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

February 9, 2015

Tiffany Goin, Administrator
Life Care Center of Lewiston
325 Warner Drive
Lewiston, ID 83501-4437

Provider #: 135128

Dear Ms. Goin:

On **January 30, 2015**, a Recertification and State Licensure survey was conducted at Life Care Center of Lewiston by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 23, 2015**. Failure to submit an acceptable PoC by **February 23, 2015**, may result in the imposition of civil monetary penalties by **March 16, 2015**.

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

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

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **March 6, 2015 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **March 6, 2015**. A change in the seriousness of the deficiencies on **March 6, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 6, 2015** includes the following:

Denial of payment for new admissions effective **April 30, 2015.** [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 30, 2015**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, Option #2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 30, 2015** 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 **February 23, 2015**. If your request for informal dispute resolution is received after **February 23, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2.

Sincerely,

D. L. Scott

DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135128	A. BUILDING _____ B. WING _____	01/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF LEWISTON	325 WARNER DRIVE LEWISTON, ID 83501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual federal recertification survey of your facility. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Amy Barkley, RN, BSN Lauren Hoard, RN, BSN Linda Hukill-Neil, RN The survey team entered the facility on January 26, 2015 and exited on January 30, 2015. Survey Definitions: ADL = Activities of Daily Living BID = Two Times per Day BIMS = Brief Interview for Mental Status CM = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligrams OOB = Out Of Bed PO = By Mouth PRN = As Needed RCM = Resident Care Manager TID = Three Times per Day	F 000	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F – 280 SPECIFIC RESIDENTS Resident #1 care plan has been updated to include current interventions related to toileting needs, discontinued PT/OT, discharge of cane rails, discharge of foley catheter as well as other interventions up to date. Resident #5 care plan has been revised to include type of cushion for wheelchair, type/setting of air mattress, turning schedules, positioning restrictions, manufacturers recommendation for linen use as well as other interventions up to date. Resident #10 care plan has been updated to reflect current toileting needs per patient's directive.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		3/6/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Mary Kai — Executive Director — 2/18/15

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 280	Continued From page 1 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to update and/or revise residents' care plans after there were changes in the residents' status. This was true for 3 of 17 (#s 1, 5, & 10) sampled residents. This failure created the potential for harm if staff were confused about bilateral cane rails utilization; urinary incontinence needs; and Physical Therapy (PT)/Occupational Therapy (OT) involvement for Resident #1, the conflicting toileting program for Resident #10, and failure to implement, review, and revise pressure ulcer interventions for Resident #5. Findings included: 1. Resident #1 was readmitted to the facility on 10/27/14 with peripheral vascular disease, chronic airway obstruction, muscle weakness, ulcer of calf, and cellulitis.	F 280	OTHER RESIDENTS All residents have the potential to be affected by this deficient practice. Care plans were reviewed to ensure current interventions are up to date. SYSTEMATIC CHANGES Root cause indicated failure to execute the process to update care plan when new orders are received and/or changed. Education provided to Nursing and Interdisciplinary team on timely care plan revisions. New orders will be reviewed at daily stand up meeting and care plans updated as applicable. Care plans will be updated and reviewed with MDS schedule. MONITOR DON or designee will perform audits to ensure care plans are updated timely. Audits will be taken and reviewed at monthly QA for ongoing education needs.	

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F 280	Continued From page 2 The resident's significant change MDS assessment, dated 11/3/14, documented the resident's cognitive level as being intact; extensive to total 2 staff assistance for bed mobility, transfers, toilet use, personal hygiene, and locomotion on and off the unit; indwelling catheter and always incontinent of bowel; and one sided lower extremity functional impairment. Resident #1's Physician's Orders documented: "...10/27/14...Bilateral cane rails to assist resident with bed mobility, transfers and bed controls..." "...11/21/14...D/C [discontinue] foley cath [catheter]..." "...11/23/14...D/C skilled PT due to patient reaching her current functional potential..." "...12/9/14...Advance to low air loss alternating pressure mattress replacement of group 2 surface..." The resident's current Care Plan documented: *Problem: ADL/Self Care Deficit "...Goals...Resident will perform ADLs to her maximum potential...Target date 2/11/15..." Interventions included: "...She has incontinence and has been assessed by the restorative LN for her toileting needs...She has a Foley catheter at present. Assess skin for breakdown; Foley cares to reduce the risk of infection..." "...She is working with PT/OT for strength and balance...She is participating with therapy for strengthening and therapeutic exercises..." *Problem: Potential for falls "...Goals...Resident to remain free of injury from falling...Target date 2/11/15..." Interventions included: "...Bed has bilateral cane rails for bed mobility	F 280		

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F 280	Continued From page 3 and bed controls..." "...Is working with therapy to improve strength and mobility..." *Problem: Skin breakdown "Goals...Intact skin will remain intact...Target date 2/11/15..." Interventions included: "...Cane rails on bed are used to assist with mobility..." *Problem: Alteration in elimination secondary to Foley catheter "Goals...Resident will have no s/s [signs or symptoms] UTI [urinary tract infection] secondary to Foley catheter...Target date 2/6/15..." Interventions included: "...Provide Q [every] shift Foley catheter care...Foley catheter in place d/t [due to] immobility...Change Foley catheter and drainage bag monthly..." On 1/26/15 at 3:20 PM, 1/27/15 at 7:40 AM, and 1/28/15 at 1:40 pm, the resident was observed in her bed. The resident was lying on a pressure-relieving mattress with bilateral bumper pads. Resident #1 did not have bilateral cane rails on the bed. The resident said the foley catheter had been removed and the staff used a Hoyer lift to transfer her to and from the commode. On 1/29/15 at 8:50 AM, the Director of PT was interviewed regarding Resident #1's PT/OT program. The Director said the resident was involved with PT from 10/28 through 11/25/14, when she "was discharged due to no progression," and OT from 9/16 through 10/3/14, when she was discharged due to reaching her "maximum level of ADL function."	F 280		

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F 280	Continued From page 4 On 1/29/15 at 12:55 PM, the DON and RCM #3 were interviewed regarding Resident #1's Care Plan with conflicting information. The DON stated the resident's Care Plan should have been revised to reflect the resident no longer had a foley catheter and needed to have a urinary incontinence focus; the resident was not currently involved with PT/OT, but had active ROM ADLs with the floor staff; and bilateral cane rails were discontinued when the resident was placed on the air bed with side bolsters. 2. Resident #10 was admitted to the facility on 12/28/12 with multiple diagnoses including urinary incontinence. The resident's annual MDS assessment, dated 12/23/14, documented the resident was continent of bowel and frequently incontinent of bladder, without a toileting plan in place. The resident's Skin Breakdown care plan, dated 1/10/13, documented, "He has been placed on a scheduled toileting plan for B&B [bowel and bladder] by the Restorative Nurse." The resident's Bowel and Bladder care plan, dated 6/27/14, documented, "Resident has requested no further toileting program at this time. Provide toileting per resident request." On 1/29/15 at 10:15 AM, the DON and RCM #3 were interviewed regarding the issue. RCM #3 said the resident was no longer on a toileting program. The DON was shown the care plans, pointed at the Skin Breakdown intervention and stated, "This should have been off."	F 280		

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F 280	Continued From page 5 3. Resident #5 was admitted to the facility on 5/22/14 with multiple diagnoses, including decubitus ulcers on his buttock and hip and generalized pain. The Quarterly MDS assessment, dated 11/23/14, coded the resident required total assist of 2 or more staff for bed mobility, transfers, and toileting; skills for daily decision making were severely impaired; functional impairment in the upper extremity on one side; and functional impairment in the bilateral lower extremities. The current Skin Care plan, dated 12/6/14, documented the following interventions: "Resident is to be the last one up OOB and the first one down after meals; and staff to position frequently for pressure relief and comfort when in bed." On 1/26/15 and throughout the survey a pressure relieving cushion was observed in the residents wheel chair and a special air mattress was observed on the resident's bed. The care plan did not document the resident had a pressure relieving cushion in his wheelchair or the type of cushion; whether or not the resident was on a special bed and/or the setting of the bed; the time frame for the resident to be turned; and if the resident had restrictions related to positioning. In addition, the care plan did not include the manufacturer's recommendations regarding specific linen to be used or not used on the air bed. On 1/26/15 and throughout the survey, the	F 280		

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F 280	Continued From page 6 following sign was observed above the resident's bed, "Head of bed 30 degrees at all times. Turn side to side only Q 2 [every two hours]." On 1/29/15 at 1:20 PM, the DNS and RCM #3 confirmed the above identified interventions were not on the resident's care plan and "should be." On 1/29/15 at 6:30 PM, the Administrator was notified related to the above concern. No further information was provided.	F 280		
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 interview, it was determined the facility failed to ensure equipment did not block access to handrails. This was true for 8 of 17 (#s 1, 3, 8, 9, 10, 12, 14, and 17) sampled residents on the 200, 300, and 400 units and any mobile resident attempting to access the facility's Grand Dining Room. This failure created the potential for injury should residents trip and fall when unable to access handrails blocked by a piano not in use. Findings included: On 1/26/15 at 3:28 PM, 1/27/15 from 8:20 AM to 3:30 PM, and 1/28/15 from 8:05 AM to 10:08 AM,	F 323	F – 323 SPECIFIC RESIDENTS This affects Resident #1, 3, 8, 9, 10, 12, 14, 17 and any mobile resident attempting to enter grand dining room. The piano has been relocated to an area that does not block access to handrails. OTHER RESIDENTS All residents are at risk from this deficient practice. Other areas have been assessed to ensure handrails are accessible.	3/6/15

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F 323	Continued From page 7 an upright piano was observed in the entryway leading into the main dining room. The piano had the power cord draped over the top of it. The piano was placed against the left side of the hallway and blocked 5 feet of the handrail. On 1/27/15 at 8:20 AM, Resident #21 was observed in a wheelchair as she exited the Grand Dining Room. The resident propelled herself with her right hand and both feet. The resident did not use the handrail, but had to maneuver her wheelchair around the piano blocking the left side of the hallway. On 1/28/15 at 10:08 AM, the Maintenance Director acknowledged the piano was in the hallway and blocked the handrails. When the Maintenance Director was informed of the earlier observations, he stated the piano belonged to the Activities Program and he did not know why it had been left there. The Maintenance Director stated, "I will move it right away." On 1/28/15 at 4:45 PM, the Administrator and DON were informed of the issue. The facility offered no additional information and the piano had been moved from the hallway.	F 323	SYSTEMATIC CHANGES Root cause indicated lack of education and safety awareness that storage location blocked access to handrails. Appropriate storage area was designated for piano. Facility-wide audit has been completed and no further deficiencies identified. Education/Inservice provided to all staff to ensure residents have access to handrails. MONITOR Executive Director or designee will perform audits to ensure handrails are accessible. Audits will be taken to monthly QA for ongoing educational needs.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning;	F 328	F – 328 SPECIFIC RESIDENT Resident #1 and #4 will have oxygen on as ordered. Resident #1 TAR and care Plan has been reviewed to ensure compliance with current MD orders for oxygen.	3/6/15

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F 328	Continued From page 8 Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure oxygen therapy was accurately administered. This affected 2 of 4 (#s 3 & 4) residents sampled for oxygen therapy. This practice created the potential for harm if residents developed hyperoxemia from being delivered too much oxygen. Findings included: 1. Resident #4 was admitted on 12/29/14 with multiple diagnoses including hypertension and congestive heart failure. The resident's January 2015 Physician recapitulation orders and MAR documented an oxygen order, dated 12/29/14, for oxygen to be administered via nasal cannula at 1 liter continuous. The resident's care plan, dated 1/9/15, documented an intervention of, "She is to wear O2 [oxygen] at 1 liter continuous." The resident's Progress notes, dated 1/1/15 at 9:27 PM, 1/2/15 at 6:38 PM, and 1/4/15 at 8:13 PM, documented the resident received oxygen at 2 liters. On 1/26/15 at 3:17 PM, the resident was observed in her bed with her nasal cannula in her nose and the room air concentrator on and set to 1.5 liters.	F 328	Resident #4 TAR and care plan have been reviewed to ensure compliance with current MD orders for oxygen. progress notes have been reviewed to ensure accuracy of oxygen documentation. OTHERS RESIDENTS Other residents that use oxygen therapy have the potential to be affected by this practice. All residents with oxygen orders were audited to ensure oxygen compliance. SYSTEMATIC CHANGES Root cause indicated failure to execute oxygen orders and properly communicate. Inservice provided to therapy and nursing staff to ensure oxygen is administered as ordered, documenting accurate oxygen usage, and updating care plan with current orders. Staff educated on location of information for current liter usage. MONITOR DON or designee will audit residents with oxygen to ensure it is placed as ordered and care plan is updated to reflect liter usage.	

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F 328	Continued From page 9 On 1/27/15 at 8:55 AM, the resident was observed on her bed without her nasal cannula on with the room air concentrator on and set to 1.5 liters. On 1/27/15 at 10:30 AM, the resident was observed in her wheelchair in her room with her nasal cannula in her nose and the room air concentrator on and set to 1 liter. The resident was observed in her wheelchair with a portable oxygen tank set at 2 liters with her nasal cannula on: -1/28/15 at 8:08 AM, 8:50 AM, and 12:10 PM, and -1/29/15 at 8:45 AM. On 1/29/15 at 10:00 AM, the DON and RCM #3 were interviewed regarding the oxygen issue. When informed of the observations, RCM #3 stated, "I don't like those observations." The DON stated, "The charge nurses should be checking that." 2. Resident #1 was readmitted to the facility on 10/27/14 with diagnoses including peripheral vascular disease, chronic airway obstruction, muscle weakness, ulcer of calf, and cellulitis. The resident's January 2015 Physician recapitulation orders and TAR documented an oxygen order, dated 10/27/14, for oxygen to be administered via nasal cannula (NC) at 1 liter continuous/PRN. The TAR contained documentation that the resident's oxygen was administered at 1 liter for all shifts. Resident #1's current Care Plan documented an intervention of, "Wears O2 at 2.5 l/min [liters per minute] via a nasal cannula continuous."	F 328	Audits will be taken to monthly QA for ongoing educational needs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135128	A. BUILDING _____ B. WING _____	01/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF LEWISTON	325 WARNER DRIVE LEWISTON, ID 83501

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F 328	Continued From page 10 The resident's Nursing Progress notes, dated 1/4/15 at 9:41 AM, 1/6/15 at 1:11 PM, 1/8/15 at 12:36 PM, 1/9/15 at 12:25 PM, and 1/12/15 at 1:07 PM, documented the resident received oxygen at 2 liters. On 1/26/15 at 3:20 PM, the resident was observed in her bed with the O2 via NC on and set at 1.5 liters from the room air concentrator. On 1/27/15 at 9:05 AM and on 1/28/15 at 8:30 AM, 12:30 PM, and 4:20 PM, the resident was observed in her wheelchair with the O2 via NC on at 2 liters from the portable oxygen tank. On 1/28/15 at 1:40 PM, the resident was observed in her bed with the O2 via NC on and set at 1 liter from the room air concentrator. On 1/29/15 at 8:01 AM, the DON and RCM #3 were interviewed regarding the oxygen observations and documentation issues. The DON stated the nurses would not be looking at the Care Plan and would be checking the TAR for the liter flow rate. The Care Plan would be updated by the RCM to reflect the ordered liter flow. The DON said the resident did had wound care appointments and thought maybe the oxygen setting could have been adjusted by their office and would address this with them. On 1/29/15 at 6:30 PM, the Administrator and DON were informed of the concerns. No additional information was provided.	F 328		
			F – 356 SPECIFIC RESIDENT	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356	Resident #1-17 was affected by failure to display correct information on the Nurse Posting Information.	3/6/15

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F 356	Continued From page 11 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 resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. 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: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to display the correct information on the nurse staff posting for residents and visitors. This affected 17 of 17 (#s 1-17) sampled residents and had the potential to affect all residents who resided in the facility and	F 356	OTHER RESIDENTS All residents and visitors have the potential to be affected by this deficient practice. SYSTEMATIC CHANGES Root cause indicated facility had hired a new staffing coordinator who did not understand the importance of updating the board daily. Facility educated staffing coordinator and back up designee of the importance of updating the staffing board and paper compliance daily. MONITOR Executive Director or designee will audit the staffing board daily to ensure compliance. Audits will be taken to monthly QA for ongoing educational needs.	

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F 356	Continued From page 12 any visitors who came into the facility. Findings included: On 1/26/15 at 3:28 PM, the nurse staffing was observed posted on the wall near the main dining room, however the date of the information was listed as 1/13/15. On 1/26/15 at 3:28 PM, the DON was asked about the posting and she stated, "It shouldn't be there." She acknowledged the information posted was for 1/13/15 and had not been updated for 13 days. On 1/27/15 at 8:00 AM, the nurse staffing posting was observed with the current date and current staffing and current census information. On 1/27/15 at 3:50 PM, the Administrator and DON were informed of the issue. No further information was provided.	F 356		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility did not provide special eating equipment for a resident who needed it. This was true for 1 of 12 sampled residents (#9). This deficient practice had the potential for harm if the resident's nutritional status declined. Findings included:	F 369	F – 369 SPECIFIC RESIDENTS Resident #9 divided plate has been discontinued per resident's choice. OTHER RESIDENTS Other residents that have adaptive equipment could be affected by this practice. Residents who have adaptive equipment for meals have been audited to ensure compliance. SYSTEMATIC CHANGES Root cause indicated execution of process with dietary staff identifying the need and placing adaptive utensils in accordance to the tray card on the tray line and nursing staff to review tray card to assure adaptive utensils are on the tray prior to delivery.	3/6/15

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F 369	Continued From page 13 Resident #9 was admitted to the facilty on 8/20/10 with multiple diagnoses including legal blindness, protein calorie malnutrition, and dysphagia. The Nutrition care plan, dated 12/22/14, documented the resident was to have a divided plate for meals. On 1/27/15 at 8:30 AM and 12:15 PM, and on 1/28/15 at 8:15 AM and 12:20 PM, the resident was observed in her recliner with her breakfast and lunch served on a regular dinner plate. On 1/28/15 at 8:00 AM, the resident confirmed it was difficult to see the items on her plate and stated she did not let the CNA leave the room until the CNA told her where everything was at on her plate. On 1/29/15 at 4:15 PM, the Administrator, DNS, and RCM #3 were informed of the above observations and stated the resident should have a divided plate for all meals. No further information was provided to resolve this concern.	F 369	Dietary staff educated on execution of the process of review for adaptive equipment on the tray card during tray line to ensure adaptive equipment is provided. Nursing staff educated to pay close attention to the meal tray card and ensure adaptive equipment is provided for all meals. MONITOR Dietary Manager or designee to audit tray line to assure placement of adaptive equipment. RCMs to audit meal tray cards and resident meal set up to ensure adaptive equipment is in place. Audits will be taken to monthly QA for ongoing educational needs.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514	F – 514 SPECIFIC RESIDENT Resident #3 and 7 were affected by this practice. Resident #3 MAR/PO was updated to reflect indications for use of Misoprostol.	3/6/15

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F 514	Continued From page 14 services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure indications for use of medications were documented on the MAR and Physician's Orders, and the correct medication was documented as administered. This was true for 2 of 17 (#s 3 & 7) sampled residents. This failure created the potential for medical decisions to be based on inaccurate and incomplete information. Findings included: 1. Resident #7 was readmitted to the facility on 8/11/14 with multiple diagnoses which included dementia with behavioral disturbance and anxiety. a. Telephone Physician's Orders for Resident #7, dated 1/9/15, documented an order to discontinue Ativan 1-2 mg by mouth every 6 hours, discontinue Risperdal 0.25 mg two times per day and start Risperdal 0.5 mg by mouth three times per day as needed (No indications were documented). The January 2015 MAR for Resident #7 included the following four handwritten orders: * 1/2/15 - "Risperdal 0.25 mg PO BID PRN," which was discontinued on 1/9/15; * 1/2/15 - "Ativan 0.5 mg PO TID PRN," which was discontinued on 1/9/15; * 1/9/15 - "Risperdal 0.5 mg PO TID PRN;" and, * 1/15/15 - "Risperdal 1 mg PO q am [every	F 514	Resident #7 MAR/PO was updated to reflect indications for use of Risperdol and Ativan. Nurse inadvertently wrote wrong medication on back of MAR but gave correct medication. Nurse was educated on correct documentation of PRN meds. OTHER RESIDENTS Other residents could be affected by this deficient practice. SYSTEMATIC CHANGES Root cause indicated nursing staff, medical records and physician failed to add diagnosis/ indication for medications. Education/Inservice to Medical Records, Nursing Staff (LNs), and Physician to ensure each medication has a diagnosis/ indication for use. Education/Inservice to LNs regarding documentation of each individual medication after administration. New orders will be reviewed daily at stand up meeting for diagnosis.	

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F 514	Continued From page 15 morning] and 1300 [1:00 PM]." The MAR did not document the indications for use of the aforementioned medications. b. A Telephone Physician's Order for Resident #7, dated 1/2/15, documented to discontinue Ativan 1-2 mg by mouth every 6 hours as needed and start Ativan 0.5 mg by mouth three times per day as needed for anxiety. The January 2015 MAR documented Resident #7 received Risperdal 0.5 mg on 1/12/15. The explanation on the back of the MAR documented Ativan 0.5 mg was administered for increased agitation and restlessness. The Narcotic log for Ativan 0.5 mg documented Resident #7 received the last dose of Ativan on 1/8/15 at 11:30 PM. There was no documentation on the log that the resident received Ativan on 1/12/15. On 1/28/15 at 10:54 AM, RCM #1 was asked about the indications for use of Risperdal and Ativan for Resident #7. After reviewing the MAR, the RCM said, "Oh, we didn't write the diagnosis." When asked about the Ativan documented as administered on 1/12/15, the RCM reviewed the narcotic log book and the MAR and stated, "She wrote down the wrong medication." On 1/29/15 at 6:30 PM, the Administrator and DON were informed of the documentation issues. No further information was provided. 2. Resident #3 was admitted to the facility on 1/21/15 with multiple diagnoses including dementia, diverticulosis, and alcohol withdrawal.	F 514	MONITOR Audits will be performed by Nurse Managers, Medical Records, and Pharmacy to ensure medications have diagnosis/ indication for use. Audits will be performed by Medical Records and Nurse Managers to ensure correct medication documented on MAR. Audits will be taken to monthly QA for ongoing educational needs.	

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F 514	Continued From page 16 The resident's Physician Order documented, "Misoprostol 100 mcg [micrograms] tablet PO [by mouth] three times daily. Administer with meals...01/21/2015..." The medication order did not include a diagnosis or an indication for use. Resident #3's January 2015 MAR documented, "...Misoprostol 100 mcg tablet. Give 1 tablet by mouth three times daily c [with] meals..." The MAR documented the Misoprostol had been given 1/22 through 1/27/15, but did not have the diagnosis or an indication for use. On 1/28/15 at 9:30 AM, LN #2 was interviewed regarding the diagnosis for Resident #3's Misoprostol. The LN stated the diagnosis "should have been on the physician orders and also on the MAR." LN #2 said the physician entered his own orders and the diagnosis was missed and staff should have asked for clarification of the medication's indication for use. On 1/29/15 at 6:30 PM, the Administrator and DON were informed of the issue. The facility provided additional documentation to reflect the diagnosis had been added for February 2015 Physician Orders and MAR.	F 514		

Bureau of Facility Standards

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	MDS001410	A. BUILDING: _____ B. WING _____	01/30/2015

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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the State licensure survey of your facility. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Amy Barkley, RN, BSN Lauren Hoard, RN, BSN Linda Hukill-Neil, RN	C 000	RECEIVED FEB 1 2015 FACILITY STANDARDS	
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F280 as it relates to reviewing and revising care plans.	C 782	Please refer to Plan of Correction for F-280	3/6/15
C 787	02.200,03,b,iii Fluid/Nutritional Intake iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Please refer to F 369 as it relates to addaptive equipment for meals.	C 787	Please refer to Plan of Correction for F-369	3/6/15
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 F328 regarding oxygen administration.	C 788	Please refer to Plan of Correction for F-328	3/6/15

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Director — 2/18/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 790	Continued From page 1	C 790		
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as related to protection of residents from accidents or injuries.	C 790	Please refer to Plan of Correction for F-323	3/6/15
C 881	02.203,02 Individual Medical Record 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 as it relates to complete and accurate documentation.	C 881	Please refer to Plan of Correction for F-514	3/6/15