</p> <p>5. Resident #11 was admitted to the facility, on 2/22/13, with diagnoses of TIA/Stroke without residual.</p> <p>Resident #11 used a Wanderguard according to the 12/1/13, 11/24/13 and 11/17/13 nursing documentation. The comprehensive care plan failed to identify the facility was using a Wander guard on the resident.</p> <p>The resident's comprehensive care plan failed to have revisions completed when changes were made. The DON and Unit manager were interviewed on 12/5/13 at 3:25 p.m. about revising of resident care plans and indicated they should have been revised when changes were made.</p>	F 280			

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F 280	Continued From page 40	F 280		
F 309 SS=G	<p>The Administrator was informed on 12/6/13 at 1:00 p.m. No further information was provided.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review it was determined the facility failed to ensure a resident who had a physician's order for NWB (non-weight bearing), on her right ankle after surgery maintained NWB and the facility failed to implement a system to direct the CNAs on the how to transfer a resident with NWB status. This was true for 1 of 8 (#7) residents sampled for quality of care. This failed practice resulted in harm when the resident required additional surgical interventions to her right ankle. Findings include:</p> <p>Resident #7 was admitted to the facility on 11/2/13 and re-admitted on 11/27/13 with multiple diagnoses to include, open right ankle fracture, diabetes mellitus, obesity, and diabetic neuropathy.</p> <p>Resident #7 did not have an MDS completed.</p>	F 309	<p>F309</p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Resident 7 weight bearing and activity status order clarified with surgeon. Resident 7 is strictly a hoier lift due to her weight bearing status. Information sheets regarding patient information such as transfer status created for all patients to be used as a tool for nursing staff when caring for residents.</p> <p>Corrective action for residents that may be affected by this deficiency:</p> <p>All residents needing transfer assistance have the potential to be affected by these identified concerns.</p> <p>CNA information tool put in place regarding resident information and care. Information sheets are updated as needed by the charge nurses to be used in shift report.</p> <p>Transfer policy implemented related to patients admitting with non or limited weight bearing status</p> <p>In-service will be provided to nursing staff by DON concerning info tool and patient transfer policy on 1/2/14</p>	

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F 309	<p>Continued From page 41</p> <p>Resident #7's Admission Care Plan for 11/2/13 or 11/27/13 did not address non-weight bearing status on her right leg nor the need to use a Hoyer lift for transfers.</p> <p>Note: The Emergency Room Addendum, dated 10/28/13, documented, Resident #7 was transported from her home to the Emergency Room, via ambulance after she felt, "her ankle turn in," and sustained an open fracture of her right ankle. This fracture required an ORIF with the application of metal plates and screws for proper alignment.</p> <p>The resident's Physician's Orders and Plan of Care, dated 11/2/13, documented the following: * Weight Bearing Status: non wt [weight] bearing RLE. * Additional Orders: Elevate RLE to heart level, do not [change] surgical dsrg [dressing]... The resident had an order written on a prescription pad, dated 11/11/13, "Pt [patient] needs to have [Right] leg elevated at all times even while in wheel chair." The resident's Physician's Orders and Plan of Care, dated 11/28/13, documented the following: * Weight Bearing Status: "No weight bearing on [Right] foot."</p> <p>Physician Progress Notes documented the following: * 11/2/13, at 1500 [3:00 p.m.], "NWB to [Right] LE." * 11/8/13, "Continue NWB [Right] LE."</p> <p>Resident #7's Plan of Care/Statement of Necessity for Physical Therapy Services, started on 11/2/13, documented the following: * Functional mobility: Bed mobility = min[imum]</p>	F 309	<p>In-service provided to therapy department by administrator on 1/3/14 regarding patient transfer policy</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Administrator or DON review 5 residents on CNA information tool and 5 transfers of patients needing assistance weekly for at least 12 weeks starting the week of 1/5. Any issues will be reported to the QA committee.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. Additionally, QA committee will review facility progress on patient transfers at least quarterly on an on-going basis to aid in monitoring compliance.</p>	1/12/14	

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F 309	<p>Continued From page 42</p> <p>[assist] supine [to] sit, max[imum] [assist times 2 people] for resituating in bed.</p> <p>* Gait: RLE = NWB, LLE = painful [secondary] recent fall and pulled muscles. Gait not attempted at this time.</p> <p>* Sensation/reflexes: [decreased] sensation in lower extremities from knees down [bilateral secondary] to diabetic neuropathy.</p> <p>* Comments: Pt is an obese woman [with] muscular injury to Left LE status post op. Right medial ankle [fracture], NWB on [Right] LE... Not strong enough to [weight bear] solely on left [leg] yet. She requires a Hoyer lift for transfers.</p> <p>The Resident's Rehabilitation Services Skilled Intervention Record, for Physical Therapy documented the following:</p> <p>* 11/4/13, "Pt is an obese woman [with] [Bilateral] LE injuries and NWB on Right [lower extremity]."</p> <p>* 11/5/13, N/S [No Service], schedule to see [with] OT did not work out today to use Hoyer to get pt OOB [patient out of bed].</p> <p>* 11/7/13, "Pt was unable to maintain NWB status on [Right] LE while standing in parallel bars..."</p> <p>* 11/8/13, "Pt states that she cannot stand from w/c [wheel chair] even with parallel bars without bearing weight on [Right] LE...Nursing was notified that the Pt is unable to comply [with] weight bearing precautions while [transferring] from w/c and that a Hoyer or other accommodations must be implemented until she is able to comply on her own."</p> <p>* 11/12/13, "Pt reports not using a Hoyer to [transfer] to bed or w/c and was advised to use Hoyer as she cannot comply [with] NWB precautions..."</p> <p>Note: The CNAs work 12 hr shifts from 6 a.m. - 6:30 p.m. or Day shift (D) and 6:00 p.m. to 6:30</p>	F 309			

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F 309	<p>Continued From page 43</p> <p>a.m. or Night shift (N). The letters (D) and/or (N) will be used to identify shifts on the Nursing assistant flow sheet below.</p> <p>Resident #7's Nursing Assistant Flow Sheet documented the following numbers under Transfers:</p> <ul style="list-style-type: none"> * 11/6/13, (N) Extensive Assistance of 1 person with the Hoyer, * 11/7/13, (D) and (N) Extensive Assistance of 1 person with the Hoyer, * 11/8/13, (D) and (N) Limited Assistance of 1 person without Hoyer, * 11/9/13, (D) Extensive Assistance of 2 people with the Hoyer, * 11/9/13, (N) Extensive Assistance of 1 person without the Hoyer, * 11/10/13, (D) Extensive Assistance of 1 person without the Hoyer, * 11/11/13 through 11/14/13 (D) and (N) Extensive Assistance of 1 person without the Hoyer. <p>Resident #7's Nursing Assistant Flow Sheet documented from 11/9/13 through 11/14/13, (N) and (D) the resident was a 1 person Extensive Assist with toileting.</p> <p>Note: Nurse's notes reviewed for 11/3/13 through 11/15/13 did not document any information related to Resident #7's transfer status via Hoyer lift nor did the notes indicate there were any concerns with the resident being "non-compliant" with the the NWB status or concerns addressed at her follow-up physician's visits.</p> <p>Note: Resident #7 was seen on 11/13/13 at the physician's office for follow-up on the right ankle fracture. The resident stated to the physician, "she [the resident] had remained non-weight bearing," however in the physician's progress</p>	F 309			

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F 309	<p>Continued From page 44</p> <p>note [Physician's name] documented, "interestingly her foot actually looks a little bit out of placement when compared to the last visit." The Physician then ordered an x-ray to check the alignment and repair of the ankle.</p> <p>On 11/14/13 the x-ray results included the following documentation, "In comparison to 10/31/13, fracture alignment has disrupted with the talus and medial malleolar fragments displaced 2.5 - 3.0 cm medially with 25 degrees medial angulation. The plates are bent, but screws are still in position."</p> <p>Note: On 11/15/13 Resident #7 was discharged from the facility and admitted to the hospital for surgical repair to her right ankle.</p> <p>The Operative Report, dated 11/15/13, documented the following:</p> <ul style="list-style-type: none"> - Preoperative/Postoperative Diagnosis: "Right ankle hardware failure from open reduction and internal fixation due to patient walking on her broken ankle." - Operative Indications: The resident recovered in the hospital and was sent to the nursing home, "where she promptly began to walk on her ankle for whatever reason in direct disobedience to the instruction of not bearing weight on her right foot... she basically displaced the fracture again, bending all the hardware and ruining the entire fixation." <p>Note: Resident #7 stated to the Physical Therapist on 11/7/13, that she [the resident] was unable to maintain NWB status on [Right] LE while standing in parallel bars... and on 11/8/13 that she was physically unable to stand from w/c [wheel chair] even with parallel bars without</p>	F 309			

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F 309	<p>Continued From page 45</p> <p>bearing weight on [Right] LE. Additionally, Resident #7's medical record did not document any instances of "non-compliance" by either the CNAs or nursing staff.</p> <p>On 12/6/13, the surveyor was provided with a letter from [Physician's name] which documented the following, "The ankle fracture had resumed its original displacement and she [the resident] had again opened the original lateral wound...It would take a very large one time force to deform these plates in such a way. I believe that there is only one explanation for the plate bending and fracture to displace and that is that the patient was walking on her fractured ankle. I do not believe that minimal weight bearing on one or a few occasions would cause this catastrophic failure of her hardware."</p> <p>On 12/2/13 at 6:45 p.m., during the initial tour the surveyor asked Resident #7 about her stay at the facility. The resident stated it had been good except she had to have a second surgery on her right ankle because the CNA's had transferred her (the resident) from her wheel chair to her bed without using the hoier lift. "We had to hurry and get me to the bed and I had to step down on my right foot."</p> <p>On 12/3/13 at 3:50 p.m., RN #3, the charge nurse was asked by the surveyor how the CNAs know how to transfer and toilet new admissions. RN #3 stated the charge nurse at the facility receives report from the nurse at the hospital or transferring facility. The charge nurse then gives a report to the floor nurse at the facility and a quick report to the CNAs. If the resident is alert and oriented the CNAs ask the resident how many times the staff got he/she up and if the</p>	F 309			

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F 309	<p>Continued From page 46</p> <p>transferring facility used any assistive devices.</p> <p>On 12/4/13 at 10:15 a.m., CNA #5 was asked by the surveyor what Resident #7's transfer status was upon admission on 11/2/13. The CNA said the resident was a two person extensive assist with transfers and stated, "They [nursing or therapy] did not tell me Resident #7 was a hooyer lift until 11/14/13. The hooyer lift was never used by me until the day before the resident went to the hospital for her second surgery." Resident #7 told CNA #5 on 11/13/13 that the resident was going to have another surgery on her right foot and was upset because the physician had told the resident she might lose her foot. CNA #5 asked the resident what happened and the resident told the CNA on 11/11/13 or 11/12/13 the resident needed to use the bathroom urgently and the CNAs working with the resident took her to the bathroom via wheel chair and had encouraged the resident not to be incontinent in the wheel chair. Resident #7 told CNA #5 that when she was transferred from the wheel chair to the toilet the CNAs transferred the resident too quickly (without the hooyer) and the resident had to put weight on her right foot.</p> <p>On 12/4/13 at 10:30 a.m., Resident #7's family member was interviewed about the use of the hooyer by the CNA's when Resident #7 was transferred. The family member stated whenever she (family member) was at the facility Resident #7 was transferred by two CNAs, and not until after the resident's second admission was the resident transferred with the hooyer lift.</p> <p>On 12/4/13 at 1:25 p.m., CNA #6 was asked by the surveyor what Resident #7's transfer status was upon admission on 11/2/13. The CNA stated</p>	F 309			

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F 309	<p>Continued From page 47</p> <p>Resident #7 was to stay in bed until Physical Therapy could evaluate the resident. CNA #6 said the hoier lift was never used to transfer the resident out of bed. The CNA said the resident was full weight bearing on her left lower extremity and "very limited" weight bearing on her right lower extremity.</p> <p>On 12/5/13 at 6:45 p.m., CNA #7 was asked about Resident #7's transferring status. CNA #7 stated on 11/11/13 or 11/12/13 she had responded to the resident's call light and the resident requested assistance to the bathroom. CNA #7 told Resident #7, the CNA did not know how to transfer the resident and would need to find another CNA to assist. The resident told the CNA, "I know how the CNAs transferred me." The resident then told the CNA, "This is how CNA #5 transferred me (the resident), CNA #5 assisted me to transfer from the bed to the wheel chair and then I (the resident) transfer myself to the toilet. I limped and tip toed on my right foot." CNA #7 stated she did not know Resident #7 was non-weight bearing and the only day the hoier was used by her (CNA #7) was on 11/15/13, when the resident transferred to the hospital.</p> <p>On 12/5/13 at 7:00 p.m. the Administrator and DNS were informed about the above findings. The DNS and the administrator provided the surveyor with additional information for review.</p> <p>On 12/6/13 at 10:15 p.m., Physical Therapist #7 was interviewed. The therapist stated when a new resident is admitted the CNAs know to seek the expertise of the Physical Therapists to identify a resident's weight bearing status and precautions. The physical therapist then stated, "the CNAs should know what weight bearing status is for</p>	F 309			

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F 309	Continued From page 48 example, NWB, 25%, 50%, it is in their (the CNAs) training." Resident #7 was harmed when: - The facility failed to ensure the physician's orders for NWB were followed. - CNAs did not receive consistent instruction on how to transfer the resident. - The facility failed to have a system in place to direct CNAs on the day to day cares for residents to ensure quality of care is maintained. - The resident's NWB status was not included on the care plan. 2. During interviews with staff it was found there was no process to assure residents received care from the CNAs in a consistent manner. [Note: See example #1] The Unit manager and DON stated in an interview, on 12/3/13 at 9:30 a.m., the Kardex's were discontinued when the DON started. They were concerned after the last survey because they were cited for not keeping the Kardex's current. The discontinuation tool and not putting a replacement process in place resulted in a resident being harmed. CNAs were providing cares to residents without a tool to provide direction of what the resident's needs were. The Administrator and DON were informed on 12/5/13 at 7:00 p.m. No further information was provided.	F 309			
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329	F329 Corrective action for residents found to have been affected by this deficiency:		

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F 329	<p>Continued From page 49</p> <p>without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to:</p> <ul style="list-style-type: none"> - consider the risks identified by the Food and Drug Administration (FDA), - ensure resident's were free from unnecessary drugs, - evaluate duplicate medication therapy, and - document clinical indications for use of psychotropic medications. <p>This was true for 4 of 12 (#s 1, 3, 5, and 11) sampled residents. The implementation of medications without adequate indications for use and full consideration of the serious side effects placed residents at risk for adverse reactions and</p>	F 329	<p>Medication regimen reviewed by pharmacist for resident 1. Any recommendations for med changes sent to attending physician. Black box consent obtained.</p> <p>Medication regimen reviewed by pharmacist for resident 3. Any recommendations for med changes sent to attending physician. Black box consent obtained.</p> <p>Medication regimen reviewed by pharmacist for resident 5. Any recommendations for med changes sent to attending physician. Black box consent obtained.</p> <p>Medication regimen reviewed by pharmacist for resident 11. Any recommendations for med changes sent to attending physician. Black box consent obtained.</p> <p>Medication regimen reviewed by pharmacist for all residents and pharmacy recommendations sent to physicians. Pharmacy review and any recommendations to the physicians are based on individual monthly evaluations for each residents regarding psychotropic needs.</p> <p>Appropriate consents for psychotropic medications with black box warning obtained for any residents needing them.</p> <p>Corrective action for residents that may be affected by this deficiency:</p> <p>All residents with psychotropic medications have the potential to be affected by these identified concerns.</p> <p>Black box warning placed on consent forms related to psychotropic medications prescribed for patients with dementia and consents obtained.</p>		

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F 329	<p>Continued From page 50 health decline. Findings include:</p> <p>1. Resident #3 was over 65 years old and admitted to the facility on 4/22/11 with diagnoses of dysthymic disorder (severe depression), episodic mood disorder, psychiatric disorder with delusions and diabetes mellitus type II without complications.</p> <p>The 11/25/13 quarterly MDS documented the resident did not have behaviors and exhibited no mood or behavioral symptoms during the assessment period. The resident required extensive assistance with bed mobility, transfers, dressing, personal hygiene and bathing. The resident was receiving antipsychotic, antianxiety, and antidepressant medications. Note: The resident's cognitive status was not coded.</p> <p>The 10/22/12 Annual MDS assessment documented the resident was moderately cognitively impaired.</p> <p>Review of the resident's November 2013 physician's recapitulation orders documented the resident received, "Seroquel XR [extended release] 400 mg at bedtime for mood/depression, Ativan 0.5 mg twice a day for anxiety, and Cymbalta 60 mg once a day for depression." The resident also had Geodon 10 mg every 2 hours as needed not to exceed 30 mg a day for "depression/mood."</p> <p>Review of the medical record, including physician progress notes revealed there was no documentation where the multiple psychiatric diagnoses came from, nor was there any documentation by the physician or pharmacist as to the effectiveness of the multiple medications.</p>	F 329	<p>Pharmacist will review patient medication regimens monthly and send any recommendations to physician. Psychotropic meeting will be held at least monthly with nursing, social services, and pharmacist to discuss pharmacy review, evaluate any duplicate psychoactive therapy to assess needs for patients, and validate defined reasons for using psychotropic medications for individual residents.</p> <p>In-service will be provided to nursing administration, social services, and nursing staff by pharmacist concerning psychotropic drugs, documentation, and black box warning for specific medications on 1/2/14</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Pharmacist will review all resident medications every month and forward any recommendations to physicians. New consent forms that include black box warning when appropriate have been implemented. Psychotropic meeting to be held monthly to assess needs of residents and monitor individual psychotropic meds & reason for use.</p> <p>DON will audit 5 residents weekly for a period of at least 12 weeks starting the week of 1/5 to ensure black box warnings are included in any consents if necessary and ensure medication regimens have been reviewed by pharmacist. Any issues will be reported to the QA committee.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p>		

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F 329	<p>Continued From page 51</p> <p>Note: The interpretive guidance at F329 states, "Admission (or Readmission) - Some residents may be admitted on medications for an undocumented chronic condition or without a clear indication as to why a medication was begun or should be continued. It is expected that the attending physician, pharmacist, and staff subsequently determine if continuing the medication is justified by evaluating the resident's clinical condition, risks, existing medication regimen, and related factors. If the indications for continuing the medication are unclear, or if the resident's symptoms could represent a clinically significant adverse consequence, additional consideration of the rationale for the medication(s) is warranted."</p> <p>The consent form signed 6/4/13 by the resident for Seroquel failed to explain the risks of the medication to the resident. Seroquel was not one of the medications listed on the back of the form which listed the side effects of multiple medications.</p> <p>The medication Seroquel has an FDA warning of: "Warning: Increased mortality in elderly patients with dementia-related psychosis and suicidal thoughts and behaviors." The FDA warning further states, "Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Seroquel is not approved for elderly patients with dementia related psychosis."</p> <p>The pharmacist was interviewed, on 12/5/13 at 4:15 p.m., about the risk verses benefits and informing the resident or family of those risks. The pharmacist was not aware of S & C:</p>	F 329	<p>The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. Additionally, QA committee will review facility progress on psychotropic drugs at least quarterly on an on-going basis to aid in monitoring compliance.</p> <p><i>Telephone conversation 11/10/14 with Administrator, 3.7.14 11.52</i></p> <p><i>- Duplicate therapy:</i></p> <p><i>Resident admitted, next week day chart reviewed by facility. The facility goes through the medications. Social services contacts pharmacy to make sure pharmacy is aware of the duplicate therapy.</i></p> <p><i>- Clinical indications for use of psychotropic medications.</i></p> <p><i>Alert charting book where communication between staff is initiated.</i></p> <p><i>Then an alert charting record - Log of who the resident is and the reason(s) why the resident is on alert charting.</i></p>	
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Charting.
Ex: Refusal of CARES
Not an all inclusive
example.

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F 329	<p>Continued From page 52</p> <p>13-35-NH letter which clarified medication issues with dementia residents. The pharmacist further said the facility had a committee that reviewed psychotropic medications. The pharmacist did confirm that the medical record lacked documentation of what the committee did with each resident who was on a psychotropic medication.</p> <p>2. Resident #5 was over 80 years old and admitted to the facility on 1/13/12 with diagnoses of bipolar with psychosis and Alzheimer's dementia.</p> <p>The most recent annual MDS assessment, dated 10/7/13, documented the resident was moderately cognitively impaired, was minimally depressed, required limited to no assistance with bed mobility, transfers, dressing and personal hygiene and received an antipsychotic and an antidepressant medication.</p> <p>Review of the resident's October 2013 physician's recapitulation orders documented the resident received: Seroquel 200 mg at bedtime for bipolar disorder, Lamictal 25 mg at bedtime for bipolar disorder and Wellbutrin XL150 mg at bedtime for depression.</p> <p>Review of the medical record including the physician progress notes revealed a lack of documentation as to where the bipolar and depression diagnoses came from, nor was there any documentation by the physician or pharmacist for the effectiveness of the multiple medications used for bipolar disorder.</p> <p>Note: The interpretive guidance for F329 states, "Duplicate therapy is generally not indicated, unless current clinical standards of practice and</p>	F 329	<p>3.7.14 11:52 continued from previous page.</p> <p>ALERT charting for 2 weeks OR AS needed depending on the circumstances, then the facility contacts the doctor for the doctor's recommendation OR ORDER.</p> <p>JM</p>		

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F 329	<p>Continued From page 53</p> <p>documented clinical rationale confirm the benefits of multiple medications from the same class or with similar therapeutic effects."</p> <p>In addition, the resident had a dementia diagnoses and the FDA had published a warning about Seroquel use. The FDA warning documents, "Warning: Increased mortality in elderly patients with dementia-related psychosis and suicidal thoughts and behaviors." The FDA warning further document, "Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Seroquel is not approved for elderly patients with dementia related psychosis."</p> <p>The pharmacist was interviewed, on 12/5/13 at 4:15 p.m., about the risk verses benefits and informing the resident or family of the risks of using Seroquel. The pharmacist was not aware of S & C: 13-35-NH letter which clarified medication issues with dementia residents. The pharmacist further said the facility had a committee that reviewed psychotropic medications. The pharmacist did confirm that the resident's record lacked documentation of what the committee did with each resident on a psychotropic medication.</p> <p>3. Resident #11 was over 65 years old and admitted to the facility, on 2/22/13, with diagnoses of TIA/Stroke without residual.</p> <p>The 8/28/13 quarterly MDS documented the resident was severely cognitively impaired, required extensive assistance with bed mobility, transfers, dressing, and personal hygiene. The resident was receiving antipsychotic and antidepressant medications.</p>	F 329			

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F 329	<p>Continued From page 54</p> <p>Review of the October 2013 physician's recapitulation orders documented the resident received, "Cymbalta 30 mg once a day for depression and Risperdal 1 mg three times a day for psychosis."</p> <p>The medical record lack documentation where the "psychosis" diagnoses came from. The "Consent to Use Psychotherapeutic Medications" signed 4/24/13, documented, "Mood Balancer" which had a line drawn through it and "Psychosis" added. The physician's recapitulation orders which list the resident's diagnoses and ICD-9 numbers did not have psychosis as a diagnoses.</p> <p>The medication Risperdal had an FDA warning of, "Warning: Increased Mortality in Elderly Patients with Dementia related Psychosis." Revised June 2012, copywrite Janssen Pharmaceuticals inc.</p> <p>The medical record was not clear whether the resident had psychosis. The resident did have severe cognitive impairment. The medications used were not evaluated to determine the continued need for the medications.</p> <p>The pharmacist was interviewed, on 12/5/13 at 4:15 p.m., about the risk verses benefits and informing the resident or family about the resident's use of Risperdal. The pharmacist was not aware of S & C: 13-35-NH letter which clarified medication issues with dementia residents. The pharmacist further said the facility had a committee that reviewed psychotropic medications. The pharmacist did confirm that the resident's record lacked documentation of what the committee did with each resident on a psychotropic medication.</p>	F 329			

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F 329	<p>Continued From page 55</p> <p>The Administrator and DON were informed of the medication issues on 12/5/13 at 7:00 p.m. No further information was provided.</p> <p>4. Resident #1 was over 65 years old and admitted to the facility with multiple diagnoses to include, anxiety disorder, depression, dementia with hallucinations, psychotic disorder, hearing loss, and blindness in both eyes.</p> <p>The resident's most recent Quarterly MDS dated, 9/12/13, during the 7 day assessment period, coded the following:</p> <ul style="list-style-type: none"> * Short Term/ Long Term memory impairment * Daily decision making skills - severely impaired * Inattention and disorganized thinking - fluctuates * Psychosis, Delusions, and/or Hallucinations - None <p>The resident's November 2013 Patient Medication Profile (Physician's Recapitulation orders) included the following:</p> <ul style="list-style-type: none"> * Celexa 20 mg tablet: Take 1 tablet daily for depression, started on 12/6/13. * Trazodone 50 mg table: Take 1/2 of 50 mg tablet (25mg) by mouth daily in the evening for organic brain syndrome, started on 6/15/13. * Seroquel 100 mg tablet: Take 1 tablet twice daily for dementia with hallucinations started 7/29/13. <p>Note: There was nothing documented in the resident's record about the resident having organic brain syndrome other than as the diagnosis for the resident's Trazodone on the November 2013 Patient Medication Profile. The Health Line, Health Reference Library, 2005-2013, defines organic brain syndrome as, "A general term used for decreases in mental</p>	F 329			

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F 329	<p>Continued From page 56</p> <p>function that are not caused by a psychiatric disorder."</p> <p>* The Nursing 2014 Drug Handbook, 34th edition, Lippincott, Williams & Williams, documented the following medication, Seroquel, has a, "Black Box warning" and is not, "Indicated for the use in elderly patients with dementia-related psychosis because of increased risk of death from CV disease or infection."</p> <p>The resident's Psychoactive Medication Monthly Flow Record, dated October 2013 (the only flow record available for review), documented the following, zero instances of hallucinations, delusions, hitting, kicking, or refusing cares present during the day, evening, or night shift for the entire month.</p> <p>The resident's IDT notes were reviewed from 1/9/13 to 11/25/13. There were only two entries related to the above listed medications. The first entry was on 5/9/13 at 12:35 p.m., "... (increase) Seroquel..." and the second entry on 8/15/13 at 12:20 p.m., "Pt decreased on Seroquel per pharm[acy] recommend noted increased chanting."</p> <p>Note: Review of the resident's medical record, including physician's progress notes, and the skilled daily nurses notes, did not document the, "Black Box warning" had been discussed with the resident or the resident's legal representative, the record did not include a documented rationale for duplicate therapy of the antidepressants, nor was there anything documented by the physician or the pharmacist related to the effectiveness of the multiple medications in use.</p>	F 329		
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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83224	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 57 The pharmacist was interviewed, on 12/5/13 at 4:15 p.m., about the risk verses benefits and informing the resident or family of those risks. The pharmacist was not aware of S &C: 13-35-NH letter which clarified medication issues with dementia residents. The pharmacist further said the facility had a committee that reviewed psychotropic medications. The pharmacist did confirm that the medical record lacked documentation of what the committee did with each resident who was on a psychotropic medication. The Administrator and DON were informed of the medication issues on 12/5/13 at 7:00 p.m. No further information was provided.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure that a resident did not have a significant medication error. This was true for random Resident #14. There was a potential for harm due to the increased risk of the resident having nausea and dyspepsia by not following physician ordered administration times of the medication. Findings include: Resident #14 was originally admitted to the facility on 4/12/11 with diagnoses of mononeuritis, esophageal reflux, intestinal obstruction and history of Crohn's disease.	F 333	<u>F333</u> Corrective action for residents found to have been affected by this deficiency: Medication error report completed on resident 14 and physician notified Medication ordered clarified with resident 14's physician Counseling and training provided to nurse who made the error Corrective action for residents that may be affected by this deficiency: All residents have the potential to be affected by these identified concerns. Counseling and training provided to nurse who made the error In-service will be provided to nursing staff by DON concerning medication administration on 1/2/14	

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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 POPLAR STREET BLACKFOOT, ID 83221		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	Continued From page 58 LN #1 was observed on 12/3/13 at 11:40 a. m. to administer a physician ordered medication of Sulfasalazine 500 milligrams to Resident #14. The physicians order documented the medication was to be administered, "4 times daily after meals and at bedtime. Give 1 tablet after every meal and at bedtime for Crohn's disease." The resident received the medication prior lunch which was scheduled for 12:00 noon. Upon review of the medication utilizing the Nursing 2013 Drug Handbook, page 1265, it was found the medication was therapeutically classified as an anti-inflammatory medication. The Pharmacological classification was Sulfonamide and Salicylate. The indication for use was, "mild to moderate ulcerative colitis, adjunct therapy in severe ulcerative colitis, prolongation of remission period between acute ulcerative colitis attacks." The "Patient Teaching" documented, "Instruct patient to take drug after eating and to space doses evenly." The medication was administered prior to the meal creating a significant medication timing error. The DON and Administrator were informed on 12/5/13 at 7:00 p.m. On 12/9/13 the pharmacist provided additional information about the action of the medication on the body and why it was to be given with meals, "Sulfasalazine causes nausea and dyspepsia in selected patients." The pharmacist failed to address that the error was a result of not following the physicians orders. No further information was provided.	F 333	Measures that will be put into place to ensure that this deficiency does not recur: Nurses will be inserviced quarterly regarding proper medication administration. DON will monitor medication administration to 10 residents weekly for a period of at least 12 weeks starting the week of 1/5 to ensure staff is properly passing medication. Any issues will be reported to the QA committee. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: The QA committee will review any issues uncovered by weekly audits and after the initial 4 weeks make a determination related to changing the frequency of those audits. Additionally, QA committee will review facility progress medication administration at least quarterly on an on-going basis to aid in monitoring compliance.		
F 363	483.35(c) MENUS MEET RES NEEDS/PREP IN	F 363			

1/19/14

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F 363 SS=C	Continued From page 59 ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on test tray results and group and staff interviews, the facility failed to follow the menu when preparing an evening meal. This had the potential to affect all residents in the facility, including 12 of 12 (#s 1- 12) sampled residents. Findings include: During the resident group interview on 12/4/13 at 9:00 a.m. there were complaints of the palatability and preparation of some of the meals. The 12/4/13 dinner meal was chosen as a test tray because turkey and pasta were part of their complaint. The items that were listed on the menu for that meal were: Turkey Piccata, Angel Hair Pasta and Steamed Broccoli. The plate that was provided to the surveyors had spaghetti rather than Angel Hair pasta, and peas and carrots rather than steamed broccoli. The dietitian accompanied the tray which was delivered at 6:40 p.m. When asked about the substitutions, she said she was not aware of them. She investigated the pasta substitution and at 6:50 p.m. told the surveyor the cook just grabbed the wrong pasta. The broccoli was not addressed. The cook did not follow the menu and prepare the correct pasta and vegetables.	F 363	F363 Corrective action for residents found to have been affected by this deficiency: No specific residents were identified Corrective action for residents that may be affected by this deficiency: All residents have the potential to be affected by these identified concerns. Counseling warning and training provided to the cook responsible the meal in question on 12/4 Substitution log implemented to be used by dietary staff should a substitution be necessary. Each substitution needs to be approved by the supervisor ahead of time. Any substitutes will be posted on the menu boards by the dietary staff prior to meals. In-service will be provided to dietary staff by administrator and dietary services manager concerning menu substitution on 1/2/14 Measures that will be put into place to ensure that this deficiency does not recur: Administrator will audit 3 meals weekly for a period of at least 12 weeks starting the week of 1/5 to ensure posted menu is being followed as well as the substitution log is being utilized. Any issues will be reported to the QA committee. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:	
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F 363	Continued From page 60	F 363		
F 367 SS=D	<p>The administrator and DON were informed on 12/6/13 at 1:00 p.m. No further information was provided.</p> <p>483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN</p> <p>Therapeutic diets must be prescribed by the attending physician.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, menu and spreadsheet review, observation and staff interview the facility failed to ensure the therapeutic diets ordered by the physician were what residents received. This was true for 3 of 12 (#s 3, 6, and 11) sampled residents. The facility's failure to ensure menus and spreadsheets aligned with physician orders for therapeutic diets related to calorie and sodium control, placed the residents at risk for adverse clinical conditions. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 4/22/11 with diagnoses of dysthymic disorder, episodic mood disorder, diabetes mellitus type II and psychiatric disorder with delusions.</p> <p>The most recent quarterly MDS assessment, dated 11/25/13, documented the resident received a therapeutic diet.</p> <p>The physician's November 2013 recapitulation orders documented the resident was to have a diabetic 1800 calorie diet.</p> <p>Utilizing the menus spreadsheet, dietary card and</p>	F 367	<p>The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. QA committee will further address and review facility progress on menus and substitutions.</p> <p><u>F367</u></p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Diet orders clarified for residents 3, 6, and 11</p> <p>Full diet audit for all residents completed by dietician on 1/8 and clarification orders received as necessary.</p> <p>Corrective action for residents that may be affected by this deficiency:</p> <p>All residents have the potential to be affected by these identified concerns.</p> <p>Facility diet list offered was provided to nurses in case any diet orders need clarified</p> <p>Facility diet list also provided to Bingham Hospital case management dept so that hospital physicians can be provided the list when determining orders</p> <p>In-service will be provided to dietary and nursing staff by administrator and/or food services manager concerning diet orders and diets offered on 1/2/14</p> <p>Full diet audit for all residents completed by dietician on 1/8 and clarification orders received as necessary</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p>	1/10/14

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F 357	<p>Continued From page 61</p> <p>observation of the cook serving up the meals confirmed during the lunch meal on 12/4/13 the resident received a carbohydrate controlled diet not an diabetic 1800 calorie diet.</p> <p>Review of the menu spreadsheet found there was no 1800 calorie diabetic diet. The therapeutic diet the resident received was not what the physician prescribed.</p> <p>2. Resident #6 was readmitted on 11/26/13 with diagnoses of diabetes mellitus type II and end stage renal failure.</p> <p>The physician's admission order, dated 11/26/13 documented the resident was to receive a 2 gram sodium, 1800 calorie diabetic diet.</p> <p>Utilizing the menus spreadsheet, dietary card and observation of the cook serving up the meals confirmed during the lunch meal on 12/4/13 the resident received a renal diet.</p> <p>Review of the menu spreadsheet found there was lacking a 2 gram sodium diet nor was there an 1800 calorie diabetic diet. The therapeutic diet the resident received was not what the physician prescribed.</p> <p>3. Resident #11 was admitted to the facility on 5/22/13 with diagnoses of dementia with psychosis and diabetes mellitus.</p> <p>The most recent quarterly MDS assessment, dated 8/28/13, documented the resident received a therapeutic diet.</p> <p>The physician's October 2013 recapitulation orders documented the resident was to receive a</p>	F 387	<p>Administrator or DON will audit 5 residents' diet orders weekly for a period of at least 12 weeks starting the week of 1/5 to ensure residents are receiving the correct diet as ordered. Any issues will be reported to the QA committee.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. Additionally, QA committee will review facility progress on maintaining compliance with diet orders at least quarterly on an on-going basis.</p>	1/10/14
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F 367	Continued From page 62 1600 calorie diabetic diet. Utilizing the menus spreadsheet, dietary card and observation of the cook serving up the meals confirmed during the lunch meal on 12/4/13 the resident received a carbohydrate controlled diet not the 1600 calorie diet ordered. Review of the menu spreadsheet found there was no 1600 calorie diabetic diet. The therapeutic diet the resident received was not what the physician prescribed. The Dietitian was interviewed on 12/5/13 at 2:30 p.m. She confirmed the menus and spreadsheets did not have a specific calorie control section. The administrator was informed of this issue on 12/6/13 at 1:00 p.m. No further information was provided.	F 367		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a	F 368	F368 Corrective action for residents found to have been affected by this deficiency: No specific residents identified All residents received a letter on 12/30 and had the opportunity to attend a resident council meeting addressing the issues of HS snacks and other resident rights. Corrective action for residents that may be affected by this deficiency: All residents have the potential to be affected by these identified concerns. Administrator will meet with Resident Council on 12/30 to discuss availability of HS snacks. Letter will be presented to all residents who do or do not attend this meeting addressing this issue.	

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F 368	<p>Continued From page 63 resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interview the facility failed to ensure residents who did not have ordered bedtime snacks were offered them. This had the potential to affect 9 of 12 (#s 3, 4, 6, 7, 8, 9, 10, 11, and 12) sampled residents. There was a potential for harm if a resident was to go to bed hungry and have gastric distress as a result. Findings include:</p> <p>During the group interview on 12/4/13 at 9:00 a.m. when the residents were asked about being offered a snack three responded, the staff do not ask them if they want a snack, they have to ask the staff for it.</p> <p>On 12/4/13 during the evening observation from 6:50 p.m. to 9:00 p.m. staff were not observed to offer a bedtime snack to residents. None of the staff were observed to go into the pantry to obtain snack items.</p> <p>On 12/5/13 at 2:30 p.m. the dietitian was interviewed about the snacks availability. She indicated the pantry located next to the dining room was stocked with items that could be used for a bedtime snack. Some residents must be getting snacks because she thought it had to be restocked each day.</p> <p>The Administrator was informed of the snack requirement on 12/6/13 at 1:00 p.m. No further information was provided.</p>	F 368	<p>Evening shift aide will offer snacks to residents. Daily documentation of HS snack offerings will be held at nurses station.</p> <p>In-service will be provided to nursing staff by administrator concerning availability and passing of HS snacks on 1/2/14 .</p> <p>Letter that was given out to residents on 12/30 is provided to residents or family with their admission packet and paperwork.</p> <p>Letter provided to residents on 12/30 will be re-distributed at least quarterly to all residents.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Administrator will interview 5 residents weekly for a period of at least 12 weeks starting the week of 1/5 to ensure residents are being offered HS snacks. Any issues will be reported to the QA committee.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. QA committee will continue to monitor progress of facility related to offering HS snacks to residents.</p>	1/10/14
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F 371 SS=F	<p>483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation of the kitchen and staff interview, the facility failed to ensure food was stored and prepared under sanitary conditions. This had the potential to effect 12 of 12 (#s 1 - 12) sampled residents and all residents in the facility. Not ensuring cleanliness of food carts, proper storage of food, smooth surfaces on cutting boards and the proper temperature of cold food placed residents at risk for food borne illnesses Findings include:</p> <p>1. During the initial tour of the kitchen on 12/2/13 at 6:25 p.m. the following unsanitary conditions were found: - In the walk-in freezer, two partial bags of mixed vegetables were found open and were not dated as to when they were opened, - In the walk-in freezer two partial bags of "tater tots" were found open. One bag had tots falling out of it onto the shelf. There was no date when they were opened. - A red and a green large cutting board had deep gouges that created an uncleanable surface. - A soiled 3 foot by 4 foot rubber mat was</p>	F 371	<p>F371</p> <p>Corrective action for residents found to have been affected by this deficiency: No specific resident identified</p> <p>Corrective action for residents that may be affected by this deficiency: All residents have the potential to be affected by these identified concerns.</p> <p>Open and undated bags were discarded without further use</p> <p>Counseling and training given to the cook responsible for the open/undated bags on 12/2 and servers of the egg salad on 12/4</p> <p>Metal framed rack not used to deliver food will now be used for drying floor mats</p> <p>In-service will be provided to dietary staff by administrator and dietary services supervisor concerning food temps and dietary processes on 1/2/14</p> <p>Measures that will be put into place to ensure that this deficiency does not recur: Administrator will audit the kitchen 3 times weekly for a period of at least 12 weeks starting the week of 1/5 to ensure progress in maintaining sanitary conditions. Further, the administrator will audit 3 meals weekly for a period of at least 12 weeks to ensure food temps are taken appropriately. Any issues will be reported to the QA committee.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not</p>	

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F 371	Continued From page 65 observed draped over a food delivery cart. The Dietitian was interviewed on 12/3/13 at 8:00 a.m. and indicated the issues were corrected. 2. During the 12/4/13 observation of the noon meal set up and delivery, three containers with egg salad, one container of cottage cheese and one container of cold slaw were observed to sit on a cart for over 20 minutes before being placed on the cold side of the steam table. The egg salad, cottage cheese and cold slaw contained protein materials that put them at risk for growing food borne bacteria. The aide did not check the temperature to assure the containers were held at a temperature less then 40 degrees Fahrenheit. Three residents asked for egg salad sandwiches during the noon meal. The Dietitian was interviewed on 12/5/13 at 2:30 p.m. She indicated that the cold food should have had the temperature taken and did not know why it was not on the list they use for temperatures. She indicated it was corrected.	F 371	The QA committee will review any issues uncovered by weekly audits, make appropriate recommendations, and after the initial 12 weeks make a determination related to changing the frequency of those audits. Additionally, QA committee will review facility progress in dietary services at least quarterly on an on-going basis to aid in monitoring compliance.	1/10/14
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced	F 387	<u>F387</u> Corrective action for residents found to have been affected by this deficiency: Resident 4 was seen by physician in the ER on 11/17/13 and resident was seen in December and will be seen in January by his physician. Resident 8 was seen in the facility on 12/17 by his attending physician Full facility audit completed by medical records and corresponding calendar created to track physician visits and progress notes. Corrective action for residents that may be affected by this deficiency: All residents have the potential to be affected by these identified concerns.	

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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221
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F 387	<p>Continued From page 66</p> <p>by:</p> <p>Based on record review and staff interview, it was determined the facility did not ensure residents were seen by their physicians as frequently as required. This was true for 2 of 12 residents (#s 4 & 8) sampled for frequency of physician's visits. The deficient practice had the potential to cause more than minimal harm if residents' multiple medical issues were not monitored by a physician. Findings included:</p> <p>1. Resident #4 was admitted to the facility with multiple diagnoses to include, heart failure, GERD, diabetes mellitus, CVA, hemiplegia, seizure disorder, depression, COPD, cerebral aneurysm, dysphagia, and neurological neglect syndrome.</p> <p>A review of physicians visits for the resident documented the resident had been seen by the physician on admit 8/16/13, zero physician visit in September, physician visit on 10/15/13, and zero physician visit in November.</p> <p>On 12/5/13 at 5:45 p.m., the DNS and MDS coordinator were interviewed regarding the lack of physician visits for Resident #4. The MDS coordinator indicated the physician may have visited and, "The physician's progress note just may have not made it to the resident's chart yet." The MDS coordinator said she would look for progress notes for the September visit and the October visit. No further information was provided.</p> <p>2. Resident #8 was admitted to the facility on 1/12/12 with diagnoses of Parkinson's disease, diabetes mellitus type II, and dementia.</p>	F 387	<p>Physician visit calendar established so that visits and progress notes can be tracked. Medical records will use calendar to track physician visits moving forward and update it accordingly</p> <p>Letter sent to all attending physicians informing them of regulations related to visits and indicating when visits are due for their patients</p> <p>Letter will be sent going forward to physicians related to the physician visit calendar notifying them when visits are required</p> <p>Physician visit calendar and physician progress notes will be audited at least quarterly by someone other than medical records to ensure it is being updated and tracked correctly.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Administrator audit 4 resident charts weekly for a period of at least 12 weeks starting the week of 1/5 to ensure residents are being seen by a physician. Any issues will be reported to the QA committee.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The QA committee will review any issues uncovered by weekly audits, make appropriate recommendations, and after the initial 12 weeks make a determination related to changing the frequency of those audits. Additionally, QA committee will review facility progress on physician visits at least quarterly on an on-going basis to aid in monitoring compliance.</p>	
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1/10/14

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F 387	Continued From page 67 The most recent annual MDS assessment, dated 10/20/13, documented the resident: - had short and long term memory problems, - had severely impaired decision making skills, - had verbal and physical behaviors 4 to 6 days a week, - required extensive assistance for bed mobility, transfers, dressing, personal hygiene and bathing, - had a trunk restraint Review of the medical record for physician's progress notes indicated the last time the physician saw the resident was on 5/20/13. When the MDS Coordinator was asked about the lack of information to show the resident had been seen by a physician, the MDS Coordinator produced a letter dated 6/12/13 showing the physician needed to make a visit. The physician still had not made the visit at the time of the survey which was more than 6 months late. The resident had multiple medical issues that should have been addressed by the physician, as evidenced by the MDS.	F 387	
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	F 441	F441 Corrective action for residents found to have been affected by this deficiency: No specific residents were identified Laundry staff will wear gown and protective shoe coverings when handling dirty laundry. Communication posted in laundry and provided to staff prior to the end of the survey. Corrective action for residents that may be affected by this deficiency: All residents have the potential to be affected by these identified concerns. Laundry staff will wear gowns and protective foot coverings when handling dirty laundry

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F 441	<p>Continued From page 68 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined the facility failed to ensure linen was handled in a manner to prevent cross contamination. This had the potential to affect all residents in the facility including 12 of 12 sampled residents. Failed infection control practices put residents at risk for acquiring nosocomial infections: Findings include:</p> <p>On 12/4/13 at 10:20 a.m. the laundry room was</p>	F 441	<p>In-service will be provided laundry staff by administrator and laundry supervisor concerning dirty linen handling and infection control on 1/2/14</p> <p>Laundry supervisor implemented a daily checklist for laundry staff to act as a reminder to wear gown, shoe coverings and gloves when handling dirty laundry.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Administrator will audit the laundry room 3 times weekly for a period of at least 12 weeks starting the week of 1/5 to ensure proper dirty laundry handling is occurring. Any issues will be reported to the QA committee.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. Additionally, QA committee will review facility progress on infection control at least quarterly on an on-going basis to aid in monitoring compliance.</p>	1/10/14
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F 441	<p>Continued From page 69</p> <p>inspected and the laundry supervisor was interviewed. The laundry room was small and contained one regular washer, two commercial washers, and two commercial dryers. The clean linen room was separated from the dirty linen room by a doorway and contained 1 table for folding clean linen. There was a wire cart in front of the washer for clean linen to be transported from the washers to the dryers. There was no cart for the dirty linen to be sorted prior to placing the laundry into the washers.</p> <p>The laundry supervisor was asked how dirty and clean linen were processed. The supervisor stated, staff glove up before emptying the plastic bags of dirty laundry onto the floor to be sorted. The dirty laundry is then placed in the washer. She stated after the laundry is washed, dried, and placed in a clean linen basket brought over from the clean side, the linen is then taken to the clean side where it is folded. The supervisor stated isolation laundry is usually done at the end of the day in the regular washing machine and then the washer is disinfected. The surveyor asked the supervisor if and when staff wear gowns to process laundry. The supervisor stated the staff only wear gowns when isolation laundry is washed. The surveyor asked how staff prevents the dirty and isolation laundry from touching the staff's clothes during the laundry process. The supervisor stated she understood the potential risk of contaminating clean laundry by not wearing a protective gown over clothing when sorting and caring dirty laundry to the washer.</p> <p>Note: The facility had 4 residents, Random Residents #'s 19-22, on isolation precautions, due to antibiotic resistant organisms.</p>	F 441		
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F 441	Continued From page 70 On 12/4/13 at 8:30 p.m. the Administrator and DNS were informed of the infection control issues. No further information was provided.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to maintain accurate, complete, and organized clinical records on each resident. This was true for 4 of 12 (#s 1, 3, 10, 11) sampled residents reviewed for clinical records. This created the potential for medical decisions to be based on inaccurate information. Findings included: 1. Resident #1 was admitted with multiple diagnoses to include, anxiety disorder, depression, senile delusions, hearing loss, and blindness related to macular degeneration. Resident #1's Patient Medication Profile	F 514	F 514 Corrective action for residents found to have been affected by this deficiency: November and December recap orders in resident 1's medical record Physician progress note from 10/25 were placed in residents 3 and 10 medical records Physician progress note from 10/28 placed in resident 11's medical record Full facility audit completed by medical records and corresponding calendar created to track physician visits and progress notes Corrective action for residents that may be affected by this deficiency: All residents have the potential to be affected by these identified concerns. In-service to nursing staff and medical records related to timely filing in medical records on 1/2/14 Physician visit calendar established so that visits and progress notes can be tracked. Medical records will use calendar to track that progress notes are in the medical record.	

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F 514	<p>Continued From page 71 (Physicians Recapitulation Orders) for the month of November and December were not in the Resident's chart.</p> <p>On 12/5/13 at 3:25 p.m. the MDS Coordinator and DNS were interviewed about the missing physician's orders. The MDS Coordinator indicated she was unsure why November 2013 orders were not in the chart. She said they should be by now it is December. She stated the December 2013 orders had been sent to the physician for his signature.</p> <p>On 12/5/13 at 4:35 p.m., the surveyor was provided with a copy of the November 2013 Patient's Medication Profile (Physician's recapitulation orders).</p> <p>2. Resident #3 was admitted to the facility on 4/22/11 with diagnoses of dysthymic disorder (severe depression), episodic mood disorder, psychiatric disorder with delusions and diabetes mellitus type II without complications.</p> <p>The medical record did not have the physician progress notes to review for his visit on 10/25/13. The DON was interviewed on 12/5/13 at 3:25 p.m. about whether the resident had been seen by the physician. She stated the resident had been seen by the physician. The physician dictated his visit and staff had not downloaded the note and placed it in her record. The notes were downloaded one and a half months after the visit, the notes were provided to the surveyors during the survey.</p> <p>3. Resident #10 was admitted to the facility on 11/21/12 with diagnoses of paralysis agitans, acute kidney failure and rehabilitation procedure.</p>	F 514	<p>Physician visit calendar and physician progress notes in chart will be audited at least quarterly by someone other than medical records to ensure it is being updated and tracked correctly.</p> <p>Copies of unsigned monthly recaps will be placed in medical records until receipt of the signed monthly recaps from the physician are received. The signed monthly recaps will then be included in the medical record.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Administrator or DON will audit 5 resident charts weekly for a period of at least 12 weeks starting the week of 1/5 to ensure residents monthly recap orders and physician progress notes are inserted timely. Any issues will be reported to the QA committee.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. Additionally, QA committee will review facility progress on medical records at least quarterly on an on-going basis to aid in monitoring compliance.</p>	1/10/14
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F 514	<p>Continued From page 72</p> <p>The medical record did not have a physician's progress note to review for his visit on 10/25/13. The DON was interviewed on 12/5/13 at 3:25 p.m. about whether the resident had been seen by the physician. She stated he had been seen. The physician dictated his visit and staff had not downloaded the note and placed it in the medical record. The notes were downloaded one and a half months after the visit, the notes were provided to the surveyors during the survey.</p> <p>4. Resident #11 was admitted to the facility, on 2/22/13, with diagnoses of TIA/Stroke without residual.</p> <p>The resident was seen by the physician on 10/28/13. The medical record did not have a progress note for the visit. The DON was interviewed on 12/5/13 at 3:25 p.m. about the lack of a progress note for the visit. The physician was contacted and he dictated a note on 12/5/13 at 2:50 p.m. The note was received and placed in the resident's medical record during the survey.</p>	F 514			

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NAME OF PROVIDER OR SUPPLIER
BINGHAM MEMORIAL SKILLED NURSING & R

STREET ADDRESS, CITY, STATE, ZIP CODE
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BLACKFOOT, ID 83221**

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual State licensure survey of your facility. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Arnold Rosling, RN, BSN, QMRP	C 000	The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as credible allegation of our intent to correct the practices identified as deficient. The Plan should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).	
C 121	02.100.03,c,v Encouraged/Assisted to Exercise Rights v. Is encouraged and assisted, throughout his period of stay, to exercise his rights as a patient/resident and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; This Rule is not met as evidenced by: Refer to F151 as it relates to resident rights. Refer to F166 as it relates to voicing grievances.	C 121	Please see POC for F151 and F166 RECEIVED MAR 06 2014 FACILITY STANDARDS	1/10/14
C 123	02.100.03,c,vii Free from Abuse or Restraints vii. Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when	C 123	Please see POC for F221	1/10/14

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

[Handwritten Signature]
[Handwritten Signature]

TITLE
Administrator
Administrator

(X6) DATE
2/14/14
3/5/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/09/2013
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C 123	Continued From page 1 necessary to protect the patient/resident from injury to himself, or to others; This Rule is not met as evidenced by: Refer to F221 as it relates to physical restraints.	C 123		1/10/14
C 297	02.107,05,a Bedtime Snacks a. Bedtime snacks of nourishing quality shall be offered, and between-meal snacks should be offered. This Rule is not met as evidenced by: Refer to F 368 as it relates to bedtime snacks.	C 297	Please see POC for F368	1/10/14
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F371 as it relates to kitchen sanitation.	C 325	Please see POC for F371	1/10/14
C 422	02.120,05,p,vii Capacity Requirments 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	C 422		

Bureau of Facility Standards

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C 422	Continued From page 2 for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water. This Rule is not met as evidenced by: Based on observation and staff interviews it was determined the facility failed to provide the minimum bathing facilities for the number of licensed beds. This affected 12 of 12 (#s 1-12) sampled residents and had the potential to affect all residents in the facility. Findings included: Note: The facility is licensed for 70 beds and has only 3 working showers. The Idaho Administrative code documents, a facility is required to have 1 tub or shower for every 12 beds; therefore, the facility should have 6 showers and/or tubs. On 12/4/13 at 10:20 a.m., the Maintenance Supervisor and the Administrator accompanied the surveyor during the General Observations Tour of the facility (Environmental Tour). The following bathing facilities were evaluated: * 300 hall shower room had one working shower, one shower stall without working plumbing, and one broken tub. The Maintenance Supervisor and Administrator identified the tub was unusable because it had a pin hole leak in it which prevented the door of the tub from sealing and the tub wouldn't hold water. * 400 hall shower room had one working shower and one broken tub. The Maintenance Supervisor and the Administrator stated the tub had ongoing problems which the facility had been able to fix up until August 2013. They said when the rep. from [Company's Name] came in to evaluate the tub on the 300 hall he looked at the 400 hall tub and told them, the tub can no longer be fixed because the tub is outdated and the company does not make parts for the tub anymore.	C 422	C422 Corrective action for residents found to have been affected by this deficiency: No specific resident was identified Corrective action for residents that may be affected by this deficiency: All residents have the potential to be affected by these identified concerns. Administrator will meet with Resident Council on 12/30 to discuss showers and bath tubs. Letter will be presented to all residents who do or do not attend this meeting addressing these highlighted concerns. New shower installed in 300 hall shower room, new bath tub installed in 300 hall shower room, and 400 hall bath tub to be fixed. Measures that will be put into place to ensure that this deficiency does not recur: Administrator will audit that all 6 showers/bath tubs are working properly weekly for a period of at least 4 weeks starting the week of 1/5. Any issues will be reported to the QA committee. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: The QA committee will review any issues uncovered by weekly audits and after the initial 4 weeks make a determination related to changing the frequency of those audits.	
				1/10/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/09/2013
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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & R	STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 422	Continued From page 3 * 500 hall shower room had one shower stall. On 12/4/13 at 10:45 a.m., the Administrator was interviewed about the inadequate number of bathing facilities. The Administrator said he had several companies submit bids for new tubs after the rep. from [Company's Name] told him the tubs were broken and could no longer be fixed. The Administrator said he ordered the new tub in September 2013 and had a 12 week delivery time.	C 422		
C 672	02.150,03,c Staff Knowledge of Infection Control c. Exhibited knowledge by staff in controlling transmission of disease. This Rule is not met as evidenced by: Please refer to F441 as it relates to staff knowledge of infection control.	C 672		
C 674	02.151,01 ACTIVITIES PROGRAM	C 674	Please see POC for F441	1/10/14
	151. ACTIVITIES PROGRAM. 01. Organized Program. There shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be designed to include a variety of processes and services which are designed to stimulate patients/residents to greater self-sufficiency, resumption of normal activities and maintenance of an		Please see POC for F248	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/09/2013
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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & R.	STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221
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C 674	Continued From page 4 optimal level of psychosocial functioning. It shall include recreation, therapeutic, leisure and religious activities. This Rule is not met as evidenced by: Refer to F248 as it relates to activities.	C 674		1/10/14
C-733	02.154.02,b Frequency of Physician Visits b. Each skilled nursing patient shall be seen by the attending physician at least once every thirty (30) days for the first ninety (90) days following admission. Thereafter, an alternative schedule may be adopted for patient/ resident visits based on physician's determination of need, and so justified in the patient's/resident's medical record. At no time may visits exceed ninety (90) day intervals. All physicians' visits shall be recorded in the patient's/ resident's medical record, with a physician's progress note. This Rule is not met as evidenced by: Refer to F 387 as it relates to physician visits.	C 733	Please see POC for F387	1/10/14
C 782	02.200.03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it relates to care planning.	C 782	Please see POC for F280	1/10/14
C 790	02.200.03,b,vi Protection from Injury/Accidents	C 790		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/09/2013
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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & R	STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221
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C 790	Continued From page 5 vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F309 as it relates to prevention of injury.	C 790	Please see POC for F309	1/10/14
C 811	02.200.04.g.vii Medication Errors Reported to Physician vii. Medication errors (which shall be reported to the charge nurse and attending physician. This Rule is not met as evidenced by: Refer to F333 as it relates to medication errors.	C 811	Please see POC for F333	1/10/14
C 881	02.203.02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 as it relates to medical records.	C 881	Please see POC for F514	1/10/14



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 208-364-1886

January 27, 2014

Arthur F. Gulden, Administrator
Bingham Memorial Skilled Nursing & Rehabilitation Center
98 Poplar Street
Blackfoot, ID 83221-1758

Provider #: 135007

Dear Mr. Gulden:

On **December 9, 2013**, a Complaint Investigation survey was conducted at Bingham Memorial Skilled Nursing & Rehabilitation Center. Amy Barkley, R.N. and Arnold Rosling, R.N., Q.M.R.P. conducted the complaint investigation. This complaint and a second complaint were investigated in conjunction with the facility's annual Recertification and State Licensure survey.

Records were reviewed, observations made and/or interviews were conducted with 22 residents, including a review of the identified resident's closed record. Facility staff, including the Director of Nursing Services (DNS) and administrator, were interviewed. Facility's incident/accident (I/A) reports were reviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005853

ALLEGATION #1:

The complainant stated staff did not respond to call lights timely. On December 1, 2012, around 3:45 a.m., the resident needed to go to the bathroom. The resident thought she rang for the nurse but when the nurse did not respond, she got out of bed to go to the bathroom and fell. She said, she laid on the floor for quite a while and screamed for help.

FINDINGS:

The identified resident's medical record nursing notes documented that on December 1, 2012, the resident was up in the lobby at 2:00 a.m. The resident was "confused and restless" at that time. Nursing notes did not document when the resident was returned to her room or if the resident was returned to bed.

The facility's I/A report and resident's medical record confirmed the resident fell on December 1, 2012, at about 3:45 a.m. Staff heard the resident yelling and found the resident on the floor laying on her right side. The resident's wheelchair and bed were next to the location of the resident on the floor. The facility's investigation of the incident documented the following:

- The resident was taken to the bathroom two hours prior to the fall and was still dry when checked out after the fall;
- The call light was working, within reach, but not activated;
- The resident did not have any alarms on prior to this fall;
- The resident thought her family was there and was trying to get up and use the toilet; and
- The resident fell on her "tailbone" and did not appear to have any injuries.

After this fall, the facility added a bed alarm and a motion monitor. In addition, the resident had an alarm added for the wheelchair.

There was no documented evidence that the resident had to wait a long time for staff to respond to her calls for help when she fell out of bed onto the floor. The Certified Nurse Aide (CNA) who found her gave the statement that he was responding to an alarm and heard the resident yelling for help. The CNA notified the nurse immediately. This was documented at 3:45 a.m. The resident was taken to the bathroom and then taken to the lobby for further observation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated that the facility has faulty equipment. Staff assured the family that they would watch the resident and that they have alarms that they would put on her bed. However, on December 1, 2012, a visitor noted that a CNA was in the resident's room and when they looked at the alarm that was on the bed, they noted it was broken. The CNA ended up getting another alarm. It was broken also.

FINDINGS:

The alarm was placed on the bed after the resident fell on December 1, 2012, at 3:45 a.m. The CNA was interviewed and provided a written statement, which was not dated. The statement verified the residents' alarm was not working on December 2, 2012, even after the batteries were changed. The CNA had to change out the whole system. This corrected the problem. The alarm was checked with the resident to verify that it was working when he finished.

It could not be determined that the resident fell because the alarm did not work.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated that family members stayed with the identified resident a couple of nights. During that time, no one came in to check on her and the alarm on her bed did not go off when she got up to go to the bathroom. On both nights, family members assisted the resident go to the bathroom.

The complainant said there were times that it would take them up to 15 to 20 minutes before anyone would come help her. Family members had to help the resident to the bathroom and back. They could get her out of bed, to the bathroom and back before anyone would respond to the call button.

FINDINGS:

The first night was the night of December 1, 2012. The resident's grandson stayed the night with her. The family member assisted the resident to the bathroom during the night. The nurse checked on the resident at 9:30 p.m. and gave the resident a pain medication. At 2:30 a.m., a CNA did vitals on the resident. The resident received pain medication at 6:00 a.m. The facility was aware that there was a family member in the room during the night.

The second night was the night of December 2, 2012. The resident's spouse stayed the night with her. The family member assisted the resident to the bathroom during the night. The resident received pain medication at 1:10 a.m. The nurse documented the resident's family member was in the room, and the resident was resting in bed. At 2:30 a.m., a CNA did vitals on the resident.

The residents' family filed a complaint with Joint Commission and the facility had to provide a response to them. A copy of the investigation was provided to the survey agency. The facility

Arthur F. Guiden, Administrator
January 27, 2014
Page 4 of 5

investigated the complaint and did not find documentation to support that staff did not respond to call lights. The staff was in the resident's room and the resident's family was also with her and assisted her to the bathroom. During an interview on December 5, 2013, at 7:00 p.m., the administrator stated that if there were complaints about answering call lights, they have video tapes of the halls and staff go back and review them to see how long a call light would ring. The average response times have been no longer than five minutes.

The residents' initial care plan dated November 29, 2012, was reviewed and there was no interventions specific to aides providing care at night. The care plan documented "Assist resident with ADLs as needed."

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated that on November 30, 2012, the resident was having chest pains. The resident found out that staff had not given the resident her heart medicine the night before.

That night, a family member waited until 9:30 p.m. to make sure the resident got her medicine.

FINDINGS:

According to the record, the resident was admitted to the facility on November 29, 2012, at 7:15 p.m. The Medication Administration Record (MAR) was reviewed. The only "heart medication" the resident received was Sotalol 80 milligrams, an anti-dysrhythmic medication.

The resident was admitted to the facility with orders for Sotalol to be administered once a day. The resident would have already received the medication when she was in the hospital prior to admission to the nursing home. The orders were changed to twice a day on November 30, 2012, after the family brought up the issue with nursing staff. The physician was contacted November 30, 2012, at 9:00 a.m. and a telephone order for twice a day was received.

The MAR documented the resident received this medication at 9:00 a.m. and 6:00 p.m. on November 30, 2012.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Arthur F. Gulden, Administrator
January 27, 2014
Page 5 of 5

ALLEGATION #5:

The complainant stated that on December 3, 2013, the resident went home. The paperwork was wrong when she was released. There were medications on the list that the resident was not taking. Three pain medicines and two antibiotics were listed.

FINDINGS:

The discharge paperwork reviewed indicated that the identified resident's family received a copy of the medication administration record. The physician circled the medications that the resident was to continue taking. The record had other medications, that included antibiotics, but there was an "X" drawn through the medications she was not to receive. Each of the medications the resident was to continue on had "cont" and the physician's initials beside it. This was so the local pharmacy would issue them to the resident after discharge.

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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

January 30, 2014

Arthur F. Gulden, Administrator
Bingham Memorial Skilled Nursing & Rehabilitation Center
98 Poplar Street
Blackfoot, ID 83221-1758

Provider #: 135007

Dear Mr. Gulden:

On **December 9, 2013**, a Complaint Investigation survey was conducted at Bingham Memorial Skilled Nursing & Rehabilitation. Amy Barkley, R.N. and Arnold Rosling, R.N., Q.M.R.P. conducted the complaint investigation. The complaint investigation was completed in conjunction with the facility's annual Recertification and State Licensure survey and one other complaint.

During the investigation, the Director of Nursing (DoN), day shift charge nurse and the Administrator were interviewed.

The following documents were reviewed:

- The identified resident's closed record and the records of 12 additional residents;
- Incident/Accident Reports from June 2013 to December 2013;
- Resident Council Meeting minutes from June 2013 to December 2013;
- Grievances from June 2013 to December 2013; and
- Hospice notes for July 2013.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006248

ALLEGATION #1:

The complainant stated an identified resident reported:

- The resident had been vomiting and had burning in his throat from July 17, 2013 through July 31, 2013.
- Medical attention was not received by the resident in a timely manner to address an upper gastrointestinal (GI) bleed.

The complainant's concern was that the resident did not receive medical services in a timely manner.

FINDINGS:

The resident's Nurses Progress Note dated July 31, 2013, documented the following:

- 3:21 p.m., "during evening res(ident) vomited x 1. Zofran 4 mg prn (as needed) given (with) 0 (zero) further episodes of vomiting. Cont(inues) to c/o (complain of) nausea."
- 8:00 a.m., Pt (Patient) c/o N/V (nausea/vomiting) has not vomited since last prn (as needed) Zofran at 4:30 a.m., but states his belly is still upset."
- 9:00 a.m., CNA reported pt starting to vomit again, vomit appears like coffee grounds. Notified (Facility's name) home, health, and hospice. (Physician's name) called facility, the facility gave the MD (medical doctor) vitals and explained vomiting, cold, clammy, pale and vs (vital signs) starting to (drop). (Physician's name) gave new order to transfer pt to Emergency Room for eval(uation) and treat(ment)."

Hospice notes reviewed from July 2, 2013 through July 31, 2013, did not document concerns related to nausea, vomiting or constipation for the identified resident until July 31, 2013, after the facility had identified the change in the resident's condition.

In addition, the resident was interviewed by surveyors during a complaint investigation the week of October 11, 2013, at the facility. The resident did not report any mistreatment to the surveyors.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

According to the complainant, the identified resident stated that on September 11, 2013, two night shift certified nurse aides (CNAs) threw him into his bed and caused him to hit his head on the head board. The resident reported that he was taken out of the facility to get his neck and spine x-rayed as a result of the injuries he sustained when his head hit the head board."

On September 19, 2013, the identified resident reported to the complainant that he was "Knocked out for ten minutes after his head hit the wall during a transfer into bed by two to four staff members." The resident indicated he did not receive any medical services immediately after the

Arthur F. Gulden, Administrator
January 30, 2014
Page 3 of 3

incident.

The complainants concern was that the resident did not receive medical services immediately after the incident.

FINDINGS:

The hospice notes reviewed for September 2013 did not document the identified resident expressed concerns to the hospice staff or facility staff related to "rough" handling or neck/back pain associated with the transfers on September 11, 2013 or September 19, 2013.

Skilled Assessment notes reviewed for September 2013 did not document the resident verbalized neck pain to the facility staff on September 11th, 12th, 13th, 14th or the 19th related to the allegation of the resident "Hitting his head on the head board or the wall."

On September 14, 2013, the resident was sent to the hospital for a two-view thoracic spine x-ray related to complaints of, "back pain." An x-ray reported dated September 14, 2013, at 7:15 a.m. documented the following findings/opinions: "There is mild scoliosis present. No compression fractures are seen. Mild progression has occurred since 024/13/2010 (sic)."

The previous six months of facility's abuse investigations were reviewed, July 2013 to December 2013, and did not document the above event had occurred. In addition, grievances and I&A's for the previous six months were reviewed, July 2013 to December 2013, and did not document the resident or the complainant had voiced concerns related to cares provided to the resident.

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

LKK/dmj