



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 1949

January 13, 2014

Teresa Bruun, Administrator
Promontory Point Rehabilitation
3909 South 25th East
Ammon, ID 83406

Provider #: 135137

Dear Ms. Bruun:

On **December 20, 2013**, a Recertification and State Licensure survey was conducted at Promontory Point Rehabilitation by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 27, 2014**. Failure to submit an acceptable PoC by **January 27, 2014**, may result in the imposition of civil monetary penalties by **February 18, 2014**.

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

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **January 24, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **January 24, 2014**. A change in the seriousness of the deficiencies on **January 24, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 24, 2014** includes the following:

Denial of payment for new admissions effective **March 20, 2014**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 20, 2014**, if substantial compliance is not achieved by that time.

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

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

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

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Regional Office or the State Medicaid Agency beginning on **December 20, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **January 27, 2014**. If your request for informal dispute resolution is received after **January 27, 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,



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

LKK/dmj
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135137	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 12/20/2013
NAME OF PROVIDER OR SUPPLIER PROMONTORY POINT REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3909 SOUTH 25TH EAST AMMON, ID	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 278	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and 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, it was determined the facility failed to accurately code a resident's weight on an admission MDS. This affected 1 of 3 (#5) residents sampled for weight loss. Findings included:</p> <p>Resident #5 was admitted to the facility on 11/26/13 with multiple diagnosis including pressure ulcers and Diabetes Mellitus.</p> <p>The resident's 12/3/13 admission MDS coded weight 63 pounds (#) and height 63 inches. Section V0200 documented nutrition status triggered and was care planned. The subsequent 12/9/13 Nutritional Status CAA Worksheet documented, in part, nutritional status triggered due to "high BMI (body mass index)."</p> <p>Note: Using the National Heart Lung and Blood Institute's standard BMI calculator, the resident's BMI was "0.1" for the weight of 63# and height of 63 inches. A BMI of less than 18.5 was considered underweight.</p> <p>The resident's 11/26/13 Nursing Admission Assessment provided evidence the facility determined the resident's height was 63 inches and weight was 175.4# on 11/26/13.</p> <p>The resident's 11/13 and 12/13 TARs provided evidence the resident's weights were: - 11/29/13, 163.3# - 12/3/13, 162.8#</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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F 278	Continued From Page 1 - 12/10/13, 155# - 12/17/13, 149.6# On 12/19/13 at 12:20 p.m., the survey team discussed the resident's weight with the facility's Registered Dietitian (RD). The RD verified the resident's weight "on admission was 175.4#."		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure licensed nurses (LNs) did not sign medications as administered before the medications were actually given. This was true for 1 of 4 LNs and it involved 1 of 2 sample residents (#2) and 2 random residents (#s 11 and 14) during medication pass observations. This failure created the potential for more than minimal harm should Resident #11 not actually receive her thyroid, blood pressure, pain, laxative, and anti-inflammatory medications; Resident #2 not receive his antiemetic (for nausea) medication; and Resident #14 not receive her pain and non-steroidal anti-inflammatory medications. Findings included: Note: Informational Letter #97-3, dated April 16, 1997: The Medication Distribution Technique Clarification To Informational Letter, 96-14, from the Bureau of Facility Standards, stated, "The issue arose when the Board of Nursing received information that long term care facility staff were signing medications as given at the time of the medication preparation, not after the resident actually received the medication. ...the Board's expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do." 1. On 12/17/13 at 8:30 a.m., LN #8 was observed as she poured Resident #11's Synthroid (thyroid), Lisinopril (blood pressure), docusate (laxative), sulfasalazine (anti-inflammatory), Mobic (non-steroidal anti-inflammatory), calcium (supplement), and hydrocodone (pain) medications. The LN then clicked the E-MAR until the name of each of the medications turned green. The LN said, "Green means it is documented." 2. On 12/17/13 at 10:30 a.m., LN #8 was observed as she poured prochlorperazine (anti-nausea) PRN (as needed) for Resident #2. The LN then clicked on the E-MAR until the name of the medication turned green. 3. On 12/19/13 at 8:05 a.m., LN #8 was observed as she poured calcium (supplement), Celebrex (non-steroidal anti-inflammatory), Megared Omega 3 (supplement), multivitamin, and hydrocodone (pain) medications for Resident #14. The LN then clicked the E-MAR until the name of each of the medications turned green. When asked about the documentation, LN #8 stated, "I can always change it if she refused one." When informed of the concern about pre-documentation, the LN stated, "I see what you mean."		

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F 281	<p>Continued From Page 2</p> <p>On 12/19/13 at about 5:00 p.m., the Administrator and DNS were informed of the issue. No other information was received from the facility which resolved the issue.</p>		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2013
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NAME OF PROVIDER OR SUPPLIER PROMONTORY POINT REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3909 SOUTH 25TH EAST AMMON, ID 83406
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual Federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Karen Marshall, MS, RD, LD Team Coordinator Linda Kelly, RN</p> <p>The survey team entered the facility on Monday 12/16/13 and exited the facility on Friday, 12/20/13.</p> <p>Survey Definitions:</p> <p>ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status BMI = Body Mass Index CAA = Care Area Assessment CNA = Certified Nurse Aide DM = Dietary Manager DON/DNS = Director of Nursing/Director Nursing Services E-MAR = Electronic Medication Administration Record LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RD = Registered Dietitian RN = Registered Nurse TAR = Treatment Administration Record</p>	F 000		
F 156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and</p>	F 156		

RECEIVED
FEB 20 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [Signature] TITLE: Executive Director (X6) DATE: 2/18/2014

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 156	Continued From page 1 regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (I)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including	F 156	F 156 POC Identified Resident Action: Other Resident Identifiers: Resident #1, #2, #3, #4, #5, #6, #8, #9, and #10 have been discharged from the facility. Resident #7 has received an addendum to the admission agreement regarding how to obtain copies of their clinical records orally, or in writing. Measures: Facility admission agreement has been amended to include: The resident's right to review their clinical record within 24 hours by oral or written request. <i>2.21.14 13:43 per telecom with DON: All residents in facility are given the new agreement.</i>	

there are currently 6 residents in the facility who were here during the annual survey. Those residents will be given a copy of the new admission agreement.

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F 156	<p>Continued From page 2</p> <p>the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 156	<p>Monitoring:</p> <p>The facility will ensure compliance through maintaining a master copy that can only be altered by committee during CQI. The admission agreement shall be reviewed by CQI committee each year. Areas of concern will be brought immediately to Administrator.</p> <p>Compliance date 02-18-2014.</p>		

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F 156	Continued From page 3 Based on review of the facility's Admission Agreement and staff interview, it was determined the facility failed to ensure the Agreement included the resident's right to review their clinical record within 24 hours by oral request. This affected 10 of 10 (#s 1-10) sampled residents and all residents who resided in the facility. Findings included: On 12/18/13 at 1:55 p.m., the surveyor and the Admission Coordinator #1 (AC #1) reviewed the facility's Admission Agreement for resident rights. The residents' right to review their clinical record within 24 hours was not written in the Agreement. The surveyor asked the AC #1 how the residents could obtain copies of their clinical records. The AC #1 indicated the resident request must be, "in writing." At that time, the surveyor referred AC #1 to the federal guidelines that the resident had the right to request and have access to all records within 24 hours by oral request.	F 156			
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents who self-administered	F 176			

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F 176	<p>Continued From page 4</p> <p>medications were assessed and determined to be safe to do so by the Interdisciplinary Team (IDT). This was true for 1 of 10 residents (#12) during medication pass observations and 1 of 1 resident (#13) during a blood glucose check observation. The failed practice created the potential for the residents to not receive the medications as ordered by their physicians. Findings included:</p> <p>1. On 12/18/13 at 7:45 a.m., LN #9 was observed as she entered Resident #13's dark room, informed the resident it was time for a blood glucose check, and then turned on the light. When the light came on, a medicine cup with one small pink oblong scored tablet in it, was observed on the resident's over bed table. The medicine cup was next to and touching the side of an uncapped urinal with 500 milliliters of a clear yellow liquid, that looked like urine, in it (Note: Refer to F 441, Infection Control, for more details).</p> <p>When LN #9 completed the blood glucose check, she was asked about the pill in the medicine cup. She stated, "That's his thyroid med. I know that's wrong." Then, the LN administered the pill to the resident. When asked if the resident had been assessed to determine if he was safe to self-administer the medication, the LN said she did not know.</p> <p>On 12/18/13 at 9:20 a.m., the DNS was asked if Resident #13 had been assessed to determine if he was safe to self-administer his thyroid medication. The DNS reviewed the resident's electronic medical record and stated, "He doesn't have anything that says he should be self-administering."</p>	F 176	<p>F 176 POC</p> <p>Identified Resident Action:</p> <p>Resident #13 and #12 have been discharged from the facility.</p> <p>Other Resident Identifiers:</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>Measures:</p> <p>On 1-22-2014 the facility has re-educated licensed nursing staff that medication administration must be witnessed by Licensed Nurse unless resident has been assessed and plan of care reflects self administration of medications.</p> <p>Monitoring:</p> <p>Starting on 1-24-2014 the Director of Nursing will monitor a medication pass weekly for a 90-day audit period.</p> <p>Compliance date 02-18-2014.</p>	

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F 176	<p>Continued From page 5</p> <p>No other information was received from the facility regarding this issue.</p> <p>2. On 12/18/13 at about 8:10 a.m., LN #9 was observed as she poured MiraLax 17 grams in the dispensing cap off the MiraLax bottle, 2 other oral medications, an injectable medication, and an inhaled medication then took them to Resident #12's room. The LN placed the dispensing cap with the MiraLax on a barrier on the resident's over bed table, then she administered all of the medications, except the MiraLax. The LN asked the resident what liquid she wanted to mix with the MiraLax. The resident said water. The LN returned to the medication cart by the nurses' station and mixed the Miralax in about 2 1/2 ounces of water (Note: Refer to F 332, Medication Errors, for more details). Then, LN #9 returned to the resident's room, placed the small plastic glass with MiraLax in water on the over bed table in front of the resident, informed the resident what it was, then left the resident's room before the resident even picked up the glass.</p> <p>At about 8:15 a.m., when asked if the resident had been assessed to determine if she was safe to self-administer the medication, LN #9 stated, "I don't know but I know she can." The LN and the surveyor returned to the resident's room a minute later and found the Miralax was still in the glass. At that point, LN #9 asked the resident to drink the Miralax and told the resident, "I need to watch you take it."</p> <p>On 12/18/13 at 9:20 a.m., the DNS was asked if Resident #12 had been assessed to determine if she was safe to self-administer Miralax. The DNS reviewed the resident's electronic medical record then stated that an assessment to self-administer</p>	F 176			

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F 176	Continued From page 6 medications had not been done.	F 176		
F 226 SS=D	<p>No other information was received from the facility regarding this issue.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of staff personnel files and staff interview, it was determined the facility failed to: 1) Verify the State Nurse Aide Registry (SNAR) for 3 of 3 Certified Nurse Aides (CNAs) hired (#A, B and C) and 2) Attempt to obtain reference checks for 1 of 5 staff hired (A). This practice created the potential to place residents at risk for and subject to abuse, neglect, or misappropriation of property. Findings included:</p> <p>Federal guidance at F226 specifies, in part, "I. Screening...screen potential employees for a history of abuse, neglect or mistreating residents as defined by the applicable requirements...This includes attempting to obtain information from previous employers and/or current employers, and checking with the appropriate licensing boards and registries."</p> <p>On 12/18/13 at 1:06 p.m., the surveyor and Executive Assistant #2 (EA #2) reviewed the</p>	F 226	<p>F 226 POC</p> <p>Identified Resident Action:</p> <p>No Residents have been affected by the deficient practice, but all have the potential to be affected.</p> <p>Other Resident Identifiers:</p> <p>No Residents identified or directly affected by the practice.</p> <p>Measures:</p> <p>The Director of Nursing and Administrator have reviewed current verification practices of State Nurse Aide Registry requirements. On 12-23-2013 the facility has re-educated the Executive Assistant regarding verification practices of State Nurse Aide Registry requirements.</p>	

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F 226	Continued From page 7 personnel files of five staff hired within the past four months. The surveyor and the EA #2 reviewed the Federal guidance at F226. The following was determined. 1. Staff A (CNA), Date of Hire (DOH): 8/19/13. a. The SNAR was not checked or verified until 8/30/13, 11 days after hire. b. Review of Staff A's personnel file did not provide evidence the facility attempted to obtain information from previous employers. 2. Staff B (CNA), DOH: 8/22/13. a. The SNAR was not checked or verified until 9/6/13, 15 days after hire. 3. Staff C (CNA), DOH: 11/13/13. a. Review of Staff C's personnel file did not provide evidence the facility checked or verified the SNAR prior to or after DOH. On 12/20/13 at 9:40 a.m., the Administrator and the DON were informed of the concerns.	F 226	The facility will ensure that all new and rehired Certified Nurse Aides (CNAs) certification is verified through the State Nurse Aide Registry on date of hire. The facility will ensure that all new and rehired employees will have references checked on date of hire. Monitoring: Starting on 01-24-2014 the Administrator will conduct audits of all new and rehired employees for compliance of State Nurse Aide Registry verification and reference checks to be conducted weekly for a 90-day audit period. Compliance date 02-18-2014.		
F 272 SS=D	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;	F 272			

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F 272	Continued From page 8 Cognitive patterns; 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 observation, record review, and staff interview, it was determined the facility failed to ensure siderails were assessed as safe for resident use. This was true for 1 of 4 (#5) sample residents reviewed for the use of side rails. This failure placed the resident at risk for harm should the resident become entrapped in the siderails. Findings included: Resident #5 was admitted to the facility on 11/26/13 with multiple diagnoses which included	F 272	F 272 POC Identified Resident Action: Resident # 5 has discharged. Facility reviewed current side rail safety assessment to include patient mobility and safety awareness. Other Resident Identifiers: All residents have the potential to be affected by the deficient practice. Facility will audit all current residents with side rails for accurate assessments. Measures: Residents admitted with a medical or personal need for side rails usage will require appropriate assessment before placement of side rails.		

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F 272	<p>Continued From page 9</p> <p>cranial osteomyelitis and diabetes mellitus.</p> <p>The resident's 5-Day MDS, dated 12/3/13, coded, in part:</p> <ul style="list-style-type: none"> * Intact cognition, with a BIMS score of 15; * Extensive assistance of 2 or more people for bed mobility/transfers/toileting; * Extensive assistance of 1 person for dressing/personal hygiene/bathing; and, * Bed rails used daily. <p>The resident's "All Active Orders for December 2013" included, "1/4 side rails x [times] 2 to aid in mobility."</p> <p>The resident's care plan for mobility included the intervention, "1/4 side rails x 2 to aid mobility." The intervention was initiated/created 11/29/13.</p> <p>The resident was observed in bed with bilateral 1/4 side rails in the raised position on 12/16/13 at about 3:20 p.m. and on 12/17/13 at 8:35 a.m., 10:25 a.m., 12:10 p.m., 2:30 p.m., and 3:00 p.m.</p> <p>On 12/18/13 at about 1:30 p.m., LN # 5 was asked to provide the side rail safety assessment for Resident #5. The LN reviewed the resident's electronic medical record then stated the assessment may have been in the resident's paper file in a drawer by the nurses' station. The LN said she would look and report back.</p> <p>A few minutes later, LN #5 returned with a Physical Restraint Consent for 1/4 side rails x 2, which was signed by the resident and a staff member on 11/29/13. When informed it was a consent, not an assessment, the LN stated she would continue to look.</p>	F 272	<p>Monitoring:</p> <p>Starting on 01-24-2014 the Director of Nursing will be notified on admission of any resident that requires or have requested side rails. Starting on 01-24-2014 the Director of Nursing will monitor all patients who require side rails to ensure appropriate assessment is completed before placement weekly for a 90-day audit period.</p> <p>Areas of concern will be immediately addressed and facility will review process in monthly CQI meeting as needed.</p> <p>Compliance date 02-18-2014.</p>	

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F 272	Continued From page 10 Later that afternoon, LN #5 provided a Side Rail Assessment, dated 12/17/13. When asked about the date of the assessment, the LN stated it was not done until 12/17/13. The resident's Progress Notes, dated 11/26/13 - 12/17/13, included the following documentation, "12/5/13 [at] 10:27 a.m. Type: Nurses Note ...Previous shift reported pt [patient] to have had episodes of severe confusion through the night..." The resident was not assessed to determine if she was safe with the use of side rails until 18 days after side rails were placed on her bed. On 12/19/13 at 5:00 p.m., the Administrator and DNS were informed of the issue. No other information or documentation was received from the facility which resolved the issue.	F 272			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	F 279			

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F 279	<p>Continued From page 11</p> <p>be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure residents' interim care plans included problem areas present upon admission and/or that care areas triggered by the RAI process and identified as care planned were actually care planned. This was true for 2 of 6 residents (#s 1 and 6) reviewed for care planning. The failure created the potential for residents' assessed needs to not be met due to lack of direction in their care plans. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 11/12/13 and readmitted on 12/3/13 with multiple diagnoses which included other specified rehabilitation, unspecified debility, and unspecified abdominal pain.</p> <p>The resident's 5-Day MDS assessment, dated 12/10/13, coded, in part:</p> <ul style="list-style-type: none"> * occasional urinary incontinence; * frequent moderate pain; and, * PRN (as needed) pain medication used. <p>The resident's CAA (Care Area Assessment) Triggers Summary, dated 12/12/13, documented, in part:</p> <ul style="list-style-type: none"> * urinary incontinence "Addressed in CP [care plan]" because CAA triggered secondary to occasional incontinence; and, * pain "Addressed in CP" because, "Pain is 	F 279	<p>F 279 POC</p> <p>Identified Resident Action:</p> <p>Resident # 1 has been discharged from the facility.</p> <p>Resident # 6 has been discharged from the facility. Patient's care plan was reviewed and a care plan was developed regarding urinary incontinence and pressure ulcer assessment.</p> <p>Other Resident Identifiers:</p> <p>Residents currently in the facility have had care plans reviewed and updated to ensure problem areas present upon admission and/or that care areas triggered by the RAI process and identified as care planned were actually care planned. New resident admission paperwork is reviewed and audited for urinary incontinence and pressure ulcer assessments and identified areas are care planned accordingly.</p>	
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F 279	<p>Continued From page 12 frequent..." and "Verbal Descriptor Scale [=] Moderate."</p> <p>On 12/18/13 at 3:00 p.m., the resident's electronic medical record (EMR) was reviewed with the Medical Record (MR) nurse's assistance. The review revealed that the resident's initial CP did not include urinary incontinence or pain. The MR nurse concurred that urinary incontinence and pain were not in the care plan.</p> <p>On 12/19/13 at about 5:00 p.m., the Administrator and DNS were informed of the care plan issue.</p> <p>No other information was received from the facility which resolved the issue.</p> <p>2. Resident #6 was admitted to the facility on 11/22/13 with multiple diagnoses which included other specified rehabilitation following total hip replacement. A stage III pressure ulcer (PU) to the coccyx was present on admission.</p> <p>The resident's TCU/SNF (transitional care unit/skilled nursing facility) Admission Orders, dated 11/22/13, included orders for wound care. And, All Active Orders and the MAR for November 2013 included an order for Santyl (collagenase) ointment topically.</p> <p>The resident's 5-Day MDS assessment, dated 11/29/13, coded, in part, * occasional urinary incontinence; * stage III PU on admission; and * ulcer care.</p> <p>The resident's CAA (Care Area Assessment) Worksheets documented, in part: * urinary incontinence CAA, dated 12/6/13,</p>	F 279	<p>Measures:</p> <p>On 1-22-2014 the facility has re-educated licensed nursing staff regarding initial care plan on admission to meet resident needs.</p> <p>Monitoring:</p> <p>Starting on 01-24-2014 the Director of Nursing will monitor all new admission care plans weekly for a 90-day audit period.</p> <p>Compliance date 02-18-2014.</p>		

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F 279	Continued From page 13 triggered secondary to occasional incontinence and "Addressed in CP [care plan];" * PU CAA, dated 12/5/13, triggered secondary to "Actual" problem with PU present on admit. On 12/18/13 at about 4:30 p.m., the resident's EMR was reviewed with the Medical Record (MR) nurse's assistance. The review included the interim CP developed when the resident was admitted and the initial CP, developed over the first 3 weeks after admission. The interim care plan did not include a plan for PU or urinary incontinence and the initial care plan did not include a plan for urinary incontinence. The MR nurse stated, "There should have been a care plan for urinary incontinence and PU on admission when [the resident] first got here." On 12/19/13 at about 5:00 p.m., the Administrator and DNS were informed of the care plan issue. No other information was received from the facility which resolved the issue.	F 279			
F 283 SS=D	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by:	F 283			

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F 283	<p>Continued From page 14</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure physician discharge orders were carried out for 1 of 1 sample resident (#10) reviewed for discharge planning. This failure created the potential for more than minimal harm when the resident did not receive physician ordered therapy and nursing care after discharge from the facility. Findings included:</p> <p>Resident #10 was admitted to the facility on 10/2/13 with multiple diagnoses which included other specified rehabilitation; unspecified hemorrhage of gastrointestinal tract, atrial fibrillation, coronary artery disease, and Alzheimer's dementia.</p> <p>Resident #10 was discharged from the facility on 11/7/13.</p> <p>On 12/19/13 at 10:15 a.m., the Medical Records (MR) nurse assisted the surveyor to review the resident's closed paper and electronic medical records and she confirmed that the resident's medical record was closed. It included the following:</p> <p>* Discharge Orders, dated 11/6/13 - "...home with...outpatient therapy to include; physical therapy [PT], occupational therapy [OT] and nursing care."</p> <p>* Discharge Checklist for Administration - "NA [not applicable] Patient has been set up with home health / outpatient...(circle one) services for continued nursing and/or therapy. Chosen agency: [blank]."</p> <p>When asked about the NA on the discharge checklist, the MR nurse referred the surveyor to the Social Service Designee (SSD).</p>	F 283	<p>F 283 POC</p> <p>Identified Resident Action:</p> <p>Resident #10 has been discharged from the facility.</p> <p>Other Resident Identifiers:</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>Measures:</p> <p>On 1-23-2014 the facility has re-educated the social service designee regarding anticipated discharge recapitulation stay/final status.</p> <p>Monitoring:</p> <p>Starting on 01-24-2014 the Administrator shall audit 5 random discharge recapitulation stay/final statuses weekly for 30 days and 5 random discharge recapitulation stay/final statuses monthly for 60 additional days, for a 90-day audit period.</p> <p>Compliance date 02-18-2014.</p>		

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F 283	<p>Continued From page 15</p> <p>On 12/19/13 at 10:30 a.m., the SSD confirmed he was the facility's Discharge Planner. When asked about the resident's discharge order for home PT/OT and nursing care, the SSD said the resident did not need nursing care because he was going to go to outpatient therapy. When asked for documentation of the referral for outpatient (OP) therapy, the SSD stated, "Well I don't know." He added, "I usually attach a list of OP Therapy providers to the paperwork after I talk to the resident and the resident chooses a provider." The SSD confirmed, however, that there was no list of OP providers and no referral to an OP therapy provider.</p> <p>On 12/19/13 at 11:10 a.m., the SSD provided a note by the previous SSD, dated 10/23/13. It documented, "Intervention Evaluate/record the resident's abilities and strengths, with family/caregivers/IDT [interdisciplinary team]. Determine gaps in abilities which will affect discharge. Address gaps by community referral to home with home health. Note Text: ...: Discussed therapy progress and discharge process with patient and patient's wife. Reviewed an update from patient's primary therapist who feels he is doing well and is coming close to discharge. Patient understands the discharge process and denies any other needs at this time." The SSD stated that the resident had asked for an order for OP therapy just in case he decided he needed it. But, at discharge the resident said he did not need it so no referral was made." Documentation of the conversations with the resident was requested; however, the SSD stated, "There are none."</p> <p>Note: The 10/23/13 SSD's note was 2 weeks before the resident's 11/7/13 discharge.</p>	F 283			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2013
NAME OF PROVIDER OR SUPPLIER PROMONTORY POINT REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3909 SOUTH 25TH EAST AMMON, ID 83406		
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F 283	<p>Continued From page 16</p> <p>The resident's PT and OT notes, both dated 10/2-11/6/13, both included, "Discharge Status and Recommendations...: Home exercise program."</p> <p>On 12/19/13 at 12:00 p.m. (noon), the Therapy Supervisory (TS) was interviewed. After the TS reviewed his OT notes and the PT notes, he stated the "intent" was that the resident would have continued therapy in the home. The TS stated, "I remember him. He was pretty high functioning but a few visits would have been good."</p> <p>The facility did not provide any evidence that the resident's physician ordered discharge plan for home therapy and nursing care was completed or that the resident declined/refused home services or requested OP therapy.</p> <p>On 12/19/13 at 5:00 p.m., the Administrator and DNS were informed of the issue. However, the facility did not provide any other information regarding the issue.</p> <p>On 12/24/13 at approximately 10:00 a.m., the Bureau of Facility Standards received a fax from the facility. The fax documented, in part, "...Progress Notes...Late Entry... 11/6/13 at 10:43[a.m.]...Social Service Note...Patient states that he will not need any DME [Durable Medical Equipment], and has set up outpatient therapy and will not need my assistance...Social services will follow up with DME and home health needs." Note: The late entry did not identify what date the late entry was for. This late entry contradicted the 12/19/13 11:10 a.m. interview with the Social Service Designee.</p>	F 283			

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F 309 SS=D	<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 record review, staff interviews, and policy and procedure (P&P) review, it was determined the facility failed to ensure verbal and/or telephone orders were written when orders were changed; laboratory (lab) tests orders were followed; a P&P was in place for interim orders (verbal, telephone, facsimile, etc.); and, resident centered individualized care plans were in place. This was true for 3 or 9 sample residents (#s 3, 6, and 7). The lack of a P&P for interim orders created the potential for residents to not receive appropriate care and treatment. Failure to obtain physician ordered lab tests placed Resident #6 at risk for undetected abnormal Coumadin levels. Failure to apply barrier cream to Resident #7's skin as ordered placed him at risk for skin breakdown. Failure to individualize Resident #3's care plan placed her at risk for unmet needs related to dementia. Findings included:</p> <p>1. Note: Perry and Potter's Fundamentals of Nursing, 7th Edition, 2010, page 402, states in part, "A telephone order (TO) involves a physician's or health care provider's stating a prescribed therapy over the phone to a registered nurse...The registered nurse is responsible for</p>	F 309	<p>F 309 POC</p> <p>Identified Resident Action:</p> <p>Resident #3 has discharged from the facility.</p> <p>Resident #6 has been discharged from the facility. The facility continued following signed physician laboratory test orders.</p> <p>Resident #7 has been discharged from the facility. The resident's wound location #1 was resolved 12-24-2013.</p> <p>Other Resident Identifiers:</p> <p>All residents have the potential to be affected by the deficient practice.</p>	

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F 309	<p>Continued From page 18³</p> <p>writing the order on the physician's or other health care provider's order sheet in the client's permanent record and signs it..."</p> <p>The same edition of Potter and Perry's Fundamentals of Nursing, page 713, also states in part, "A verbal order is a medication or treatment order received by the registered nurse in the presence of the prescriber. Telephone orders are medication or treatment orders given to the nurse by the prescriber over the phone... The registered nurse follows institutional policy regarding the receiving, recording, and transcription of verbal and telephone orders..."</p> <p>Resident #6 was admitted to the facility on 11/22/13 with multiple diagnoses which included rehabilitation following hip joint replacement.</p> <p>On 12/18/13 at about 4:00 p.m., the Medical Records (MR) nurse assisted the surveyor to review the resident's electronic medical record (EMR) and she provided a copy of the resident's TCU/SNF (Transitional Care Unit/Skilled Nursing Facility) Admission Orders, dated 11/22/13, and All Active Orders for November 2013 and December 2013.</p> <p>The 11/22/13 TCU/SNF Admission Orders included: * "Coumadin 3 mg [milligrams] po [by mouth] daily;" and, * "PT/INR [prothrombin time/international normalized ratio] checked daily until stable."</p> <p>The All Active Orders for November 2013, signed by the physician 11/25/13, included: * "Coumadin 3 mg oral (by mouth) - once daily Everyday..." and,</p>	F 309	<p>Measures:</p> <p>On 1-22-2014 the facility has re-educated all licensed nursing staff regarding orders that are received from a physician. All orders must be entered into the electronic medical records, orders must specify how the order was received (ie. telephone, verbal, written.), orders must then be signed by nurse receiving order and then countersigned by the physician.</p> <p>On 1-22-2014 the facility has re-educated all licensed nursing staff regarding current policy and procedure regarding laboratory test interim orders (verbal, telephone, facsimile, etc.).</p> <p>On 1-22-2014 the facility has re-educated all licensed nursing staff regarding updated policy and procedure of entering all physician orders (verbal, telephone, facsimile, etc.).</p>		

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F 309	<p>Continued From page 19</p> <p>* "PT/INR on 11/25/13, primary physician to determine next draw."</p> <p>When asked for the daily PT/INR reports for 11/23, 11/24, and 11/25, the MR nurse reviewed the resident's EMR and said she did not find the reports. She said she would check the resident's "paper file" at the nurses' station and get back with the surveyor.</p> <p>On 12/18/13 at 4:30 p.m., the MR nurse provided 2 PT/INR reports as follows: * 11/25/13 - PT=31.5 (reference range 10.5-13.7) and INR=3.0 (reference range 0.3-2.0). Handwritten on the report was, "Pt [patient] taking 3 mg Coumadin PO Q [every] day. Please review [and] advise. Thanks" and "OK" in similar handwriting. Neither entry was dated, signed, or initialed. A different handwritten entry was, "Noted 11/25/13 [signed by an LN (licensed nurse)]." * 12/2/13 - PT=19.0 (reference range 10.5-13.7) and INR=1.9 (reference range 0.3-2.0). Handwritten on the report was, "Same Coumadin dose PT/INR in 1 week," initialed and dated 12/2/13 and noted by a LN on 12/2/13.</p> <p>Again, the MR nurse was asked for the 11/23 and 11/24 PT/INR reports, as well as the physician's order for the 12/2/13 PT/INR and the PT/INR report for 12/7/13. The MR nurse said she would "keep looking."</p> <p>On 12/19/13 at 7:45 a.m., the DNS was asked about the resident's PT/INR orders and reports. The DNS stated that when the resident was admitted, the nurse talked to the physician about the daily PT/INRs. The DNS stated the physician discontinued (D/C) the daily PT/INRs and changed it to a PT/INR on 11/25/13. The DNS</p>	F 309	<p>On 1-22-2014 the facility has re-educated all licensed nursing staff regarding current policy on care planning process for residents with dementia.</p> <p>Monitoring:</p> <p>Starting on 01-24-2014 the Director of Nursing shall audit 5 random lab requisitions weekly for 30 days and 5 random lab requisitions monthly for 60 additional days, for a 90 day audit period.</p> <p>Starting on 1-24-2014 the Director of Nursing shall audit 5 random physician orders weekly for 30 days, and 5 random physician orders monthly for 60 additional days, for a 90 day audit period.</p>		

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F 309	<p>Continued From page 20</p> <p>was asked to provide the order to D/C daily PT/INRs. She said she would look for it.</p> <p>On 12/19/13 at 8:45 a.m., the DNS pointed to the order for PT/INR on 11/25/13 in the resident's All Active Orders for November 2013. She said that was the order to change from daily PT/INRs to one on 11/25/13. The DNS was asked to provide documentation of the date and time the order was given. She said the All Active Orders for November 2013 included that order. When asked how interim physician orders were documented and processed, the DNS said the interim orders were included in the resident's All Active Orders for November. (Note: The "All Active Orders" did not include the order date or start date of each order.) The DNS was asked to provide the documentation of the communication between the nurse and physician about the PT/INRs. After the DNS reviewed nursing progress notes in the resident's EMR, she said she did not find any documentation of that communication between the nurse and physician.</p> <p>On 12/19/13 at about 5:00 p.m., the Administrator was informed of the issues regarding physician orders and PT/INRs. The policy and procedure and/or guidelines for processing interim orders was requested.</p> <p>On 12/20/13 at 9:30 a.m., the DNS provided an Electronic Medical Records policy which documented, in part: a statement about EMR for all medical record management and policy interpretation and implementation, which included electronic records as an acceptable form of medical record management; only authorized persons permitted access; permission to access based on the need to access; restricted access</p>	F 309	<p>Starting on 1-24-2014 the Director of Nursing shall audit all care plans for patients with dementia for a 90 day audit period. Areas of concern will be immediately addressed and facility will review process in monthly CQI meeting as needed.</p> <p>Compliance date 02-18-2014.</p>	

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F 309	<p>Continued From page 21</p> <p>by staff to view/modify only what they need to; personnel changes; access by authorized Federal and State survey agents; and, safeguards to prevent unauthorized access; individual passwords and user ID codes; records each entry (date/time) into the medical record at the time of entry; and, will not permit a change in the record once it has been recorded without the approval of the Administrator and Director of Nursing Services.</p> <p>Note: This policy did not address physician orders in any way.</p> <p>No other information or documentation was received from the facility which resolved the issue regarding no orders to discontinue daily PT/INR, no order for a PT/INR on 12/2/13, and the order for a PT/INR on 12/9/13 was not followed. In addition, the facility did not provide any evidence of a P&P or guidelines for how interim orders were processed.</p> <p>2. Resident #7 was admitted to the facility on 12/12/13 for rehabilitation therapy services after lumbar surgery.</p> <p>On 12/19/13 at 10:05 a.m., the MR nurse assisted the surveyor to review the resident's EMR.</p> <p>The resident's undated Transfer Orders/Instructions, with a facsimile (fax) date stamp of 12/11/13, included the following: * Wound location #1: bilateral buttock; and, * Wound treatment #1: Barrier cream to bilateral buttocks 4 times/day and as needed.</p> <p>The resident's All Active Orders for December 2013 and the MAR and TAR for December 2013</p>	F 309		

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F 309	<p>Continued From page 22</p> <p>did not include an order for barrier cream.</p> <p>When asked for evidence that barrier cream was applied as ordered, the MR nurse said she did not find any documentation that it was.</p> <p>On 12/19/13 at 2:05 p.m., CNA #6 and CNA #7 were observed as they provided incontinence care. CNA #7 applied a barrier cream to the resident's buttocks, dry scabbed dark red vertical lines, approximately 5 centimeters (cm) long by 0.5 cm wide, one on each side of the resident's buttocks. When asked how often the barrier cream was applied, CNA #7 stated, "When he needs it."</p> <p>On 12/19/13 at 4:15 p.m., the DNS was informed of the resident's barrier cream order and lack of documentation that it was provided as ordered. The DNS stated, "It probably didn't get transcribed over and if it's not on the orders, it's not on the MAR."</p> <p>No other information or documentation was received from the facility which resolved the issue.</p> <p>3. Resident #3 was admitted to the facility for rehabilitation and with multiple diagnoses including Alzheimer's type dementia.</p> <p>The resident's 10/30/13 admission MDS coded moderately impaired cognitive skills, required extensive physical assistance of one person for most ADLs, and prior to admission one fall with fracture.</p> <p>The resident's "All Active Orders for December 2013" (recapitulation) contained the order,</p>	F 309			

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F 309	<p>Continued From page 23</p> <p>Donepezil 10 mg by mouth at bedtime every day for denentia (sic).</p> <p>The resident's Care Plan contained:</p> <ul style="list-style-type: none"> - Focus area: (Resident #3) has impaired cognitive function/dementia or impaired thought processes related to Alzheimer's disease - Focus goal was: (Resident #3) will be able to communicate basic needs on a daily basis through the review date. - The two Focus Interventions were: - -Monitor/document/report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status. - -Please assist her with all decision making. <p>On 12/18/13 at 9:55 a.m., the resident's family member was interviewed and said the only concern was the resident "can't use a call light." Staff can tell her how to use it but she "can't remember to use it."</p> <p>On 12/18/13 at 11:35 a.m., the surveyor asked LN #4 about the resident's capability to use the call light and how the use of the call light was addressed on the resident's care plan. LN #4 stated, "The spouse has mentioned the use of the call light before and said don't tell her how to use the call light, she will forget in 2 minutes." The LN acknowledged the use of the call light was not included in the care plan.</p> <p>On 12/19/13 at 9:10 a.m., the surveyor asked CNA #6 about Resident #3 sitting in her room when not in therapies and how the resident could use her call light. CNA #6 stated, "I have seen</p>	F 309		

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F 309	<p>Continued From page 24</p> <p>[Resident #3] get up and out of her chair before. She made it to the doorway of her room. She used her call light when first admitted but the longer she was here, the less she used it. When I walk up and down the hall, I check on her."</p> <p>On 12/19/13 at 10:30 a.m., the surveyor asked CNA #7 about the resident's use of the call light. The CNA stated, "We [the CNAs] try to check on her frequently. Especially in the afternoon, she becomes restless and will want to move around more. There are times when she uses her call light to tell us she has to use the bathroom. Usually, she is not able to determine she has to use the bathroom. One time, when we were charting, we looked up and there she was, going for a walk. So we take her for walks when she is restless. She wants to go home because she misses her husband."</p> <p>On 12/19/13 at 11:55 a.m., the surveyor asked the Administrator if the facility had a policy and procedure related to care planning for a resident with deentia. The Administrator said, "I'll check." Later the same day, the Administrator said the facility did not have a policy and procedure specifically for care planning for a resident with dmentia.</p> <p>On 12/19/13 at 9:20 a.m., the surveyor asked the Social Services Designee (SSD) about how the SSD was involved with care planning for residents with dementia. The SSD indicated he was not involved in the care planning process for residents with dementia.</p> <p>On 12/20/13 at 9:540 a.m., the Administrator and the DON were informed the survey team had a concern for a resident with dementia and how the</p>	F 309		

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F 309	Continued From page 25 use of the call light was not addressed in the care plan.	F 309	F 314 POC		
F 314 SS=G	The facility failed to develop interventions to ensure the needs of the resident were met in light of her inability to consistently use a call light. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy and procedure review, it was determined the facility failed to ensure a care plan/interventions for pressure ulcers were in place on admission and that new pressure ulcers did not develop for a resident admitted with multiple stage II pressure ulcers. This was true for 1 of 3 residents (#5) reviewed for pressure ulcers. Resident #5 was harmed when 2 new stage II pressure ulcers developed (coccyx and right buttock) three days after admission; an unstaged left upper thigh pressure ulcer developed 4 days after admission; and one unidentified PU progressed to stage III. In addition, the facility failed to ensure the thigh pressure ulcer was staged, measured, and	F 314	Identified Resident Action: Resident # 5 has been discharged from the facility. The resident's wound had resolved on 12-20-2013. Other Resident Identifiers: All residents have the potential to be affected by the deficient practice. Facility will audit all current residents post the date of compliance to ensure proper wound treatment protocol. Measures: On 1-22-2014 the facility has re-educated licensed nursing staff regarding current skin management policy to include accurate staging and treatment protocol as appropriate per wound status. Resident's medical record will accurately reflect continued monitoring and care.		

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* F 314	<p>Continued From page 26</p> <p>characteristics were monitored and tracked; and, that the characteristics and status of each pressure ulcer was monitored and tracked. Findings include:</p> <p>Resident #5 was admitted to the facility on 11/26/13 with multiple diagnoses which included cranial osteomyelitis and diabetes mellitus.</p> <p>The resident's 5-Day MDS, dated 12/3/13, coded, in part:</p> <ul style="list-style-type: none"> * Intact cognition, with a BIMS score of 15; * Extensive assistance of 2 or more people for bed mobility , transfers, and toileting; * Extensive assistance of 1 person for dressing, personal hygiene, and bathing; * At risk for pressure ulcers (PU); and, * Three unhealed stage II PU. <p>The resident's "All Active Orders for December 2013" included:</p> <ul style="list-style-type: none"> * "Left Buttock: Complete a new "Wound/Skin Healing" assessment weekly until resolved...Tue[sday]." * Low air loss mattress to promote skin integrity and offload pressure; and, * "Weekly skin check-document on a progress note... Tue." <p>Note: There order/start date was not given for any of the orders.</p> <p>The resident's Nursing Admission Assessment documentation, dated 11/26/13, included:</p> <ul style="list-style-type: none"> * Section IV: Skin Condition - Six skin problems were listed, 3 of which were stage II PUs on the left buttock. Two of the PUs measured 1 centimeter (cm) by 1 cm each, the 3rd PU measured 3 cm by 2 cm. The "site" for the each of the listed skin problems included the 	* F 314	<p>Monitoring:</p> <p>Starting on 1-24-2014 the Director of Nursing will be notified immediately of all new skin issues. Director of Nursing will further implement plan of care based on wound staging. The Administrator will audit 5 random admission / weekly skin checks monthly for 90 day audit period. Areas of concern will be immediately addressed and facility will review process in monthly CQI meeting as needed.</p> <p>Compliance date 02-18-2014.</p>	

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F 314	<p>Continued From page 27</p> <p>anatomical location and a number that correlated to numbers on a front and a back body diagram. The "site" for each of the 3 stage II PUs was, "32) Left buttock" which correlated to the left buttock on the back body diagram.</p> <p>* Braden Scale For Predicting Pressure Sore Risk - total score = 16, or low risk.</p> <p>The resident's Care Plan included, "Focus area[:] Potential/Actual Alteration in skin integrity r/t [related to] stage II pressure ulcer on left buttock." Interventions for this focus area were, "Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Encourage good nutrition and hydration in order to promote healthier skin. Follow facility protocols for treatment of injury. Low air loss mattress to promote skin integrity and offload. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx [signs and symptoms] of infection, maceration etc. to MD [physician]." This part of the care plan and all of its interventions were initiated/created 11/29/13, 3 days after admission.</p> <p>The resident's Wound/Skin Healing Records (W/SHR) dated 11/29/13, 12/3/13, 12/10/13, and 12/17/13 were reviewed. The W/SHR included 3 pages with the following instructions at the top of each page, "USE SEPARATE ASSESSMENT FOR EACH PRESSURE ULCER SITE[:] Identify and describe site." Page 1 contained a front and a back body diagram with numbered areas, such as 32 for left buttock, 31 for right buttock, 53 for the lower back along the spinal column, and 23 for the coccyx; PU definitions, which included, "Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough..." and "Stage III -</p>	F 314		

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F 314	<p>Continued From page 28</p> <p>...Slough may be present but does not obscure the depth of tissue loss..."; and, multiple lines on which to list skin conditions and the site, type, and measurements, in centimeters, for each condition. Page 2 contained areas to document the description of the wound bed and surrounding tissue/wound edges. PThe left upper thigh PU was not mentioned at all in the PN and the facility did not provide any documentation regarding the left thigh PU. age 3 asked about pain experienced related to the wound and included an area for comments.</p> <p>The resident's W/SHR documentation included: *11/29/13 - 2 PU listed on page 1: - Coccyx (noted as 23 which correlated to the tailbone area on the back body diagram), 0.5 by 0.5, depth blank, stage II; and, - Right buttock (noted as 31 which correlated to the right buttock on the back body diagram), 4 by 2, depth blank, stage II. Pages 2 and 3 documented no exudate, odor, normal periwound skin, and no pain. Note: There was no indication as to which PU, the coccyx or right buttock, the information on pages 2 and 3 applied. *12/3/13 - 5 PU listed on page 1: - Sacrum (noted as 53 which correlated to the lower back area on the back body diagram), 2 by 1.2, depth blank, stage II; - Left buttock (noted as 32 which correlated to the back body diagram), 3 by 1, depth blank, stage I; - Left buttock (noted as 32), 1 by 1, depth blank, stage II; - Left buttock (noted as 32), 1 by 2, depth blank, stage II; and, - Right buttock (noted as 31 which correlated to the right buttock on the back body diagram), 1 by 2, depth blank, stage II.</p>	F 314		

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F 314	<p>Continued From page 29*</p> <p>Pages 2 and 3 noted small amount of exudate, rolled edges, "Hurts a Little Bit," and "...Wounds appear to be less inflammed [sic] and healing well since I last observed them..."</p> <p>Note: There was no indication as to which PU, the sacrum, one of the 3 left buttock, or the right buttock, the information on pages 2 and 3 applied. And, a new PU, on the sacrum was listed while the coccyx PU was not mentioned.</p> <p>*12/10/13 - 5 PU listed on page 1:</p> <ul style="list-style-type: none"> - Sacrum (noted as 53), 2 by 1.3 by 0.2, stage II; - Left buttock (noted as 32), 2 by 1 by 0, stage I; - Left buttock (noted as 32), 1 by 1 by 0, stage I; - Left buttock (noted as 32), 1 by 2 by 0, stage I; <p>and,</p> <ul style="list-style-type: none"> - Left buttock (noted as 32), 1 by 1 by 0, stage I. <p>Pages 2 and 3 noted epithelial tissue, granulation tissue, and slough, scant amount of serous exudate, normal color/tissue of the surrounding skin, "Hurts a Little Bit," and, "Wounds have improved overall..."</p> <p>Note: Again, there was no indication as to which PU the information on pages 2 and 3 applied. And, 4 left buttock PUs were listed while the coccyx and right buttock PUs were not mentioned.</p> <p>*12/17/13 - Only 1 PU listed on page 1:</p> <ul style="list-style-type: none"> - Left buttock (noted as 32), 0.9 by 0.7 by 0, stage I, with epithelial tissue, no exudate, normal color/tissue of surrounding skin, no pain, and no comments on pages 2 and 3. <p>Note: None of the other previously noted PU were mentioned.</p> <p>The resident's Progress Notes (PN), dated 11/26/13 - 12/17/13, included:</p> <p>* 11/26/13 at 11:37 p.m. - "...new admit...arrived at [6:00 p.m.]...Pt [patient] has 3 pressure wounds on left glute [buttock]...All wounds showed broken</p>	F 314		

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F 314	<p>Continued From page 30</p> <p>skin, no odor, no drainage, no s/s [signs/symptoms] of infection. [C]overed with 2 optifoam bandages...not painful..."</p> <p>* 11/29/13 at 1:42 p.m. - "...2 new pressure ulcers noted, see wound assessment. Pt received an air mattress..., pt is to be turned Q [every] 2 hours..."</p> <p>* 11/30/13 at 9:54 a.m. - "...New pressure ulcer noted on L [left] upper thigh. Optifoam placed..."</p> <p>Note: The left upper thigh PU was not included on the aforementioned W/SHRs.</p> <p>* 12/3/13 at 1:36 p.m. - "...Weekly skin assessment completed. See assessment for wound measurements..."</p> <p>* 12/5/13 at 10:27 a.m. - "...Pt coccyx wound dressings changed, all are healing well and no longer draining. New pink tissue is forming and there are no s/sx [signs/symptoms] of infection..."</p> <p>* 12/10/13 at 12:33 p.m. - "...Wound healing assessment completed, weekly skin check completed..."</p> <p>* 12/17/13 at 10:06 a.m. - "...Skin check completed, no new issues noted. Barrier cream applied to pressure sores on left buttock..."</p> <p>Note: The left upper thigh PU was not mentioned again in the PN. In addition, the facility did not provide W/SHR or any other documentation regarding the stage, size, or condition of left thigh PU.</p> <p>Resident #5 was observed lying in bed as follows:</p> <p>* 12/16/13 at about 3:20 p.m. - asleep on back, head of bed (HOB) up 25-30 degrees;</p> <p>* 12/17/13 at 8:35 a.m. - awake on back and turned slightly to right, HOB up about 30 degrees;</p> <p>* 12/17/13 at 10:25 a.m. - same as above;</p> <p>* 12/17/13 at 12:10 p.m. - awake on back, HOB up about 35 degrees;</p> <p>* 12/17/13 at 2:30 p.m. - awake on back, HOB up 35 degrees; and,</p>	F 314		

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F 314	<p>Continued From page 31</p> <p>* 12/17/13 at 3:00 p.m. - awake on back, HOB up about 30 degrees.</p> <p>On 12/17/13 at 3:00 p.m., the resident's lower torso and thighs were observed when LN #8 and CNA #6 provided incontinence care and the following was noted:</p> <ul style="list-style-type: none"> * An intact, dark reddened area, about 4 cm by 3 cm near the center of the left buttock; * An intact, slightly reddened rounded area, about 1 cm by 1 cm on the left buttock and about 2 inches below the larger area noted above; * An intact, scaly, slightly reddened rounded area, about 1.5 cm by 1.5 cm on the right buttock; * An intact, reddened area at the coccyx, about 0.5 cm by 1 cm; and, * Intact skin on the left thigh. <p>On 12/18/13 at 9:30 a.m., the DNS, who said she used to be a wound nurse, was interviewed about the resident's PU and documentation. The DNS reviewed the 11/26/13 Nursing Admission Assessment and the aforementioned W/SHRs and PNs, then stated, "They are not doing it right. There should be a description for each one [PU] but there's only one each time." She added, "They are using coccyx and sacrum interchangeably." When asked which PU had slough in the wound bed, the DNS said, "I don't know which PU it is." When asked what, if any, interventions were in place when the resident was admitted to the facility, the DNS said that a regular facility mattress was used initially and an air mattress on put in place on 11/29/13. When asked if there was any other documentation about the resident's PUs, the DNS stated, "No."</p> <p>Resident #5, who was admitted with 3 stage II left buttock PU, developed 2 new stage II PU 3 days</p>	F 314			

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*F 314	<p>Continued From page 32</p> <p>after admission and a left thigh PU (which was not staged, sized, or described) 4 days after admission when the facility failed to implement a pressure ulcer care plan and interventions on admission. The facility failed to identify which PU had slough in the wound bed, which by definition meant it had progressed to stage III. The facility also failed to document the characteristics of each PU and used different anatomical site terminology (coccyx and sacrum) interchangeable, which confused the issue even more.</p> <p>On 12/18/13 at about 5:30 p.m., the Administrator and DNS were informed of the findings and the facility's P&P regarding PU were requested at that time.</p> <p>On 12/19/13 at about 11:05 a.m., the DNS provided 3 policies and procedures (P&P), which included Pressure Ulcer Risk Assessment, Pressure Ulcer Treatment, and Support Surface Guidelines.</p> <p>The PU Risk Assessment P&P documentation, under Assessment, included, "Because a resident at risk can develop a pressure ulcer within 2 to 6 hours of the onset of pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. The admission evaluation helps define those initial care approaches."</p> <p>The PU Treatment P&P documentation included, "Preparation 1. Review the resident's care plan to assess for any special needs of the resident..." This P&P also provided definitions and descriptions of different stages of PU, which</p>	*F 314		

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F 314	Continued From page 33 included, "Stage II...Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough... Stage III...Slough may be present..." The Support Surface Guidelines P&P documentation, under Interventions/Care Strategies, included, "Any individual at risk for developing pressure ulcers should be placed on a pressure-reducing device, such as foam, static air, alternating air, gel, or water mattresses when lying in bed. [and] ...If resident has a Stage I or above pressure ulcer, q [every] 2 hour turning is inadequate." The facility did not provide any other information or documentation regarding the PU issue for Resident #5.	F 314			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure the residents' environment was as free of accident hazards as possible. This was true when a lit fireplace did not have a screen or guard in place to protect against possible burns; the restroom	F 323			

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F 323	<p>Continued From page 34</p> <p>across from the North Nurses' Station was found open or unlocked without a call light system in place; and, the commercial dryer in the South Wing laundry room had an accumulation of lint below the drum. These failures created the potential for more than minimal harm for any resident or visitor who touched the hot glass/metal on the fireplace; should any resident use the restroom and not be able to summons assistance if needed; and, the build-up of dryer lint created the potential for a fire hazard. Findings included:</p> <p>1. On 12/16/13 at 3:00 p.m., the survey team entered the facility. A double sided gas fireplace was noted in the main lobby. The fireplace was turned on and flames were observed. One side of the side of the fireplace faced the main entrance. It had a 1 foot wide hearth. The other side of the fireplace that faced a common sitting area. It had a 30 inch wide hearth. Both sides of the fireplace had a glass front and metal surround. The survey team asked the Administrator to touch the glass/metal surface of the fireplace that faced the entrance. The Administrator placed her hand on the glass/metal surface for about 3 seconds and said, "Not hot to the touch."</p> <p>On 12/17/13 at 10:00 a.m., the survey team noticed that the glass/metal surface of the entrance side fireplace was very hot to the touch. The temperature of the glass/metal surface was 109.5 degrees Fahrenheit.</p> <p>At 10:03 a.m., the DNS accompanied the survey team to the entrance side fireplace. At the team's request, the DNS touched the glass/metal surface of the fireplace. The DNS held her fingers to the surface for about 2 seconds and said, "It's</p>	F 323	<p>F 323 POC</p> <p>Identified Resident Action:</p> <p>No Residents have been affected by the deficient practice, but all have the potential to be affected.</p> <p>Other Resident Identifiers:</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>Measures:</p> <p>The facility has placed a screen/guard in front of fireplace to protect against possible burns.</p> <p>The facility has placed self-closure hinges on bathroom doors that do not have a call light in place. The facility has also placed door knobs that are unable to be unlocked on bathroom doors across from north and south nurse station that do not have a call light in place.</p>		

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F 323	<p>Continued From page 35</p> <p>a little hot." The DNS acknowledged that a screen or guard for protection was not in place. The DNS immediately tried to lower the flame on the fireplace; however, she was not successful. The DNS then turned off the fireplace and it remained off throughout the remainder of the survey.</p> <p>2. On 12/16/13 at 3:20 p.m., during an initial tour of the facility with the DNS in attendance, the door to the restroom adjacent to resident room 107 and across the hall from the North Nurses Station was found opened slightly. There was no call system located in the restroom. The DNS shut the door and checked the knob. It was locked.</p> <p>On 12/19/13 at 8:05 a.m., the same restroom door was found open again. LN #8, who was with the surveyor at the time, was asked if the door was supposed to be closed. The LN stated, "Yes. Sometimes they leave it open on nights." When asked if there was a call system in the restroom, the LN stated, "No." The LN shut the door and checked the knob. It was locked.</p> <p>On 12/19/13 at 10:20 a.m., the same restroom was found unlocked. The restroom door was closed and when the surveyor moved the door handle, the door opened. The locking mechanism on the inside handle was in the "out or unlocked position." The surveyor asked LN #8 about the unlocked door. The LN and the surveyor evaluated the door's locking mechanism. With the door shut and locking mechanism in the locked position, the LN opened the door using the key kept at the Nurses Station. When the key was placed in the lock and the handle turned and the door opened, the locking mechanism stayed in place. A person would have to manually turn the</p>	F 323	<p>On 1-21-2014 the facility has re-educated staff regarding cleaning lint filter of commercial dryer after each load of laundry.</p> <p>Monitoring:</p> <p>Starting on 01-24-2014 the Administrator shall audit the bathroom doors across from north and south nurses stating to ensure they are closed and locked once weekly for a 90-day audit period.</p> <p>Starting on 1-24-2014 the Administrator shall audit the cleaning of lint filter of commercial dryer daily for 30 days then twice a week for an additional 60 days, for a total 90 day audit period.</p> <p>Compliance date 02-18-2014.</p>		

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F 323	Continued From page 36 locking mechanism on the inside handle to leave the door "unlocked." The LN stated, "This door is not supposed to be left unlocked." 3. On 12/19/13 at 2:10 p.m., the Administrator accompanied the surveyor during the General Observations of the Facility (Environmental Tour). The following was observed. Resident laundry, bed linens and clothes, was laundered by facility staff. There were two laundry areas, North and South side. The South side laundry room had a large commercial sized washing machine and clothes dryer. The clothes dryer had an open area under the dryer drum. This area will be referred to as the dryer box. The dryer box contained the lint screen. There was a build-up of lint on the lint screen. There was a build-up of lint around the inside left and right side edges of the dryer box. The lint around the edges of the dryer box was approximately 1/2 inch in depth and extended approximately 3 inches from the outer inside edges toward the bottom center of the box.	F 323			
F 325 SS=D	483.25(j) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325			

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F 325	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure Boost (a dietary supplement) was implemented in a timely manner for a resident with weight loss, a process was in place to ensure Boost was provided, and physician orders included the date of the order. This affected 1 of 3 (#5) residents sampled for weight loss. This practice created the potential for more than minimal harm should the resident experience a compromised nutritional status. Findings included: Resident #5 was admitted to the facility on 11/26/13 with multiple diagnosis including pressure ulcers, Diabetes Mellitus, and aftercare for malignant neoplasm. The resident's 11/26/13 Nursing Admission Assessment documented the resident's height was 63 inches and weight was 175.4 pounds (#) on 11/26/13. The resident's 12/3/13 admission MDS coded cognitively intact, no swallowing disorders, no known weight loss or gain in the past 6 months, not on a weight loss regimen, weight 63 pounds, and height 63 inches. Section V0200 documented nutrition status triggered and was care planned. The subsequent 12/9/13 Nutritional Status CAA Worksheet documented, in part, nutritional status triggered due to " high BMI (body mass index) and referral to MD for orders related to nutritional supplements." (Note: Refer to F278, MDS coding accuracy, regarding the inaccurate weight. Using	F 325	F 325 POC Identified Resident Action: Resident # 5 has been discharged from the facility. The resident was re-evaluated for nutritional needs upon re-admission to facility. The resident was re-evaluated to prefer a different kind of nutrition supplement. That supplement was implemented upon re-admission. Upon re-admission, the facility continued all other previously successful nutritional interventions to prevent compromised nutritional status. The facility will continue all other nutritional interventions recommended by Registered Dietician, initiated by Licensed Nursing Staff and or Certified Dietary Manager for prevention of any nutritional decline for all residents and further strengthen the nutrition care process.		

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F 325	<p>Continued From page 38</p> <p>the National Heart Lung and Blood Institute's standard BMI calculator, the resident's BMI was "0.1" for the weight and height of "63." A BMI of less than 18.5 was considered underweight.)</p> <p>The resident's Care Plan documented, in part:</p> <ul style="list-style-type: none"> - Focus area: Has increased calorie, protein, micronutrient and fluid needs related to multiple pressure ulcers and diagnosis of Diabetes Mellitus Type II. Date Initiated: 11/27/13. Revision on: 12/6/13. Revision by: RD. - Goals: Will comply with recommended controlled carbohydrate (CCHO) diet. Will maintain good oral intakes of 50% or more most meals. Wounds to continue towards healing. (Resident #5's name) will maintain weights approximate usual body weight of 160# plus or minus 5#. - Interventions: Provide and serve Yogurt and coffee with morning meal, large protein with meals, no milk or juice with meals per request. Provide, serve diet as ordered. Monitor intake and record every meal. <p>The resident's "All Active Orders for December 2013" included an order for Diet Boost 4 ounces twice a day with meals - "no chocolate/pt [patient] request, refers vanilla..." (Note: The order did not include the date of the order.)</p> <p>Another "All Active Orders for December 2013" contained an order to discontinue (D/C) the Boost. It was noted as "D/C'd" by LN #11 on 12/11/13. The order was:</p> <p>The resident's 12/13 MAR included the aforementioned order for diet Boost. It was dated 12/9/13. The MAR provided evidence that the diet</p>	F 325	<p>Other Resident Identifiers:</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>Measures:</p> <p>Nursing will communicate to dietary department immediately any new order of nutritional supplement and / or change of nutritional supplement times offered or amount.</p> <p>On 1-22-2014 the facility re-educated licensed nursing staff and dietary staff on use of dietary supplements, monitoring success of nutritional supplements.</p> <p>Supplements may be offered to resident on a trial basis for 72 hours as appropriate; care planed, and noted in progress notes and re-evaluated after the 72 hours for effectiveness and need to continue.</p>		

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F 325	<p>Continued From page 39</p> <p>Boost was administered 4 times (12/9 at 4:00 p.m., 12/10 at 10:00 a.m. and 4:00 p.m., and 12/11 at 10:00 a.m.) before it was D/C'd 12/11/13.</p> <p>As documented on the resident's 11/26/13 Nursing Admission Assessment, the resident's weight was 175.4# on 11/26/13.</p> <p>The resident's 11/13 and 12/13 TARs provided evidence the resident's weights were:</p> <ul style="list-style-type: none"> - 11/29/13, 163.3# - 12/3/13, 162.8# - 12/10/13, 155# - 12/17/13, 149.6# <p>Note: The resident lost 25.8# in 20 days: 175.4# to 149.6# from 11/26/13 to 12/17/13. The 25.8# loss resulted in an 14.7% weight loss. Federal guidance at F325 indicated, in part, "...Suggested parameters for...significance of ...weight loss are:... Severe Loss...6 months...Greater than 10%..."</p> <p>On 12/19/13 at 9:40 a.m., the surveyor asked the Dietary Manager (DM) about the D/C'd diet boost order. The DM stated, "We were providing diet Boost 2 times a day with meals, then the order was d/c'd. I told the Registered Dietitian (RD) about it. My hands are tied if it is not on the Physician's Orders [recapitulation orders]." At this time the DM indicated to the surveyor, Dietary Services "could not" provide Boost if it was not on the recapitulation orders.</p> <p>On 12/19/13 at 12:20 p.m., the survey team discussed the D/C'd Boost order with the facility's RD. The RD stated, "On 12/6/13 I made the recommendation for the diet Boost because Boost was what I could get Resident #5 to agree</p>	F 325	<p>Monitoring:</p> <p>Starting on 1-24-2014 the Certified Dietary Manager will monitor the use of supplements and intake documentation records weekly for 90-day audit period</p> <p>Compliance date 02-18-2014.</p>		

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F 325

Continued From page 40

to." The surveyor informed the RD, the order was not implemented until 12/9/13. The RD did not reply. The surveyor asked why the boost was D/C'd on 12/11/13. The RD stated, "I do not know why it was D/C'd."

- At approximately 12:30 p.m., the DM stated, "I came back to work on 12/16/13, after the weekend, and found the Boost order was D/C'd. I talked to the DON. The DON told me the nurses thought Dietary Services were providing Boost so it was D/C'd by nursing." The DM also stated, "I did speak to Resident #5, she said she really did not want it anymore." The survey team asked the DM if the conversation between the DM and the resident was documented. The DM indicated an entry about the resident not wanting or refusing the Boost "was not entered" in the electronic medical record progress notes.

On 12/19/13 at 2:34 p.m., the DM provided the survey team with page 2 of 11 from Resident #5's care plan. One of the Interventions was, "CANCELLED: ...Boost 4 oz...with meals...DietaryRevision on: 12/17/13...by: [DM's name]..."

On 12/19/13 at 2:55 p.m., the surveyor asked LN #11 why the Boost order was D/C'd. The LN stated, "I wrote the D/C order on 12/11/13 after the DM and I talked about who was actually providing the Boost. Was Dietary Services and Nursing Services both providing the Boost? If both services were providing the Boost then [Resident #5] would receive twice as much Boost as ordered. It was conflicting as to who was actually providing the supplement to the resident."

- At 2:57 p.m., the DM again stated, "I did not see the D/C order until Monday, 12/16/13."

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F 325	Continued From page 41 On 12/19/13 at 3:05 p.m., the surveyor asked both the RD and the DM how long the resident received the Boost. The RD said, "If it was on the care plan, the resident received it until it was discontinued on 12/17/13. We could look on the daily diet cards, but those diet cards were shredded." On 12/20/13 at 10:00 a.m., the survey team informed the Administrator the survey team had concerns about a resident who was at risk for compromised nutritional status, lost 25# in a short period of time, and the nutritional care process was conflicting. The facility did not provide additional information regarding the issue.	F 325			
F 329 SS=D	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 without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329			

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F 329	Continued From page 42 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure; - residents did not receive duplicative medications, antipsychotic medication, medication doses did not exceed the recommended maximum amount without adequate indication and adequate monitoring, and - a psychoactive medication care plan was in place for a resident admitted with psychoactive medications; - clarification was obtained for an antibiotic administration time that was not identified on the admission orders, the antibiotic order date was identified on the recapitulation orders, and - the resident's care plan was individualized for use of the antibiotic. This affected 2 of 2 (#s 1 & 2) residents sampled for psychoactive medications and infections. These failures placed Resident #1 at risk for more than minimal harm when the facility did not perform an assessment to determine if continued use of psychoactive medications and an excessive lorazepam dosage were appropriate, adequate monitoring and a psychoactive medication care plan were in place on admission. Resident #2's administration time for Cubicin (antibiotic) was not verified with the physician and the care plan did not include potential antibiotic	F 329	F 329 POC Identified Resident Action: Resident # 1 has been discharged from the facility. Resident # 2 has been discharged from the facility. The resident's IV antibiotic discontinued on 12-23-2013 Other Resident Identifiers: All residents have the potential to be affected by the deficient practice. Measures: On 1-22-2014 the facility has re-educated licensed nursing staff regarding residents admitted on duplicate psychoactive medications to clarify proper dose and diagnosis from physician.		

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F 329	<p>Continued From page 43 adverse reactions. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 11/12/13 and readmitted on 12/3/13 with multiple diagnoses which included other specified rehabilitation, cerebral artery occlusion with infarct (stroke), esophageal reflux, and unspecified abdominal pain.</p> <p>The resident's "TCU/SNF [transitional care unit/skilled nursing facility] Admission Orders, dated 12/3/13, included: * continue clonazepam (brand Klonopin) 0.5 milligrams (mg) by mouth (PO) once daily for anxiety; * continue lorazepam (brand Ativan) 1 mg PO at bedtime, "Label's Comments: for nausea;" * continue lorazepam 0.5 mg PO every 6 hours as needed (PRN) for nausea; and, * continue risperidone 0.25 mg PO twice a day, "Label's Comments: Avoid alcohol." (Note: An indication for use of risperidone was not documented.) and, * prochlorperazine 5 mg PO every 4 hours PRN for nausea/vomiting.</p> <p>The resident's "All Active & Discontinued Orders for December 2013" included: * the clonazepam, lorazepam (scheduled and PRN), risperidone, and prochlorperazine, with the same doses as previously noted. (Note: However, the indication for use of the scheduled and PRN lorazepam was documented as "anxiety," not nausea; and, the indication for use of risperidone was documented as "Anxiety with psychotic features," not "avoid alcohol.") * "Monitor for s/sx [signs/symptoms] of ANXIETY that may include but are not limited to irritability, verbalizations of anxiety, and increased</p>	F 329	<p>On 1-22-2014 the facility re-educated social services designee regarding completion of initial social service assessments as well as follow up monitoring regarding psychoactive medications.</p> <p>On 1-22-2014 the facility re-educated licensed nursing staff on monitoring signs/symptoms for anxiety and anxiety with psychotic features and documenting signs/symptoms of anxiety and anxiety with psychotic features.</p> <p>On 12-20-2013 the facility updated the plan of care to include interventions related to adverse reactions of the IV antibiotic.</p> <p>On 1-22-2014 the facility re-educated licensed nursing staff on input of physician orders and reviewed the five rights of medication administration.</p> <p><i>telephone call 2.21.14 13:45 hrs Rev DON A psychoactive medication care plan</i></p>		

*will be developed on admission for those residents on psychoactive medications.
Jm*

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F 329	<p>Continued From page 44</p> <p>restlessness. Document number of episodes Q [every] shift. - twice daily Everyday."</p> <p>On 12/18/13 at 2:30 p.m., the Medical Records (MR) nurse assisted the surveyor to review the resident's electronic medical record (EMR). The review revealed that anxiety and/or anxiety with psychotic features was not included in the list of medical diagnoses or documented in an 11/12/13 Discharge (DC) Summary from a local hospital. (Note: The DC Summary documented chronic nausea as a diagnosis.)</p> <p>The MR nurse provided a care plan, which she said was initiated when the resident was admitted. This care plan identified the following focus areas, nutrition risk and ADLs (toileting, transfers, mobility, and personal hygiene). This care plan did not include the use of psychoactive medications.</p> <p>The MR nurse provided a psychoactive medication use care plan and stated, "It was just revised." This care plan was documented as initiated/created 12/17/13. It identified the focus area, "...uses psychotropic medications (Risperidone [sic], Clonazepam [sic], Lorazepam [sic]) r/t [related to] history of anxiety disorder." This care plan was initiated/created 2 weeks after the resident was admitted and received clonazepam, lorazepam, and risperidone.</p> <p>The resident's MAR, dated 12/1-12/31/13, documented, in part:</p> <ul style="list-style-type: none"> * clonazepam - administered daily from 12/4-12/17/13; * lorazepam 1 mg - administered every bedtime 12/3-12/16/13; * PRN lorazepam 0.5 mg - administered 12/5 	F 329	<p>Monitoring:</p> <p>Starting on 1-24-2014 the Director of Nursing will monitor 5 random antipsychotic medications to review documentation for signs/symptoms of anxiety and anxiety with psychotic features weekly for 30 days and 5 random audits monthly for an additional 60 days for a 90 day total audit period.</p> <p>Starting on 1-24-2014 the Director of Nursing monitor 5 random IV antibiotic care plans weekly for 30 days and 5 random audits monthly for an additional 60 days for a 90 day total audit period to ensure they include interventions related to adverse reactions of the IV antibiotic.</p> <p>Starting on 1-24-2014 the Administrator will monitor 5 random Social Service Assessments are completed weekly for a 90 day audit period.</p> <p>Compliance date 02-18-2014.</p>		

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F 329	<p>Continued From page 45</p> <p>twice, 12/7-12/9 once each day, 12/10 twice, 12/11 once, 12/12 and 12/13 twice both days, 12/14 and 12/15 once both days, and 12/16 twice. The scheduled lorazepam dose of 1 mg daily plus the potential for 2 mg/day if the PRN lorazepam 0.5 mg dose was given every 6 hours (4 times/day) created the potential for the resident to receive more than 2 mg/day.</p> <p>* "Monitor for s/sx [signs/symptoms] of ANXIETY that may include but are not limited to irritability, verbalizations of anxiety, and increased restlessness. Document number of episodes Q [every] shift. Order date: 12/12/2013 twice daily." This monitor was initiated 9 days after the resident was admitted and received the 2 benzodiazepines and risperidone. In addition, a monitor of "anxiety with psychotic features" was not included on the MAR, or TAR, and none was provided.); and,</p> <p>* prochlorperazine - administered 1 to 3 times daily 12/5-12/17.</p> <p>Adjacent to the "Monitor for s/sx..." entry on the MAR, in a column labeled "Hours" were 4 boxes. Two of the boxes documented "S/Sx [signs/symptoms]" and 2 boxes contained a time, 5 a.m. or 5 p.m. One of the time boxes was below each of the S/Sx. Adjacent to the hours column were 31 columns numbered 1-31 (represented the days of the month). The days columns also contained 4 boxed areas which correlated to the "S/Sx" and times.</p> <p>The MAR documentation regarding the number of episodes of "s/sx of anxiety" was:</p> <ul style="list-style-type: none"> * 12/12 - 1 at 5:00 p.m. ; * 12/13 - 7 at 5:00 a.m. and 1 at 5:00 p.m.; * 12/14 - 0 at 5:00 a.m. and 5:00 p.m.; * 12/15 - 0 at 5:00 a.m. and 1 at 5:00 p.m.; 	F 329		

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F 329	<p>Continued From page 46</p> <p>* 12/16 - 0 at 5:00 a.m. and 1 at 5:00 p.m.; and, * 12/17 - 1 at 5:00 a.m.</p> <p>There was no indication as to which s/sx of anxiety (irritability, verbalizations of anxiety, or increased restlessness) these numbers of episodes referred.</p> <p>On 12/18/13, at 3:00 p.m., the MR nurse was asked if there was any other behavior monitor documentation. She said, "No."</p> <p>Nurses Notes (NN), dated 12/4/13 at 12:55 p.m.-12/18/13 at 2:53 p.m., included: * 12/8 at 10:52 a.m. - "...c/o [complaint of] nausea medicated with positive results..." * 12/9 at 10:32 a.m. - "...c/o nausea medicated with positive results..." * 12/10 at 2:33 p.m. - "...c/o pain, nausea, and anxiety. Medicated with positive results..." * 12/15 at 10:38 a.m. - "...Patient requests medication for pain/nausea...received..." * 12/16 at 3:25 p.m. - "...Patient requests medication for pain/nausea...received..." * 12/17 at 11:53 a.m. - "...medicated for nausea/anxiety/pain pm with positive results..."</p> <p>There was no other documentation of anxiety, s/sx of anxiety, or any behaviors in any of the other NN for the resident.</p> <p>The surveyor requested documentation of any assessments regarding the 3 psychoactive medications. The MR nurse provided a "Psychotropic Drug Use Assessment," with an "Effective Date: 12/3/2013 [9:36 p.m.]."</p> <p>The Psychotropic Drug Use Assessment documentation included, "Does resident have a diagnosed psychiatric disorder? Yes. If yes, specify[:] Anxiety. Is resident currently receiving</p>	F 329			

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F 329	<p>Continued From page 47</p> <p>any of the following classes of medications? Antipsychotic [blank]...Antianxiety [checked]. If yes to any of the above, specify medication(s):] Clonazepam [sic], Lorazepam [sic]...If yes to "Antianxiety," list patient symptoms to monitor for:] Aggitation [sic], irritability [sic]. Does physician's order include reason drug is prescribed, dosage, and frequency it is to be taken? Yes. Indicate reason(s):] Anxiety. How long has the resident been receiving the medication(s)? years. Is medication(s) a temporary treatment program? no...Based on the above review, are there cognitive, behavior and/or mood factors that are impacting the resident's ability to function? No."</p> <p>Note: There was no indication regarding who/which discipline completed the assessment. In addition, the use of risperidone was not noted on the document.</p> <p>On 12/18/13 at 3:30 p.m., the DNS was asked about the resident's duplicative therapy with 2 benzodiazepines, risperidone, and behavior monitoring. The former DNS was present and identified herself as a consultant. Regarding duplicative therapy, the former DNS stated, "Upon admission we continue ordered meds and begin data collection and monitoring for s/sx of anxiety. Then we communicate the findings and results to the physician by 2-3 weeks after admit to request a rationale to continue or decrease or discontinue one or both meds." Regarding behavior monitoring, the DNS stated the monitor for anxiety on the resident's MAR was the monitor. She and the former DNS were adamant that the behavior monitor was adequate. In addition, the former DNS stated that the same behavior monitor was for the use of risperidone. The former DNS agreed, however, that no</p>	F 329			

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F 329	<p>Continued From page 48</p> <p>specific behaviors were identified regarding psychotic features.</p> <p>On 12/18/13 at 4:45 p.m., the DNS provided the resident's Medical Social Services (SS) Initial Comprehensive Assessment and Plan of Care, dated 12/17/13. It documented no nursing or dietary problems and no social interaction or mental/emotional status deficits. Attached to the assessment was an unnamed page which documented, "Anti-anxiety: clonazepam, Lorazepam [sic], Risperidol [sic]; Symptoms: Agitation [sic], irritability Denies any increase. BEHAVIOR TRACKING[:]; Date: Symptom occurrence: blank [in 2 areas]."</p> <p>On 12/18/13 at 4:50 p.m., the DNS provided 2 notes by the consultant pharmacist to the resident's attending physician. Both were dated 12/18/13.</p> <p>One of the notes by the consultant pharmacist addressed the use of clonazepam and lorazepam. It documented, in part, "Current orders include Clonazepam [sic]...Because of an increased risk of confusion, sedation, falls, and fractures, it (and all long acting benzodiazepines) is considered to be potentially inappropriate...and is not suggested for use in the nursing home resident...also has routine and prn orders for Lorazepam [sic]. The use of more than one benzodiazepine greatly increases the potential for side effects and negative outcomes..."</p> <p>The second note by the consultant pharmacist addressed lorazepam. It documented, in part, "The resident's prn Lorazepam [sic] order allows for dosing that is higher than the 2 mg/day CMS (Center for Medicare/Medicaid Services)</p>	F 329			

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F 329	<p>Continued From page 49</p> <p>maximum recommended dose for nursing home residents..."</p> <p>On 12/19/13 at 8:30 a.m., the Social Services Designee (SSD) was asked about his involvement with residents who were on psychoactive medications, including duplicative medications. The SSD stated, "I review medications on admission and inform the DON of my discussion with the resident about their medications."</p> <p>Note: The Medical SS Initial Assessment on 12/17/13 was 2 weeks after the resident's admission.</p> <p>Resident #1 was admitted to the facility with orders in place for 2 benzodiazepines (lorazepam and clonazepam), a lorazepam dose that exceeded the recommended maximum dose, and risperidone. However, the resident was placed at risk for more than minimal harm when the facility did not perform an assessment to determine if continued use of the psychoactive medications and the excessive lorazepam dosage was appropriate. Also, the facility did not develop a care plan on admission to address the use of psychoactive medications. The behavior monitor was vague and did not identify which behavior was monitored. In addition, no target behaviors for anxiety for psychotic features were identified.</p> <p>On 12/19/13 at about 5:00 p.m., the Administrator and DNS were informed of the findings. However, no other information or documentation was received from the facility which resolved the issue.</p> <p>2. Resident #2 was admitted to the facility for rehabilitation and with multiple diagnoses</p>	F 329			

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F 329	<p>Continued From page 50 including Staphylococcus epidermidis.</p> <p>The resident's 12/3/13 admission MDS coded independent cognitive skills and received antibiotic therapy.</p> <p>The resident's admission orders included a 11/25/13 order for Cubicin 800 milligrams intravenous every day for 6 weeks (mg IV qd x6 weeks).</p> <p>The resident's "All Active Orders for December 2013" (recapitulation) contained the order, Cubicin 800 mg IV - "at bedtime" For 6 weeks. Infuse 800 mg qd x6 weeks. Note: There was no Cubicin "order date" on the recapitulation orders. Please refer to F309 as it related to the facility's policies and procedures for orders. Note: In addition, the resident's admission orders did not order a specific time of day for the medication administration.</p> <p>The resident's December 2013 electronic MAR (e-MAR) documented in the far left hand column: Cubicin - Intravenous Dose: 800 mg Order Date: 11/26/13 "at bedtime" Infuse 800 mg qd x6 weeks, Wound Infection Solution Reconstituted. The "Hours" column documented "1100 [11:00 a.m.)."</p> <p>a. On 12/17/13 at 4:45 p.m., the DON was asked why the resident's above identified e-MAR documented both of the following: in the far left hand column, "at bedtime" and in the Hours column, "1100" for Cubicin administration. The DON stated, "When the resident was admitted, Cubicin was ordered. Nursing staff thought 'at bedtime' would be the most convenient time to</p>	F 329			

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F 329	<p>Continued From page 51</p> <p>administer the antibiotic. However, when nursing staff attempted to administer the medication 'at bedtime' on the first day the resident was here, the resident told the nurse 'I get it at [Cubicin] 11:00 a.m.' " The DON went on to state, "Based on what the resident said about the time the medication was received while at the hospital, we put 11:00 a.m. on the e-MAR for the administration time."</p> <p>The surveyor asked the DON if the facility made an attempt to contact the resident's physician when the resident was admitted to determine when the Cubicin should be administered. The DON indicated the facility "did not attempt" to contact the resident's physician to determine what time of day the medication should be administered.</p> <p>The surveyor then asked what would have happened in the event the resident was cognitively impaired and would not have been able to tell nursing staff the medication was already administered on the day of admission. The DON did not have a reply.</p> <p>Note: The potential existed on the day of admission the resident would have received Cubicin two times. Two Cubicin administrations in one day would have resulted in an excessive dose for the resident.</p> <p>Note: The survey team informed the DON there was a concern the original Cubicin order did not include the administration time of "at bedtime." However the recapitulation orders and the e-MAR documented "at bedtime" and at "11:00 a.m."</p> <p>b. The resident's care plan documented in part: - Focus: (Resident #2) is on IV medications</p>	F 329			

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F 329	<p>Continued From page 52</p> <p>(Cubicin) related to wound infection." - Focus Goal was, "[Resident #2] will have not have {sic} any complications related to IV therapy through the review date." - The three Focus Interventions were: --check dressing at site daily --monitor/document/report to MD prn s/sx (medical doctor as needed for signs and or symptoms) of infection at the site: Drainage, Inflammation, Swelling, Redness, Warmth. --Monitor/document/report to MD prn s/sx of infiltration at the site; Edema at the insertion site, Taut or stretched skin, Blanching or coolness of the skin, Slowing or stopping of the infusion, Leaking of IV fluid out of the insertion site. Note: The above interventions did not include interventions for adverse reactions or nursing considerations for the administration of Cubicin.</p> <p>On 12/18/13 at 7:55 a.m., the survey team discussed with LN #5, the care plan addressed s/sx at the IV site but did not include interventions related to adverse reactions to the medication or nursing considerations. At this time, the survey team and the LN reviewed the Cubicin Indications and Dosages, Adverse Reactions and Nursing Considerations as identified in the 2014 Nursing Drug Handbook.</p> <p>The 2014 Nursing Drug Handbook documented the indications and dosages were either 6 mg per kilogram of body weight (6mg/kg) or 4mg/kg. The resident's current weight was 237.0 pounds. Pounds divided by 2.2 kg per pound equaled 107.7 kg body weight. The dosages were calculated as follows: -107.7 multiplied by 6 mg equaled 646 mg. -107.7 multiplied by 4 mg equaled 430.8 mg.</p>	F 329		

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F 329	<p>Continued From page 53</p> <p>Note: The resident received 800 mg every day which was 154 mg over the dosage of 6 mg/kg of body weight and 369.2 mg over the dosage of 4 mg/kg of body weight.</p> <p>Adverse Reactions included, in part, abdominal pain, fever, sore throat, cough, confusion, dizziness, headache, constipation, diarrhea, and fungal infections. Nursing Considerations included, in part, Watch for evidence of Clostridium difficile-associated diarrhea and treat accordingly and Monitor for superinfection because drug may cause overgrowth of non-susceptible organisms.</p> <p>On 12/18/13 at 10:30 a.m., the survey team discussed with LN #4 the resident's care plan did not address potential adverse reactions of the medication. The LN reviewed the 2014 Nursing Drug Handbook with the surveyors and acknowledged the 800 mg dosage of Cubicin "was a large dose and the care plan should be individualized."</p> <p>Note: The resident's care plan was not individualized for the use of the antibiotic medication, Cubicin.</p> <p>On 12/18/13 at 11:15 a.m., LN #4 provided a 11/25/13 laboratory report. The organism was identified as Staphylococcus epidermidis.</p> <p>The resident was admitted with an order for the antibiotic, Cubicin, and the dosage of the antibiotic was above the 6mg/kg and 4mg/kg identified in the 2014 Nursing Drug Handbook. The order date for the antibiotic was not identified on the resident's recapitulation orders. The nursing staff attempted to administer the</p>	F 329			

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F 329	Continued From page 54 antibiotic without contacting the physician to determine the specific time of day to administer the medication. The resident's care plan was not individualized for adverse reactions and nursing considerations related to the use of the antibiotic.	F 329	F 332 POC		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility had a 7.69 percent medication error rate. This was true for 2 of 26 medications which affected 2 of 10 residents (#s 11 and 12) during medication pass observations. The failure created the potential for more than minimal harm if residents received less than optimum benefit from the prescribed medications. Findings include: 1. On 12/17/13 at 8:30 a.m., LN #8 was observed as she poured then administered 7 oral medications, which included Calcium 500 + (plus) D 200 I.U. (international units) 1 tablet, for Resident #11. Review of the resident's All Active Orders for December 2013 revealed the calcium order was,	F 332	Identified Resident Action: Resident #11 and #12 has been discharged from the facility. Other Resident Identifiers: All residents have the potential to be affected by the deficient practice. Measures: On 1-22-2014 the facility re-educated the licensed nursing staff regarding the 5 rights of medication administration. Monitoring: Starting on 1-24-2014 the Director of Nursing will monitor a medication pass weekly for a 90-day audit period. Compliance date 02-18-2014.		

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F 332	<p>Continued From page 55</p> <p>"Super Calcium 600 + D 400...1 tab[let] [by mouth] BID [twice/day]."</p> <p>The resident's MAR, dated 12/1/13-12/31/13, contained documentation that Super Calcium 600 + D 400 was administered on 12/14/13 at 8:00 p.m., twice on 12/15 and 12/16, and at 8:00 a.m. on 12/17/13.</p> <p>On 12/17/13 at 12:15 p.m., LN #8 was asked about the discrepancy between the order for Super Calcium and the lower dose of calcium + D administered to the resident that morning. The LN took a medication card labeled Calcium 600 + D 400 out of the medication cart drawer, showed it to the surveyor, and stated, "It came in about 11 this morning. I gave a little less dose because I didn't want her to miss it." When asked if there was an order for the lower dose of calcium + D, the LN pointed to the label on the medication card and said "That's the order." The LN added, "If it was for blood pressure or something like that I would get an order."</p> <p>2. On 12/18/13 at about 8:10 a.m., LN #9 was observed as she poured MiraLax 17 grams in the dispensing cap off the MiraLax bottle, 2 other oral medications, an injectable medication, and an inhaled medication then took them to Resident #12's room. The LN placed the dispensing cap with the MiraLax on a barrier on the resident's over bed table, then she administered all of the medications, except the MiraLax. The LN asked the resident what liquid she wanted to mix with the MiraLax. The resident said water. The LN returned to the medication cart, mixed the MiraLax in about 2 1/2 ounces of water, then, returned to the resident's room, placed the small plastic glass with MiraLax in water on the over</p>	F 332			

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F 332	Continued From page 56 bed table in front of the resident, informed the resident what it was, then left the room before the resident even picked up the glass (Refer to F 176, Medication Self-Administration, for details). Immediately upon return to the medication cart by the nurses' station, LN #9 was asked how much water she mixed with the MiraLax. The LN stated, "I don't know. That's about how much I always use." To mark the approximate level of liquid that was used, the surveyor drew a line on a clean plastic glass identical to the one the LN had used. The LN agreed the line was in the right place. Using a 30 milliliter (1 ounce) medicine cup, the LN poured 2 and 1/2 medicine cups, or 2 and 1/2 ounces, of water to the line in the plastic glass. She stated, "I didn't use enough." The LN read the directions on the MiraLax bottle then said, "Four to 8 ounces." The LN also read the directions on the resident's pharmacy label on the MiraLax bottle and confirmed it said to mix in 8 ounces. On 12/19/13 about 5:00 p.m., the Administrator and DNS were informed of the issue regarding the medication error rate. No other information was received from the facility which resolved the issue.	F 332		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 356		

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F 356	<p>Continued From page 57</p> <p>resident care per shift:</p> <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, review of the nurse posting format, and staff interview, it was determined the facility failed to update the nurse posting at the beginning of each day. The format did not include the actual hours worked of licensed and unlicensed nursing staff, was not in a readable format, and was not in a prominent place readily accessible to residents and visitors. This affected 9 of 10 (#s 1-9) sampled residents and had the potential to affect all residents who resided in the facility and any visitors in the facility. Findings included:</p>	F 356	<p>F 356 POC</p> <p>Identified Resident Action:</p> <p>No residents have been affected by the deficient practice, but all have the potential to be affected.</p> <p>Other Resident Identifiers:</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>Measures:</p> <p>The facility will post the nurse staffing data at the beginning of each shift in a clear and readable format. The information will be placed in a prominent place readily accessible to residents and visitors in front lobby area.</p> <p>Monitoring:</p> <p>The Administrator will audit placement of information weekly for a 90-day audit period.</p> <p>Compliance date 02-18-2014.</p>		

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F 356	Continued From page 58 On 12/17/13 at 11:20 p.m., the surveyor asked the Administrator where the nurse staffing was posted. The Administrator took the surveyor to the North side nurses station. The Administrator pointed to an 8 by 11 inch paper located in a protective plastic sleeve taped to the inside of a divider wall of the North side nurses station. The surveyor stood five feet away from the posting. The font was too small to read from 5 feet away. The date at the top of the posting was, "12/16/13." The format identified single digit numbers for registered nurses, licensed practical nurses, and certified nurse aides. The surveyor verified with the Administrator the single digit numbers were for the number of staff working, not hours worked. At this time the surveyor asked the Administrator if nurse staffing was posted in any other location in the facility. The Administrator said, "No." The surveyor and the Administrator reviewed the Federal guidance at F356 which required the posting at the beginning of each day, in a readable format, and in a prominent place readily accessible to residents and visitors.	F 356			
F 371 SS=F	On 12/20/13 at 9:45 a.m., the Administrator and the DON were informed of the finding. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371			

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F 371	Continued From page 59 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the ice machine and the overhead hood were cleaned on a schedule to prevent the mineral deposits, dust and debris accumulation or build-up. This affected 9 of 10 (#s 1-9) sampled residents and had the potential to affect all residents who dined in the facility. This practice created the potential for contamination of food contact surfaces and exposed residents to potential sources of disease causing pathogens. Findings included: On 12/16/13 at 3:06 p.m., the Dietary Manager (DM) accompanied the surveyor during the initial tour of the facility's kitchen. The following was observed: 1. At 3:10 p.m., the inside surface of the ice machine had an accumulation of what appeared to be hard water mineral deposits. These deposits were located on the ice machine's right inside surface above where the ice was stored. The DM said the ice machine was cleaned "about once a month." 2. At 3:30 p.m., one of three fire extinguisher nozzles had visible brown dust and debris accumulation on the red, plastic end portion directly above the range. 3. At 3:31 p.m., the overhead hood inside stainless steel surface had visible debris on the surface directly above the range. The DM stated, "The debris is from the sealant where the	F 371	F 371 POC Identified Resident Action: Resident # 1, #2, #3, #4, #5, #6, #8 and #9 have been discharged from the facility. Resident #7 was not affected by the deficient practice, but had the potential to be affected. Other Resident Identifiers: No residents identified or directly affected by practice. Measures: The facility has contacted the contracted cleaning company regarding the ice machine maintenance. The company has been re-educated by the Ice-O-Matic Instillation, Start-up, and maintenance manual on ICE machine cleaning and sanitizing instructions.		

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F 371	Continued From page 60 stainless steel panels meet. When we clean the inside of the hood, pieces of the sealant come loose." The DM touched a piece of the debris. The debris fell onto the top of the range. At this time there were no food items located on the top of the range. The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart 601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils indicated, "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch... (C) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris...(5) At any time during the operation when contamination may have occurred." Subpart 602.13, Nonfood-Contact Surfaces, indicated, "Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues." On 12/20/13 at 9:45 a.m., the Administrator and the DON were informed of the concerns.	F 371	The facility has initiated a weekly deep cleaning procedure for the overhead hood including fire extinguisher nozzles, light covers, vents, etc. The facility has cut the sealant flush with the panels to prevent sealant from coming loose when cleaning. Monitoring: Starting on 1-24-2014 the Certified Dietary Manager will monitor the ice machine to prevent mineral deposits weekly for a 90-day audit period. Starting 1-24-2014 the Certified Dietary Manager will monitor the deep cleaning procedure of overhead hood weekly for a 90-day audit period. Starting on 1-24-2014 the Certified Dietary Manager will monitor the overhead hood sealant for a 90-day audit period. Compliance date 02-18-2014.		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431			

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F 431	<p>Continued From page 61</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure (P&P) review, it was determined the facility failed to ensure controlled medications were properly stored and expired medication was not available for resident use. This was true for 2 of 2 medication rooms. The failures created the potential for diversion of controlled medications that were not stored in separately locked, permanently affixed compartments and could have resulted in inadequate pain, nausea, or anxiety control for any resident if one or more of the controlled medications were not available</p>	F 431	<p>F 431 POC</p> <p>Identified Resident Action:</p> <p>No residents have been affected by the deficient practice, but all have the potential to be affected.</p> <p>Other Resident Identifiers:</p> <p>No residents identified or directly affected by practice.</p> <p>Measures:</p> <p>The facility has placed E-Kit in a locked cabinet that is located in the locked medication room.</p> <p>On 1-22-2014 the facility re-educated licensed nursing staff regarding policy and procedure of discarding expired medications.</p>		

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F 431	<p>Continued From page 62</p> <p>when needed; and, for sub-optimal efficacy for any resident who may have received expired bacteriostatic sodium chloride. Findings included:</p> <p>1. a) On 12/19/13 at 1:50 p.m., the North Wing Medication room was inspected with LN #8 in attendance. A tackle box, approximately 18 inches tall by 10 inches wide by 18 inches long, labeled as E-Kit (emergency kit) #20 was noted on the counter. A paper taped to the front of the tackle box, labeled "Main E-Kit Box Locator by Generic Name," listed the medications in each section of the E-Kit. A zip-tie secured the top and bottom sections of the E-Kit together. Three "trays" were in the bottom section of the E-Kit. Tray 3 contained numerous controlled medications.</p> <p>The controlled medications in tray 3 included:</p> <ul style="list-style-type: none"> * alprazolam (brand Xanax, for anxiety) 0.5 milligrams (mg) - 10 tablets (tabs); * diazepam (brand Valium, for anxiety) 5 mg - 5 tabs; * diazepam 5 mg/ml (milligrams/milliliter) - 2 vials for injection; * Fentanyl 25 microgram (mcg) patches - 4 (long acting opioid analgesic, for pain); * hydrocodone/APAP 5/500 mg (brand name Lortab, for pain) - 10 tabs; * hydrocodone/APAP 7.5/500 mg - 10 tabs; * lorazepam (brand Ativan, for anxiety) 0.5 mg - 10 tabs; * lorazepam 2 mg/ml - 2 vials for injection; * methadone (brand Methadose, opioid analgesic, for pain) 10 mg - 10 tabs; * morphine sulfate ER (extended release) (brand MS Contin, opioid analgesic, for pain) 15 mg - 10 tabs; * morphine sulfate 10 mg/ml - 2 vials for injection; 	F 431	<p>Monitoring:</p> <p>Starting on 1-24-2014 the Administrator will perform weekly audits to ensure E-Kit is in a locked cabinet in the locked medication room for a 90-day audit period.</p> <p>Starting on 1-24-2014 the Director of Nursing will perform weekly audits to ensure no expired medications for a 90-day audit period.</p> <p>Compliance date 02-18-2014</p>		

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F 431	<p>Continued From page 63</p> <ul style="list-style-type: none"> * morphine sulfate 20 mg/ml - 6 syringes for oral administration; * hydrocodone/APAP 5/325 mg (brand Norco, for pain) - 15 tabs; * hydrocodone/APAP 7.5/325 mg - 15 tabs; * oxycodone/APAP 5/325 mg (brand Percocet, for pain) - 15 tabs; * oxycodone/APAP 10/325 mg - 10 tabs; * oxycodone (brand Oxy-IR, for pain) 5 mg - 20 tabs; * oxycodone 10 mg - 20 tabs; and, * zolpidem (brand Ambien, hypnotic) 5 mg - 10 tabs; <p>When asked if it was possible someone could cut or break the zip ties or simple pick up the E-Kit and walk off with it, LN #8 stated, "Yes." The LN stated, "The pharmacy replaces the E-Kits every 3 days." She added, "I guess we could take it (tray 3) out (of the tackle box) and put in a cabinet." A lock was noted on all of the cabinets in the room.</p> <p>b) On 12/19/13 at 2:15 p.m., the South Wing Medication room was inspected with LN #11 in attendance. A tackle box, similar to the one described in a) above, was noted on the counter. This tackle box, labeled E-Kit #24, contained numerous controlled medications in tray 3, again as noted in a) above. When asked if it was possible someone could cut or break the zip ties or simple pick up the E-Kit and walk off with it, LN #11 stated, "Yes, I suppose they could."</p> <p>On 12/19/13 at 3:10 p.m., when asked about storage of controlled medications, the DNS stated, "The room is permanently affixed." When asked if it was possible that someone could pick up an E-kit and walk off with it, the DNS stated,</p>	F 431			

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F 431	<p>Continued From page 64</p> <p>"Not without being seen." (Note: The medication rooms were locked, however, the controlled medications were not secured in a locked cabinet or drawer. Should the medication room door not close properly for any reason, the controlled medications in the tackle box E-Kits would not be secured at all. In addition, Per LN #8, someone did bring in and take out the E-Kits every 3 days.)</p> <p>On 12/19/13 at about 5:00 p.m., the Administrator was informed of the issue and the facility's P&P regarding storage of controlled medication was requested.</p> <p>On 12/20/13 at 9:30 a.m., the DNS provided an Emergency Pharmacy Services and Emergency Kits P&P. It documented, in part, "Schedule II medications that are part of the emergency medication supply shall be stored in a locked cabinet or locked drawer separate from non-controlled medications."</p> <p>3. On 12/18/13 at 1:20 p.m., during a brief inspection of the South Wing Medication room with LN #10 in attendance, 4 expired 30 milliliter bottles of Bacteriostatic 0.9% sodium chloride were found. One of the bottles expired in June 2013, the other 3 expired in August 2013. The LN stated, "I'm gonna put them in the sharps container."</p> <p>On 12/19/13, the Administrator and DNS were informed of the issue.</p> <p>No other information or documentation was received from the facility which resolved the controlled medication storage and expired medication issues.</p>	F 431			

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F 441 F 441 SS=F	Continued From page 65 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441 F 441	F 441 POC Identified Resident Action: Resident #5 bed linens have been changed and pillows have been cleaned and room has been deep cleaned. Resident # 13 has been discharged from the facility. Other Resident Identifiers: All residents have the potential to be affected by the deficient practice. Measures: On 1-21-2014 and 1-22-2014 the facility re-educated the licensed nursing staff regarding proper hand hygiene and infection control policies and procedures. On 1-21-2014 and 1-22-2014 the facility re-educated the licensed nursing staff regarding proper storage and emptying of urinals and infection control policies and procedures.		

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F 441	Continued From page 66 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of policies and procedures (P&P), it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 1 of 9 sample residents (#5), 1 random resident (#13), 2 of 2 laundry facilities (North and South wing laundry rooms), and any CNA who performed laundry services. These failures created the potential for the growth and spread of infection causing organisms and placed all residents at risk for infection when: - staff did not perform hand hygiene after peri-care for Resident #5; - a used, uncapped urinal was on Resident #13's over bed table; - wet towels were left in the South Wing clothes washing machine for hours; - CNAs who were providing resident cares, did not use personal protective equipment when performing laundry duties; - CNAs provided care to residents and performed laundry duties, such as washing dirty clothing and linens, during the same shift; - clothes washing machines were not sanitized between loads; and, - laundry room hot water temperatures were not monitored for sanitizing temperatures. Findings included: 1. On 12/17/13 at 3:00 p.m., LN #8 and CNA #6 were observed as they provided incontinence care and CNA #6 applied a barrier to Resident #5 buttocks. After that, neither the LN or CNA removed their used gloves before they repositioned the resident in bed, the CNA handled	F 441	On 1-21-2014 and 1-22-2014, the facility re-educated the licensed nursing staff regarding laundry procedures. The facility has supplied the staff with appropriate P.P.E. (i.e., gloves and apron) available for staff to wear while sorting linens. The facility has contacted EcoLab company to install sanitizing agent AdvaCare 120 Sanitizer/Sour to be added to each commercial laundry batch. The facility has evaluated laundry process of linens left in machine. The Long Term Care Survey October 2010 Edition pp-766 state in part "It is recommended that damp linen is not left in machines overnight." Facility will monitor time laundry wash cycle is started and time laundry is moved to dryer. The facility will initiate weekly water temperature logs of washing machine to ensure appropriate temperature is achieved.		

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F 441	<p>Continued From page 67</p> <p>the resident's bed control and clipped the call light to the sheet, and the LN adjusted 2 pillows under the resident's head. Afterward, the LN and CNA removed the used gloves and washed their hands.</p> <p>Immediately afterward, when asked about the hand hygiene issue, CNA #6 nodded her head yes and she stated, "Okay."</p> <p>On 12/19/13 at about 5:00 p.m., the Administrator and DNS were informed of the infection control issue. The facility did not provide any other information regarding the issue.</p> <p>2. On 12/18/13 at 7:45 a.m., an uncapped urinal with approximately 500 milliliters of urine was observed on Resident #13's over bed table when LN #9 entered the room, turned on the light, and informed the resident it was time for a blood glucose check. A medicine cup and a water mug were also on the over bed table. The medicine cup, which contained one medication (please refer to F176 for details regarding self-administration of medications), touched the handle of the urinal. And, the water mug was about 2 inches from the urinal. The LN performed the blood glucose check then she emptied the urinal. However, the LN placed the urinal back on the over bed table. When asked about the urinal on the over bed table, she stated, "I don't know. I haven't paid attention."</p> <p>On 12/19/13 at about 5:00 p.m., the Administrator and DNS were informed of the infection control issue. The facility did not provide any other information regarding the issue.</p> <p>3. On 12/19/13 at 2:10 p.m., the Administrator</p>	F 441	<p>Monitoring:</p> <p>Starting on 1-24-2014 the Director of Nursing will perform 1 random incontinence care audit weekly for a 30 day audit period, then 5 random incontinence care audits monthly for an additional 60 day audit period.</p> <p>Starting on 1-24-2014 the Administrator will perform 5 random audits weekly to ensure urinal use and storage for a 90-day audit period.</p> <p>Starting on 1-24-2014 the Administrator will perform a weekly audit to ensure PPE is available for staff in the laundry area for a 90-day audit period.</p> <p>Starting on 2-18-2014 the Administrator will monitor wash cycle logs weekly for a 90 day audit period.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2013
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F 441	<p>Continued From page 68</p> <p>accompanied the surveyor during the General Observations of the Facility (Environmental Tour). The following was observed.</p> <p>- In the South side laundry room, the commercial washing machine had what appeared to be a load of wet, white towels. The surveyor asked the Administrator who did the laundry. The Administrator stated, "The CNAs." The surveyor asked the Administrator how the CNAs could do laundry and provide resident cares at the same time? The Administrator stated, "CNAs on night shift do the laundry." The surveyor pointed to the wet towels in the washing machine and asked when the load of towels was put in the machine? The Administrator stated, "That has probably been in there since the night shift."</p> <p>4. On 12/19/13 at 3:15 p.m., the surveyor asked CNA #6 about doing laundry. The CNA said she did the laundry before. The surveyor, CNA, and the Administrator went into the North side laundry room. There was a household sized washing machine and dryer in this laundry room. The washing machine was in use during this observation. The surveyor asked CNA #6 what protective equipment was used when the CNA washed residents' laundry. The CNA stated, "I put gloves on only and make sure my clothes do not become soiled from the laundry."</p> <p>5. On 12/19/13 at 3:30 p.m., the surveyor, Administrator, and CNA #6 were in the North side laundry room. The surveyor asked the CNA if the washing machine was sanitized between loads. CNA #6 replied, "No, I don't do that and haven't heard [anything about doing that]."</p> <p>On 12/19/13 at 3:20 p.m., the surveyor informed the Administrator of the following concerns:</p>	F 441	<p>Starting on 1-24-2014 the Administrator will review the weekly water temperature log for a 90-day audit period.</p> <p>Compliance date 02-18-2014.</p>	

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F 441	<p>Continued From page 69</p> <ul style="list-style-type: none"> * The CNAs providing resident cares and washing residents' dirty laundry and linens during the same shifts, and * The CNAs did not use protective equipment other than gloves while doing dirty laundry, and * The washers and dryers were not sanitized between loads. The Administrator did not reply to the concerns. <p>6. On 12/19/13 at 3:15 p.m. during the Environmental Tour, the surveyor asked the Administrator how the laundry hot water temperatures were checked. The Administrator stated, "For South side laundry room water temperatures, we go by the dials or gauges on the machines." The Administrator said the Housekeeping Supervisor (HS) checked the hot water temperatures for the North side laundry room.</p> <p>-At approximately 3:25 p.m., the HS stated, "I do weekly water temperatures on Tuesday. The hot water temperatures range between 120 and 124 degrees Fahrenheit [*F]." The surveyor requested to review documentation of the actual hot water temperatures.</p> <p>- At 4:50 p.m., the HS provided the surveyor with a "Maintenance Inspection Checklist." One of the line items was Hot Water Temperatures. The HS stated, "I make a check mark when I do the water temperatures. I do not write down what the actual hot water temperatures are."</p> <p>Note: The Checklist did not provide evidence the actual temperatures were evaluated to ensure hot water reached temperatures to sanitize residents' laundry.</p> <p>Review of the facility's Infection Control Procedures revealed, in part, the following:</p>	F 441			

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F 441	<p>Continued From page 70</p> <p>- Department (Environmental Services) - Laundry and Linen, General Guidelines, "...7. Employees sorting and washing linens must wear gloves. They may also choose to wear other barrier attire...9. Wash linen in water that is at least 140°F, for at least twenty-five (25) minutes...Steps in Procedures...In Resident Rooms...2. Handle all soiled linen as though it is potentially infectious..."</p> <p>Note: The Steps in Procedures section included a different section titled, "Steps in the Procedure, In the Laundry." This section did not instruct staff to handle all soiled linen as though it was potentially infectious although the "In Resident Rooms" section did instruct staff to handle all soiled linen as though it was potentially infectious.</p> <p>Federal guidance at F441 indicated, in part, "It is important that laundry areas have...appropriate PPE (i.e., gloves and gowns) available for workers to wear while sorting linens. Laundry equipment should be used and maintained according to the manufacturer's instructions to prevent microbial contamination of the system. It is recommended that damp linen is not left in machines overnight...An effective way to destroy microorganisms in laundry items is through hot water washing at temperatures above 160°F...for 25 minutes. Alternatively, low temperature washing at 71 to 77°F...plus a 125-part-per-million (ppm) chlorine bleach rinse has been found to be effective and comparable to high temperature wash cycles."</p> <p>On 12/20/13 at 10:00 a.m., the Administrator and the DON were informed of the above identified concerns. The facility did not provide any additional information.</p>	F 441			

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F 518 SS=D	<p>483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of in-service records, it was determined the facility failed to ensure staff was trained to respond in emergency situations. This was true for 2 of 3 staff (CNA #s 12 and 13) interviewed regarding emergency procedures. This resulted in the potential for employees to respond inappropriately in the event of an earthquake or missing resident. Findings included:</p> <p>a) On 12/17/13 at 2:50 p.m., CNA #12 was asked about the facility's emergency procedures. The CNA stated she had worked full time in the facility for 1 1/2 years. Regarding earthquake, the CNA indicated she did not know then stated, "I would make sure the residents are safe." When asked if she had received training about earthquakes, the CNA stated, "I don't remember any training." Regarding missing resident, the CNA stated that she would look for the resident and tell the nurse. When asked if she had received training about missing residents, the CNA stated, "Not here."</p> <p>b) On 12/17/13 at 3:15 p.m., CNA #13 was asked about the facility's emergency procedures. The CNA stated she had worked full time in the facility for 1 year. Regarding earthquake, the CNA indicated she did not know what to do. When</p>	F 518	<p>F 518 POC</p> <p>Identified Resident Action:</p> <p>No residents have been affected by the deficient practice, but all have the potential to be affected.</p> <p>Other Resident Identifiers:</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>Measures:</p> <p>On 12-30-2013 the facility has re-educated all current employees regarding emergency procedures. All newly hired employees will be educated on emergency procedures during new hire paperwork process.</p>	

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F 518	<p>Continued From page 72</p> <p>asked if she had received training about earthquakes, the CNA stated, "No, no, no!" Regarding missing resident, the CNA stated, "Well, we would need to look for them." However, the CNA did not offer anything more. When asked if she had received training about missing residents, the CNA stated, "No, no training."</p> <p>On 12/17/13 at 5:15 p.m., the Administrator was asked to provide documentation of staff training regarding earthquake and missing resident since 11/30/12. She agreed.</p> <p>On 12/18/13, the Administrator provided agendas and attendance records for 3 All Staff Meetings, dated 3/21/13, 5/30/13, and 9/26/13. The records documented, in part</p> <ul style="list-style-type: none"> * 3/21/13 - "1. Fire & Life Safety a. Quarterly Safety Training..." * 5/30/13 - "1. Fire & Life Safety a. Fire Drills..." and, * 9/26/13 - "...2. Fire & Life Safety..." <p>No evidence of training on earthquakes and missing residents was provided.</p> <p>No other information or documentation was received from the facility which resolved the issue.</p>	F 518	<p>Monitoring:</p> <p>Starting on 02-18-2014 the administrator will randomly question 1 employee weekly regarding emergency procedures in the facility.</p> <p>The facility shall also performing re-education of all staff during quarterly in-service training. The facility will maintain a master copy of emergency procedures that can only be altered by committee during CQI. CQI committee shall review the emergency procedure each year. Areas of concern will be brought immediately to administrator.</p> <p>Compliance date 02-18-2014.</p>	

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the State licensure survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Karen Marshall, MS, RD, LD Team Coordinator Linda Kelly, RN</p> <p>Survey Definitions:</p> <p>LSW = License Social Worker RN = Registered Nurse SSD = Social Services Designee</p>	C 000		
C 099	<p>02.009 CRIMINAL HISTORY AND BACKGROUND CHECK REQUIRE</p> <p>01. Criminal History and Background Check. A skilled nursing and intermediate care facility must complete a criminal history and background check on employees and contractors hired or contracted with after October 1, 2007, who have direct patient access to residents in the skilled nursing and intermediate care facility. A Department check conducted under IDAPA 16.05.06, "Criminal History and Background Checks," satisfies this requirement. Other criminal history and background checks may be accepted provided they meet the criteria in Subsection 009.02 of this rule and the entity conducting the check issues written findings. The entity must provide a copy of these written findings to both the facility and the employee. (3-26-08)</p>	C 099	<p>C 099 POC</p> <p>Identified Resident Action:</p> <p>No Residents have been affected by the deficient practice, but all have the potential to be affected.</p> <p>Other Resident Identifiers:</p> <p>No Residents identified or directly affected by the practice.</p>	<p>RECEIVED</p> <p>JAN 27 2014</p> <p>FACILITY STANDARDS</p>

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

Executive Director

(X6) DATE

1/24/2014

Bureau of Facility Standards

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C 099	<p>Continued From page 1</p> <p>02. Scope of a Criminal History and Background Check. The criminal history and background check must, at a minimum, be a fingerprint-based criminal history and background check that includes a search of the following record sources: (3-26-08)</p> <p>a. Federal Bureau of Investigation (FBI); (3-26-08)</p> <p>b. Idaho State Police Bureau of Criminal Identification; (3-26-08)</p> <p>c. Sexual Offender Registry; (3-26-08)</p> <p>d. Office of Inspector General List of Excluded Individuals and Entities; and (3-26-08)</p> <p>e. Nurse Aide Registry. (3-26-08)</p> <p>03. Availability to Work. Any direct patient access individual hired or contracted with on or after October 1, 2007, must self-disclose all arrests and convictions before having access to residents. The individual is allowed to only work under supervision until the criminal history and background check is completed. If a disqualifying crime as described in IDAPA 16.05.06, "Criminal History and Background Checks," is disclosed, the individual cannot have access to any resident. (3-26-08)</p> <p>04. Submission of Fingerprints. The individual's fingerprints must be submitted to the entity conducting the criminal history and background check within twenty-one (21) days of his date of hire. (3-26-08)</p> <p>05. New Criminal History and Background Check. An individual must have a criminal history and background check when: (3-26-08)</p> <p>a. Accepting employment with a new employer; and (3-26-08)</p> <p>b. His last criminal history and background check</p>	C 099	<p>Measures:</p> <p>The Director of Nursing and Administrator have reviewed current Criminal History and Background check requirements. The facility has re-educated the Executive Assistant regarding Criminal History and Background check requirements. The facility will ensure that all new and rehired employees receive a background check</p> <p>Monitoring:</p> <p>Starting on 01-24-2014 the Administrator will conduct audits of all new and rehired employees for compliance of Criminal History and Background Check Requirements to be conducted weekly for a 90 day audit period.</p> <p>Compliance date 01-24-2014.</p>	

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C 099	<p>Continued From page 2</p> <p>was completed more than three (3) years prior to his date of hire. (3-26-08)</p> <p>06. Use of Criminal History Check Within Three Years of Completion. Any employer may use a previous criminal history and background check obtained under these rules if: (3-26-08)</p> <p>a. The individual has received a criminal history and background check within three (3) years of his date of hire; (3-26-08)</p> <p>b. The employer has documentation of the criminal history and background check findings; (3-26-08)</p> <p>c. The employer completes a state-only background check of the individual through the Idaho State Police Bureau of Criminal Identification, and (3-26-08)</p> <p>d. No disqualifying crimes are found. (3-26-08)</p> <p>07. Employer Discretion. The new employer, at its discretion, may require an individual to complete a criminal history and background check at any time, even if the individual has received a criminal history and background check within the three (3) years of his date of hire. (3-26-08)</p> <p>This Rule is not met as evidenced by: Based on review of staff personnel files and staff interview, it was determined the facility failed to ensure criminal history checks for staff were checked within 21 days of hire. This affected 1 of 5 (B) staff reviewed for criminal history checks. Findings included:</p> <p>On 12/18/13 at 1:06 p.m., the surveyor and Executive Assistance #2 (EA #2) reviewed Staff B's personnel file. Staff B's date of hire (DOH)</p>	C 099		
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C 099	<p>Continued From page 3</p> <p>was 8/22/13. The personnel file contained a Notice of Clearance letter dated 6/2/11.</p> <p>-At approximately 1:10 p.m., the surveyor requested to review verification of Staff B's background through the Idaho State Police Bureau of Criminal Identification (ISP BCI form). The surveyor and the EA #2 discussed Staff B's Notice of Clearance letter dated 6/2/11 was prior to 8/22/13 DOH; therefore, the state requirement was to verify no disqualifying crimes through the Idaho State Police. The surveyor and the EA then reviewed the Idaho Administrative Procedures Act.</p> <p>- At approximately 1:12 p.m., the EA #2 provided a copy of an ISP BCI form, signed by Staff B on 5/16/11. The form was also signed by the Administrator; however, there was no date documented of when the Administrator signed the form. The bottom portion of the form contained a section title, "Results of Non-Certified Record Search." This section was blank. It appeared the form was signed by Staff B and the Administrator but was not used to verify Staff B had no disqualifying crimes.</p> <p>On 12/20/13 at 9:45 a.m., the Administrator and the DON were informed of the concern.</p>	C 099		
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C 117	<p>02.100,03,c,i Fully Informed of Rights</p> <p>i. Is fully informed, as evidenced by the patient's/resident's written acknowledgement, prior to or at the time of admission and during his stay, of these rights and of all rules, regulations and minimum standards governing patient/resident conduct and responsibilities. Should the patient/resident be medically or</p>	C 117	<p>C 117 POC</p> <p>See Form CMS-2567 POC for F 156</p>	
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C 117	Continued From page 4 legally unable to understand these rights, the patient's/resident's guardian or responsible person (not an employee of the facility) has been informed on the patient's/resident's behalf; This Rule is not met as evidenced by: Please refer to F156 as it related to resident rights in the Admission Agreement.	C 117		
C 228	02.106,01,b Barriers to Natural/Man-Made Hazards b. Where natural or man-made hazards are present on the premises, the facility shall provide suitable fences, guards, and/or railings to isolate the hazard from the patient's/resident's environment. This Rule is not met as evidenced by: Refer to F 323 as it related to a fireplace.	C 228	C 228 POC See Form CMS-2567 for F 323	
C 243	02.106,05 ORIENTATION, TRAINING & DRILLS 05. Orientation, Training and Drills. All employees shall be instructed in basic fire and life safety procedures. This Rule is not met as evidenced by: Refer to F 518 as it related to staff training regarding emergency procedures.	C 243	C 243 POC See Form CMS-2567 for F 518	
C 252	02.106,07 MAINTENANCE OF EQUIPMENT 07. Maintenance of Equipment. The facility shall establish routine test, check and maintenance procedures for all equipment.	C 252	C 252 POC See Form CMS-2567 for F 323	

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C 252	Continued From page 5 This Rule is not met as evidenced by: Please refer to F323 as it related to the build-up of lint in the commercial clothes dryer.	C 252		
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F371 as it related to the cleaning of the ice machine and the overhead hood.	C 325	C 325 POC See Form CMS-2567 F 371	
C 349	02.108,06,a,i Adequate Laundry Facilities & Procedures i. Adequate facilities and procedures shall be provided for the proper and sanitary washing of linen and other washable goods laundered in the facility. This Rule is not met as evidenced by: Please refer to F441 as it related to not evaluating the hot water temperatures for the North side and the South side laundry rooms to ensure residents' laundry was sanitized during the laundry process.	C 349	C 349 POC See Form CMS-2567 for F 441	
C 393	02.120,04,b Staff Calling System at Each Bed/Room b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet,	C 393		

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C 393	Continued From page 6 bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Refer to F 323 as it related to a restroom without a call system.	C 393	C 393 POC See Form CMS-2567 for F 323	
C 644	02.150,01,a,i Handwashing Techniques a. Methods of maintaining sanitary conditions in the facility such as: i. Handwashing techniques. This Rule is not met as evidenced by: Refer to F 441 as it related to infection control.	C 644	C 644 POC See Form CMS-2567 for F 441	
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of Infection Control Committee (ICC) meeting attendance records, it was determined the facility did not ensure the Food Services Director	C 664	C 664 POC Identified Resident Action: No Residents have been affected by the deficient practice, but all have the potential to be affected.	

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C 664	Continued From page 7 attended/participated in quarterly ICC meetings. This failure created the potential for a negative affect for all residents, staff, and visitors in the facility when ICC members were not involved in the ICC meetings. Findings included: On 12/19/13 at 3:30 p.m., the DNS, who stated she was the Infection Control Nurse, was interviewed about the Infection Control Program. The DNS stated the meetings were conducted "at least quarterly." The DNS was asked to provide attendance records for the ICC meetings. On 12/19/13 at about 5:00 p.m., the DNS provided ICC meeting attendance records dated 6/26/13, 7/26/13, 8/22/13, 9/11/13, 10/30/13, and 12/18/13. The attendance records documented that the Food Services Director was "absent" for all of the aforementioned ICC meetings. No other information or documentation was received from the facility which resolved the issue.	C 664	Other Resident Identifiers: No Residents identified or directly affected by the practice. Measures: The Director of Nursing and Administrator have reviewed current Infection control Committee policy and cross referenced with state guidelines. The facility will ensure that required staff members are in attendance quarterly. Monitoring: The Administrator will monitor infection control meeting minutes to ensure compliance for 2 consecutive quarterly meetings. Areas of concern will be immediately addressed and facility shall review process in monthly CQI meeting as needed. Compliance date 01-24-2014.	
C 703	02.152,03,a,i Idaho Licensed Social Worker i. Is a social worker licensed by the state of Idaho as a social worker or who receives regular consultation from such a qualified social worker. This Rule is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure the social services designee (SSD) received regular consultation from a License Social Worker (LSW). This affected 9 of 10 (#s 1-9) sampled residents and had the potential to	C 703		

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C 703	<p>Continued From page 8</p> <p>affect all residents who resided in the facility. Findings included:</p> <p>On 12/16/13 at 3:00 p.m., the survey team entered the facility. As part of the survey process, the facility provided the survey team with a List of Key Facility Personnel. The facility listed the name of a LSW and the LSW's license number. The List also contained the name of the SSD.</p> <p>On 12/17/13 at 3:07 p.m., the surveyor asked the Administrator about LSW consultation received for the SSD. The Administrator stated, "We call the LSW but do not have consultation reports."</p> <p>12/19/13 at 9:20 a., the survey asked the SSD if he received consultation from a LSW. The SSD stated, "The LSW is available if I need to speak with her. I can call her. I have not seen her come to the building."</p> <p>On 12/19/13 at 4:00 p.m., the surveyor asked the Administrator for an agreement or contract with the LSW named on the List of Key Facility Personnel. The Administrator stated, "Our LSW is the Corporate LSW based out of our Corporate office. The Corporate LSW does not come to our facility and does not review records electronically but is available by phone if we need the LSW. We have not needed to call the LSW. We also have a contract with a different LSW in the local area. We have not needed to call that LSW [for consultation]."</p> <p>On 12/19/13 at 4:05 p.m., the Administrator provided a copy of an 11 page Consultant Agreement with what appeared to be an Agreement between the facility's corporation and LSW #3 signed on 5/14/10.</p>	C 703	<p>C 703 POC</p> <p>Identified Resident Action:</p> <p>No Residents have been affected by the deficient practice, but all have the potential to be affected.</p> <p>Other Resident Identifiers:</p> <p>No Residents identified or directly affected by the practice.</p> <p>Measures:</p> <p>Facility has had an MSW perform audit of patient charts by 1-24-2014. The Director of Nursing and Administrator will look to hire an LSW to work in the facility to provide required social work consultation. Telephone 2.7.14 2:00 PM with Executive Director Monitoring: LSW on staff.</p> <p>The Administrator will monitor that all new residents receive an Initial Comprehensive Assessment from the LSW weekly for 90 days.</p> <p>Compliance date 01-24-2014.</p>	
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C 703	Continued From page 9 Although the facility had access to two different LSWs to provide consultation services for the SSD, the facility did not provide evidence the SSD received social service consultation. On 12/20/13 at 9:45 a.m., the Administrator and the DON were informed of the finding.	C 703		
C 745	02.200,01,c Develop/Maintain Goals/Objectives c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Refer to F 281 as it related to standards of practice.	C 745	C 745 See Form CMS-2567 for F 281	
C 747	02.200,01,e Individualized Resident Care Plan e. Observing and evaluating the condition of each patient/resident and developing a written, individualized patient care plan which shall be based upon an assessment of the needs of each patient/resident, and which shall be kept current through review and revision; This Rule is not met as evidenced by: Refer to F 279 and F 309 as it related to interim and initial care plans.	C 747	C 747 See Form CMS-2567 for F 279 See Form CMS-2567 for F 309	
C 761	02.200,02,c,i When Average Census of 59 or Less i. In SNFs with an average occupancy rate of fifty-nine (59) patients/residents or less a	C 761		

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C 761	<p>Continued From page 10</p> <p>registered professional nurse shall be on duty eight (8) hours of each day and no less than a licensed practical nurse shall be on duty for each of the other two (2) shifts.</p> <p>This Rule is not met as evidenced by: Based on review of the three week staff schedule, and staff interview, it was determined the facility failed to ensure a RN was on duty 8 hours on 12/8/13. This affected 9 of 10 (#s 1-9) sampled residents and had the potential to affect all residents who resided in the facility. Findings included:</p> <p>On 12/17/13 at 2:05 p.m., the DON provided the survey team with a copy of the facility's "Three-Week Nursing Schedule" from 11/24/13 through 12/14/13. The Schedule provided evidence the facility had 4 hours of RN coverage on 12/8/13. The DON stated, "A registered nurse (RN) called in sick. I could not find a RN to come in and cover the whole 8 hours. I know this is a State requirement."</p> <p>On 12/20/13 at 9:45 a.m., the survey team informed the Administrator of the concern.</p>	C 761	<p>C 761 POC</p> <p>Identified Resident Action:</p> <p>No Residents have been affected by the deficient practice, but all have the potential to be affected.</p> <p>Other Resident Identifiers:</p> <p>No Residents identified or directly affected by the practice.</p> <p>Measures:</p> <p>The Director of Nursing and Administrator have reviewed registered professional nurse scheduling process and cross referenced with state guidelines. The facility will ensure that required registered nurse will be on duty eight (8) hours of each day.</p>	
C 784	<p>02.200,03,b Resident Needs Identified</p> <p>b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to:</p> <p>This Rule is not met as evidenced by: Please refer to F309 as it related to identifying needs related to Dementia.</p>	C 784	<p>Monitoring:</p> <p>Starting on 01-24-2014 the Director of Nursing will conduct audits of registered professing nurse hours on duty to be conducted weekly for a 90 day audit period.</p> <p>Compliance date 01-24-2014.</p>	

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C 784	Continued From page 11 Please refer to F325 as it related to diet order dates, implementing Registered Dietitian recommendations in a timely manner, and the nutritional care process for a resident with severe weight loss.	C 784	C 784 See Form CMS-2567 for F 309 See Form CMS-2567 for F 325	
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F 309 as it related to physician ordered treatment.	C 788	C 788 See Form CMS-2567 for F 309	
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F 314 as it related to the development of pressure ulcers.	C 789	C 789 See Form CMS-2567 for F 314	
C 803	02.200,04,f Observed for Reactions f. Patients/residents are observed for reactions to medications and if a reaction occurs, it is immediately reported to the charge nurse and attending physician; This Rule is not met as evidenced by:	C 803		

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C 803	Continued From page 12 Please refer to F329 as it related to identifying potential adverse reactions related to the use of Cubicin and developing the care plan related to the use of the Cubicin.	C 803	C 803 See Form CMS-2567 for F 329	
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 F 332 as it related to medication errors.	C 811	C 811 See Form CMS-2567 for F 332	
C 821	02.201,01,b Removal of Expired Meds b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days. This Rule is not met as evidenced by: Refer to F 431 as it related to expired medication.	C 821	C 821 See Form CMS-2567 for F 431	
C 835	02.201,02,i Meds in Possession of Resident Limitations i. No medication shall be in the possession of the patient/resident unless specifically ordered by the physician on the patient's/resident's medical record, and in no case shall exceed two (2) units of dosage. All such medications shall be individually packaged by the pharmacist in units of dose, labeled with the	C 835	C 835 See Form CMS-2567 for F 176	

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C 835	Continued From page 13 patient's/resident's name, unit of dose, and date of distribution. The charge nurse shall maintain an inventory of these drugs on the patient's/resident's medical record. This Rule is not met as evidenced by: Refer to F 176 as it related to medication self administration.	C 835			
C 851	02.201,03,e Storage of Schedule II Drugs e. Schedule II drugs shall be stored in a separate, locked section of the medication storage area or cabinet. (Alternate allowed under Unit Dose Pharmacy and emergency drug kit provisions.) This Rule is not met as evidenced by: Refer to F 431 as it related to controlled medication storage.	C 851	C 851 See Form CMS-2567 for F 431		