



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

April 1, 2016

Paul McVay, Administrator
Life Care Center of Coeur d'Alene
500 West Aqua Avenue
Coeur d'Alene, ID 83815-7764

Provider #: 135122

Dear Mr. McVay:

On **March 18, 2016**, a survey was conducted at Life Care Center of Coeur d'Alene 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.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) 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 the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 14, 2016**. Failure to submit an acceptable PoC by **April 14, 2016**, may result in the imposition of civil monetary penalties by **May 4, 2016**.

Paul McVay, Administrator
April 1, 2016
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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; and
- 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 the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

- A 'per instance' civil money penalty of **\$1,500**.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 18, 2016**, 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.

Paul McVay, Administrator

April 1, 2016

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If you believe these deficiencies have been corrected, you may contact 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.

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 **April 14, 2016**. If your request for informal dispute resolution is received after **April 14, 2016**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,



David Scott, R.N., Supervisor
Long Term Care

DS/lj

Enclosures



500 West Aqua Avenue / Coeur d'Alene, Idaho 83815
(208) 762-1122 / FAX (208) 762-9191 / LCCA.com

October 5, 2016

RECEIVED

OCT - 7 2016

FACILITY STANDARDS

Debra Ransom – R.N., R.H.I.T., Chief
Bureau of Facility Standards
Idaho Department of Health & Welfare
3232 Elder Street
Boise, Idaho 83720-0009

RE: Amended Deficiency and Plan of Correction Form re-submittal
Provider # 135122

Dear Ms. Ransom,

Enclosed please find a copy of the re-submission of our Plan of Correction reflecting the reduction of our "G" to a "D" from the Informal Dispute Resolution decision. We understand this amended Statement of Deficiencies and Plan of Correction, Form CMS-2567 will become our facility's survey of record.

We appreciate your time in this matter.

Regards,



Valeri Zaharie – Interim Administrator
Life Care Center of Coeur d'Alene

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

PRINTED: 09/24/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/18/2016
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COEUR D'ALENE			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST AQUA AVENUE COEUR D ALENE, ID 83815	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from March 14 to March 18, 2016.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Evelyn Floyd, JD, MSN, RN Linda Close, RN-BC, RAC-CT Tina Hicks, RN</p> <p>This report reflects changes resulting from the Informal Dispute Resolution (IDR) hearing held on August 17, 2016.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status BMI = Body Mass Index C-Diff = Clostridium Difficile CAA = Care Area Assessment CM = Case Manager CNA = Certified Nurse Aide C&S = Culture and Sensitivity d/c = Discontinue DON = Director of Nursing FSM = Food Service Manager FWW = Front Wheel Walker HAI = Healthcare Associated Infection ICP = Infection Control Program IDT = Interdisciplinary Team kcal = Kilocalorie's lbs = Pounds LN = Licensed Nurse MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set assessment Milligram = mg</p>	F 000	<p><i>This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.</i></p> <p><i>Corrective action will be completed on April 20, 2016.</i></p> <p style="text-align: center;">RECEIVED OCT - 7 2016 FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jafar M. Zahraie* TITLE *Executive Director* 10-5-16 (X6) DATE 04/13/2016

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 000	Continued From page 1 Milliliter = ml MRSA = Methicillin-Resistant Staphylococcus Aureus OZ = Ounces PPE = Personal Protection Equipment PRN = As Needed PT= Physical Therapy PVR= Post Void Residual RAI = Resident Assessment Instrument RD = Registered Dietician RNA= Restorative Nurses Aide ROM= Range of Motion RX = Prescription S/S = Signs and Symptoms TB = Tuberculosis TBI = Traumatic Brain Injury TX = Treatment UA= Urinary Analysis UTI= Urinary Tract Infection VRE = Vancomycin Resistant Enterococci W/C = Wheelchair	F 000	F151 SPECIFIC RESIDENT (s): Resident # 11 provided with a copy of residents rights and encouraged to post personal signage as long as the signage does not infringe upon other residents rights. Resident offered to change case managers and resident declined. Resident #11 encouraged to post signage. OTHER RESIDENT(s): Resident council provided a copy of residents' rights and encouraged to post personal signage as long as the signage does not infringe upon other residents rights. Residents surveyed to ensure resident posted signage has not been removed without permission.	
F 151 SS=D	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure a resident could exercise individual rights when a sign placed on her bathroom door was	F 151	SYSTEMATIC CHANGE: Staff educated regarding residents rights, residents posting personal signage, and appropriate approach and tone communicating with residents. Education also includes referring complaints of inappropriate signs to Executive Director for follow up and compromise between residents.	4/20/16

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F 151	<p>Continued From page 2</p> <p>removed by staff without the resident's permission. This was true for 1 of 14 (#11) residents sampled for resident rights and had the potential to cause adverse psychosocial effects when the resident wasn't consulted first about the sign's removal. Findings included:</p> <p>On 3/14/16 at 1:30 pm, Resident #11 stated CM #3 "lectured her" about an inappropriate sign that was on her bathroom door. Resident #11 said, "I was very upset about it, I didn't even put the sign there to begin with and I don't know who took it down. I think it's my right to put a sign up in my own bathroom. The sign was not inappropriate, my roommate's family complained about it and someone took it down. No one talked to me about it until CM #3 told me the sign was taken down."</p> <p>Resident #11 was admitted to the facility in 2014 with diagnoses of hypertension, depression, edema, and panic disorder.</p> <p>An MDS comprehensive assessment, dated 12/20/15, documented Resident #11 had no cognitive impairment, was understood by others, and was capable of understanding others, had no memory impairment, and could make her own decisions.</p> <p>On 3/15/16 at 1:25 pm, Resident #11 said, "I have a high I.Q. and I was an accountant; I don't have to be lectured by [CM #3] about anything. I'm still mad at her and I won't go to her for help unless there is no one else to talk to. I haven't talked to her since and she hasn't tried to talk to me." Resident #11 stated the sign was removed a month prior. The sign, which the resident had stored in a folder in her room, read, "UNISEX, MEN & WOMEN, BOYS & GIRLS, MALE &</p>	F 151	<p>Facility admissions staff to educate new admits regarding residents rights and to encourage residents to post personal signage as long as the signage does not infringe upon other residents rights.</p> <p>MONITOR: Activities Director will ask Resident Council attendees at monthly meetings x 3 months to ensure residents retain the right to post personal signage without the signage being taken down without permission. Activities Director or designee to interview those residents who do not attend Resident Council Meetings at a rate of 5 residents per week x 8 weeks, then 5 Residents per month x 3 months, to ensure resident's right to post signage is in place. Monthly Performance Improvement Meeting to review audits and implement system changes as necessary.</p>	4-20-16	

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F 151	<p>Continued From page 3</p> <p>FEMALE BATHROOM." Resident #11 said another resident made the sign and put it on the bathroom door as a joke. Resident #11 also stated, "Men have never used my bathroom and I didn't think it was that big a deal; it wasn't that inappropriate."</p> <p>A social service note, signed by CM #3 and dated 2/9/16, documented, "I addressed resident about a [sic] inappropriate sign that was hanging on her bathroom door. When I asked her about it she said that someone put it up there as a joke. I explained to her that the bathroom was for her and her roommate. Not for males top [sic] use. She said that she understood. SS will continue to monitor."</p> <p>On 3/17/16 at 8:45 am, CM #3 stated the sign, with a sticky note attached, had been placed in her mailbox by, according to the note, a night shift CNA. CM #3 could not recall who the CNA was who took the sign down, but said, "It was brought up at morning meeting and I went to talk to [Resident #11]. She said another resident put the sign up. I told her, 'You have a roommate and the sign said men allowed.' I told her we can't have a sign like this." CM #3 said she was not sure if Resident #11 gave permission to have the sign removed.</p> <p>On 3/17/16 at 10:30 am, the Administrator said he knew about the sign, but had not seen it and didn't know who removed it. The Administrator noted the issue was broached in morning meeting and said, "I thought the issue was resolved when the roommate was moved to another room. I didn't know [Resident #11] was upset about it. I do recall referring it to social services."</p>	F 151		4-20-16	

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F 151	Continued From page 4 On 3/18/16 at 11 am, UM #4 stated she did not know who took the sign down and said, "I heard about it at the morning meeting. They said a CNA on the evening or night shift took it down, I have no idea who it was. Whoever took it down should have talked to the resident and asked permission before taking the sign down."	F 151			
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and observation, it was determined the facility failed to effectively communicate and address concerns related to residents' social interactions with each other and the removal of personal signage in the resident's room. This was true for 2 of 3 residents for sampled for social services and created the potential to limit residents' social interactions (#7 and #12). Findings include: 1. Resident #7 was admitted to the facility on 4/15/15 with diagnoses of depression, and dementia with moderate cognitive impairment. Progress Notes, dated 12/21/15, documented the resident, "wanted to go over and visit the gentlemen in [another room] and was noted to be holding hands and cuddling, social services was informed. "	F 250	F 250 *SPECIFIC RESIDENTS: Case Management consulted with Resident # 12, Resident # 7 and with Resident # 7's guardian and all expressed a desire to have social interactions, including touching, holding hands and kissing, continue between Resident # 12 and Resident # 7. Case Management encouraged Resident # 7 and # 12 to continue social interactions as described, and resident # 7's guardian consented to care plan of touching, holding hands, and kissing, however, guardian wishes residents to be separated if social interactions exceeds care plan. OTHER RESIDENTS: Resident Council provided with education and encouragement for consenting adults to have social interactions, including touching, holding hands, and kissing with other residents of the facility.	4/20/16	

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F 250	<p>Continued From page 5</p> <p>On 12/24/15, Progress Notes documented the resident had walked into another resident's room.</p> <p>On 12/26/15, Progress Notes documented resident #7 "didn't visit [Resident #12] last night." Resident #7's Progress Notes did not contain documentation regarding the resident visiting or entering another resident's room after 12/26/15.</p> <p>Social Service Quarterly Progress Notes for Resident #7, dated 1/7/16, documented the resident was prescribed Zoloft for depression and the resident was being monitored for increased tearfulness, sadness and verbalizations of hopelessness related to her husband's death.</p> <p>Social Service Progress Notes did not contain documentation regarding any discussions with the resident related to Resident #12, entering other residents' room(s), visiting other residents, or other "inappropriate" behaviors.</p> <p>On 3/16/16 at 8:30 am, Resident #7, stated she was not allowed to go into other residents' rooms or Resident #12's room because staff told her it was "inappropriate." The resident stated if she wanted to talk to [Resident #12], she had to be outside the door in the hallway. She stated, she liked talking to him and was "not sure what they [staff] think I ' m going to do with him ...he's missing a leg and [is] in a wheel chair. "</p> <p>2. Resident #12 was admitted to the facility on 4/24/06 with diagnoses of below the knee amputation, depression, and brain anoxia with moderate cognitive impairment.</p> <p>Progress Notes, dated 11/24/15, documented the</p>	F 250	<p>SYSTEMATIC CHANGES: Case Management and staff educated regarding consenting residents right to social interactions, including touching, holding hands, and kissing, with other resident of the facility. Case Management also provided specific education to effectively communicate and address concerns of residents engaged in social interactions, regulations regarding Idaho department of Health and Welfare Resident Abuse Reporting in SNF/NF's, and regarding residents rights to personal signage.</p> <p>MONITOR: Exécutive Director, E.D., or designee to review 24 hour report and concern/grievance log Monday through Friday daily at Stand Up Meeting x 8 weeks, and monthly x 3 months to ensure residents with social interaction concerns, and/or personal signage concerns have their concerns addressed, documented, and communicated effectively by Case Management. Monthly Performance Improvement Meeting to review audits and implement system changes as necessary.</p>	4-20-16	

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F 250	<p>Continued From page 6</p> <p>resident was making inappropriate sexual remarks to staff and the psychiatrist was notified. On 11/28/15, the progress notes documented the absence of inappropriate comments during the shift. On 12/22/15, the progress notes documented the resident had not visited with female resident in his room that day. The record did not contain documentation regarding the resident's behaviors toward other residents.</p> <p>Social Service Progress Notes documented the resident had a diagnosis of depression which was treated with Zoloft, Cymbalta, and Ritalin. Behavior monitoring included statements of worthlessness, happiness, and inappropriate sexual comments directed at staff.</p> <p>Social Service Progress Notes did not contain documentation regarding any discussions with the resident related to Resident #7, entering other residents' room(s), or visiting other residents, inappropriate behaviors.</p> <p>On 3/16/16 at 10:15 am, Resident #12 stated he was not allowed to go into other resident's rooms. He stated he had seen other residents repeatedly going in and out of each other rooms, but that he had been told by staff it was "inappropriate," for him to do so. The resident said he didn't understand why he was prohibited from doing what other residents were allowed to do.</p> <p>On 3/15/16 at 1:30 pm, during a group interview, (5 of 5 residents) stated they were not allowed to "kiss, hold hands [or] fraternize" with other residents because they were told by staff these behaviors were " inappropriate." They stated that Resident Council or Social Serviced had not talked with them about this prohibition.</p>	F 250			

4-20-16

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F 250	Continued From page 7	F 250			
F 280 SS=E	<p>On 3/17/15 at 10:10 am, Social Service' case managers [CM #3 and #19] stated they were unaware the residents felt like they could not touch each other, hold hands, kiss, or fraternize with each other. CM #3 and CM #19, stated their concern would be safety and whether the residents could consent. The case managers stated they were not aware of any behaviors preventing Residents #7 and #12 from interacting. CM #3 and CM #19 stated that Resident #7 would not leave her room without encouragement, and Resident #12, who was easily engaged, went into other residents' rooms. CM #3 and CM #19 stated Resident #7 and Resident #12 would have the capacity to consent and they were not aware of any issues with either resident. CM #19 stated that in November or December 2015 a staff member reported to the nurse that Residents #7 and #12 were in Resident ' s #7 room holding hands. CM #3 and #19 stated they were unsure about what happened or what had been done, and that neither of them were involved in following up with either resident and could not explain why there was not any documentation. CMs #3 and #19 stated that all social service documentation would either be in social service progress notes or in psychiatric notes for medication reviews.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p>	F 280	<p>F 280</p> <p>SPECIFIC RESIDENT: Resident # 7 care plan updated to reflect current mood and behaviors regarding suicidal statements. Residents # 3 and # 15 discharged from the facility. Resident # 1's care-plan updated to reflect appropriate interventions for weight gain.</p>	4/20/16	

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F 280	<p>Continued From page 8</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and observation, it was determined the facility failed to update and revise resident care plans. This was true for 4 of 14 sampled residents without care plan revisions regarding behaviors (#7); acute infections (#s 3 & 15); and nutrition (#1). This created the potential for inappropriate care for these residents. Findings include:</p> <p>1. Resident #7 was admitted to the facility on 4/15/15 with diagnoses of Type II diabetes, dementia, history of falls, and depression.</p> <p>The care plan, dated 5/4/15, documented the resident exhibited tearfulness, sadness and verbalized hopelessness related to the death of her husband.</p> <p>A Physician Progress Note, dated 10/22/15, documented the resident was tearful, and "saying she wishes she would die." On 2/23/16,</p>	F 280	<p>OTHER RESIDENTS: Residents verbalizing suicidal statements, and/or residents with acute infections, and/or residents requiring isolation precautions, and/or residents requiring weight gain interventions have had their charts audited to ensure care plans updated with appropriate interventions.</p> <p>SYSTEMATIC CHANGES: Nurse Managers, nursing staff, and Interdisciplinary staff educated regarding the necessity to update care plans when residents verbalize suicidal statements, and/or when residents have acute infections, and/or when residents require isolation precautions, and/or when residents require weight gain interventions.</p> <p>MONITOR: Director of Nursing or designee will review new orders and the 24 hour report weekly x 8 weeks and monthly x 3 months and select 15 care plans to review. The selected care plans will be reviewed to ensure care plan updates are completed on residents verbalizing suicidal statements, and/or residents with acute infections, and/or residents requiring weight gain interventions.</p>	4-20-16	

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F 280	<p>Continued From page 9</p> <p>the psychologist documented the resident stated, "I thought about killing myself yesterday."</p> <p>On 2/23/16, behavior monitoring was initiated for, "verbalizing her desire to die," and "statements of wanting to die."</p> <p>On 2/29/16, a Physician Progress Note documented the resident told her priest how depressed she was and did not think her life was worth living.</p> <p>The resident s care plan did not contain documentation identifying or addressing the resident's verbalizations of wanting to kill herself or die.</p> <p>On 3/16/16 at 12:10 pm, the DON stated the care plan should have included monitored behaviors and that the resident's suicidal statements should have been addressed on the care plan.</p> <p>#2. Resident #1 was admitted to the facility on 10/29/15 with multiple diagnoses, including TBI.</p> <p>The resident's 1/5/16 quarterly MDS assessment documented the resident: *was severely cognitively impaired, *had experienced significant weight gain, and *required limited one-person assistance with meals.</p> <p>The resident's 2/23/16 nutritional note documented, "Rec[ommned] to only provide 1 2% milk w[ith] each meal in order to [decrease] excess kcal."</p>	F 280	<p>Monthly Performance Improvement Meeting, to review audits and implement system changes as necessary.</p>		

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F 280	<p>Continued From page 10</p> <p>The resident's 3/1/16 Diet Order & Communication form documented, "1-2% milk each [meal] tray..."</p> <p>The resident's 3/1/16 faxed physician's order documented, "1 carton of 2% milk" to reduce calories with a goal of weight loss.</p> <p>The resident's nutritional care plan intervention on 12/23/15 of "2 2% milks each tray," was crossed out with a discontinued date of 3/1/16. There was no other intervention on the nutritional care plan regarding milk.</p> <p>On 3/17/16 at 8:35 am, the DON said the nutrition care plan should have been updated.</p> <p>Refer to F325 regarding nutritional concerns regarding milk.</p> <p>3. Resident #3 was admitted to the facility on 1/19/16, and readmitted on 1/28/16, with diagnoses of renal failure, Stage V chronic kidney disease, hypertension, anemia, Crohn's disease, pneumonia, and heart failure.</p> <p>The most recent comprehensive MDS assessment, dated 2/4/16, documented Resident #3 understood others and was understood, was cognitively intact, and required extensive staff assistance with ADLs.</p> <p>A lab report, dated 2/25/16, documented Resident #3 had C-diff and MRSA.</p> <p>The resident's current care plan did not include documentation pertaining to isolation precautions</p>	F 280		4-20-16	

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F 280	Continued From page 11 due to C-diff. On 3/15/16 at 2:00 pm, Resident #3 was observed in her room with isolation precautions in place. The resident stated she did not know why she was on isolation precautions. 4. Resident #15 was admitted to the facility on 2/10/16 with diagnoses of anemia, thrombocytopenia, pathological fracture of the pelvis, B-cell lymphoma, chronic kidney disease, gout, and squamous cell carcinoma of face and ear. The most recent MDS, dated 2/17/16, documented Resident #15 understood others and was understood, was cognitively intact, and required extensive assistance with ADLs. A laboratory report, dated 3/11/16, documented Resident #15 had staphylococcus aureus MRSA of the sputum. Resident #15's care plan did not reflect the acute MRSA respiratory infection. On 3/17/16 at 3:15 pm, the DON said LPNs were responsible for formulating comprehensive care plans from RAI-CAA triggers. The DON said she was currently responsible for the acute care plans and that acute infection care plans, including that for Resident #15, are commonly not completed as she had to "pick her battles."	F 280			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a	F 315	F 315 SPECIFIC RESIDENT (s)Resident # 7 catheter use reviewed by Urologist, primary care physician, and guardian. Trial d/c of Foley catheter completed and unsuccessful due to ongoing retention of urine due to neurogenic bladder. Resident with history of post-void residuals greater than 200 ml. Foley catheter reinserted.	4/20/16	

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F 315	<p>Continued From page 12</p> <p>resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interviews and observation, it was determined the facility failed to ensure a resident was not catheterized without a valid medical justification and received treatment to restore as much normal bladder function as possible. This was true for 1 of 7 sampled residents for urinary incontinence (#7). Findings include:</p> <p>Resident #7 was admitted to the facility on 4/15/15 with diagnoses of Type II diabetes, history of falls, depression, and dementia.</p> <p>On 4/20/15, a Urinary Incontinence Assessment documented the resident had stress incontinence; occasional bladder incontinence; recognized the urge to void; could learn to control the urge; and could contract her pelvic muscles. A schedule of toileting the resident before or after meals, at nighttime, and as needed was implemented.</p> <p>On 4/22/15, the MDS admission assessment documented the resident did not have an indwelling catheter; was in a toileting program or trial; had frequent urinary incontinence; and required extensive assistance of one person for</p>	F 315	<p>OTHER RESIDENT(S): Residents with Foley catheters audited to ensure appropriate diagnosis and use of Foley catheters. No other residents with post admissions Foley catheters present in facility.</p> <p>SYSTEMATIC: Education provided to nursing staff regarding facility policy and federal regulations regarding the appropriate use and documentation of Foley catheters. Nurse Managers educated to question and follow up with Medical Doctor, IDT, and urologist before insertion of any Foley catheter.</p> <p>MONITOR: Residents with Foley catheters will be monitored weekly x 8 weeks, and monthly x 3 months to ensure resident with continued Foley catheter placement have appropriate medical justification and diagnosis for use of Foley catheters.</p>	4-20-16	

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F 315	<p>Continued From page 13 toileting.</p> <p>On 8/3/15, an urologist documented the resident was assessed for recurrent UTI's and nocturnal enuresis [urinary incontinence]. A urinalysis was ordered and the urologist advised decreasing the resident's liquid intake in the evening.</p> <p>On 8/13/15, 10/6/15, and 1/7/16, Bladder Training Assessments documented the resident: * had stress incontinence; * was a candidate for toileting; * was a candidate for timed or scheduled voiding; and * was to be offered toileting before or after meals, at nighttime and as needed. The assessments did not include decreasing the resident ' s fluid intake at night as an intervention.</p> <p>On 9/4/15, a Physician Progress Note documented the resident had "several falls while trying to self-transfer rather than using her call light. Alarms have been placed on her recliner, wheel chair, and bed. There was also an alarmed mat placed at the feet of her recliner." The physician documented the resident had a history of UTIs, tested positive for a UTI, and was on antibiotics for the UTI.</p> <p>On 9/15/15, a Physician Progress Note documented the resident had fallen. It documented the resident had short-term memory loss and when she experienced the urge to urinate she has to go immediately and did not use her call light for help. "Apparently she is up frequently to use the restroom and likely has overflow incontinence."</p> <p>On 10/5/15, a Physician Progress Note</p>	F 315		4-20-16

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F 315	<p>Continued From page 14</p> <p>documented the resident was assessed with a UTI. On 10/21/15, an Incident and Accident Report documented the resident fell from the toilet while reaching for a brief without calling for help.</p> <p>On 11/19/15, Physician Progress Note documented the resident had mild dehydration and another UTI.</p> <p>On 12/5/15, a Fall Risk Evaluation documented the resident fell on 10/13/15, 11/24/15, and 12/05/15. The evaluation documented the resident required assistance for elimination.</p> <p>On 12/24/15, a Physician Progress Note documented the resident had a UTI and diarrhea with C. difficile enterocolitis.</p> <p>On 1/12/16, a Physician Progress Note documented "out of control " blood sugars and mental confusion. The physician ordered a UA with C&S.</p> <p>On 1/22/16, a Physician Progress Note documented the resident ' s UA was positive for Kelbsiella, E-coli and beta strep bacteria. The plan was to "consider Foley catheter because she goes from 1 UTI to the other primarily because she doesn ' t notify staff of needing to use the restroom frequently enough."</p> <p>On 1/24/16, an Incident and Accident report documented the resident fell at 3:30 am.</p> <p>On 1/25/16, a Physician Progress Note documented the resident had a history of urinary incontinence and neurogenic bladder. The physician progress note further documented, "</p>	F 315		4-20-16	

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F 315	<p>Continued From page 15</p> <p>...it may be reasonable to put a Foley in her because of previous observations that she tends to cross contaminate herself between her rectum and her vaginal area and this may decrease her incidence of recurrent UTIs ...unfortunately she had another slight fall over the weekend which was no-injury. "</p> <p>On 2/29/16, a Physician Progress Note documented the resident had not had an UTI since the Foley was placed on 1/25/16. Neither the resident ' s admission nor her quarterly MDS, dated 4/22/15 and 1/5/16 respectively, documented the resident had a diagnosis of neurogenic bladder. Physician Progress Notes prior to 1/25/16 also did not contain documentation regarding a neurogenic bladder.</p> <p>On 1/26/16, a Catheter Justification form documented the resident had a neurogenic bladder resulting in urinary retention. All previous documentation noted urgency, overflow, and bladder incontinence, but did not contain documentation of urinary retention or neurogenic bladder.</p> <p>On 2/2/16, a Progress Note documented the Foley catheter was changed due to the resident pulling it out.</p> <p>On 2/8/16, a Resident/Family Education Assessment & Interdisciplinary Flow Record documented nursing had "spoke [sic] with resident about her alarms and her safety, that we [the facility] are not holding her hostage. She has many falls."</p> <p>On 3/14/16 at 9 am, the resident stated she had the catheter because she was "wetting the bed."</p>	F 315		4-20-16	

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F 315	Continued From page 16 On 3/16/16 at 8:50 am, the resident stated she was "stuck in the [her] room," and could not go where she wanted because of the many alarms and because she was "tied down with the catheter." She stated she did not want the catheter and that the aides helped her with cleaning herself after toileting. On 3/16/16 at 8:55 am, CNA #8 stated the resident typically fell while getting up to use the bathroom without using the call light for help. She stated the resident required assistance of one staff to toilet and that staff performed peri-care. On 3/16/16 at 12:10 pm, the DON stated the resident had a quick succession of falls; shuffled her feet; and could not safely toilet without assistance. She stated aides performed peri-care for the resident and that the physician ordered the Foley catheter to "remove issues with the bladder." She stated that prior to the insertion of the catheter, the resident had not been seen by an urologist, had a bladder scan had not been performed, and post-void residuals had not been determined. On 3/17/16 at 8:30 am, the resident stated she felt like a "prisoner" who was "blocked everywhere I turn." The catheter does not even reach the dresser." She repeated that she did not want the catheter, which was inserted because she was "wetting the bed." The resident stated she could "feel" the urge to toilet and had wet the bed only because staff did not respond to her call light in a timely manner. On 3/17/16 at 11 am, the DON stated the resident voiced that she felt like a prisoner since she was	F 315		4-20-16	

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F 315	<p>Continued From page 17</p> <p>admitted. She stated the physician wanted to try the Foley to keep the resident from acquiring C-Difficile. The DON stated staff performed peri care on the resident, who had not had an UTI or fall since the catheter was inserted. The DON noted the physician wanted a catheter because the resident "could get an infection that would kill her."</p> <p>On 3/18/16 at 12:20 pm, Physician #14 stated the resident fell multiple times since admission, typically while trying to access the bathroom. He stated the resident had repeated UTIs and despite trying every means to keep her dry, she was continually incontinent. He stated he had assumed she continued to cross contaminate herself. He stated he ordered the catheter: because the resident had recurrent UTIs; increased risk of resistance to bacteria from high doses of IV antibiotics; and to keep her from cross-contaminating herself. He stated the resident had not experienced any UTIs or falls since the catheter had been placed. Physician #14 stated that although staff performed peri-care for the resident, and the catheter did not prevent the resident from putting her hands in her peri area, he thought the benefits outweighed the risks. Physician #14 stated the facility had not performed a bladder scan or PVR prior to the Foley catheter's placement, and had not been referred to an urologist after seeing one in August for UTIs. He stated he was unaware the resident had pulled out the catheter on 2/2/16.</p> <p>When asked about the notation on 1/25/16 asserting the resident had a neurogenic bladder, the physician stated that although the resident did not have any neurological issues, and had not had any tests performed, he thought she probably</p>	F 315		4-20-16	

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F 315	Continued From page 18 had a neurogenic bladder and there were no plans to remove the catheter.	F 315			
F 318 SS=D	<p>The facility provided a letter from Physician #14, dated 3/22/16, that documented the Foley catheter was a "trial" measure. The resident's clinical record did not include any such "trial" reference or contradict Physician #14's statement on 3/18/16 that there were no plans to attempt removing the catheter.</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interviews and observation, it was determined the facility failed ensure 1 of 2 residents (#7) sampled for receiving restorative exercises as care planned to prevent further decreases in range of motion. This deficient practice resulted in the resident requiring increased assistance with ADLs. Findings include:</p> <p>Resident #7 was admitted to the facility on 4/15/15 with diagnoses of Type II diabetes, coronary artery disease, history of falls, depression, and dementia with moderate cognitive impairment.</p>	F 318	<p>F318 SPECIFIC RESIDENT(s): Resident # 7 restorative exercises were resumed.</p> <p>OTHER RESIDENT(s): Residents currently receiving restorative exercises had their programs reviewed to ensure appropriate restorative programs care planned and appropriate restorative exercise's being completed.</p> <p>SYSTEMATIC CHANGES: Restorative Nursing Assistants educated to provide daily, Monday through Friday information regarding residents refusing, and/or-missing restorative exercises to Restorative Nurse Manager.</p>	4/20/16	

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F 318	<p>Continued From page 19</p> <p>On 4/22/15, the MDS admission assessment documented the resident required extensive assistance of one staff for bed mobility, transfers, and toileting, and required limited assistance of one staff to walk in the room and corridor.</p> <p>On 1/5/16, the MDS quarterly assessment documented the resident required extensive assistance of two staff for bed mobility and toileting, and extensive assistance of one staff for transfers. The resident had walked in the room once or twice with one staff assisting and had not walked in the corridor. Neither the admission nor the quarterly MDS documented Restorative Nursing Programs.</p> <p>Physical Therapy Notes documented the resident received physical therapy: on 5/11/15 when she had reached the treatment goal of walking 150-275 feet using a FWW with standby assistance. On 1/3/16, the resident met the plan of treatment goal by walking 300 feet using a FWW with standby assistance.</p> <p>Incident and Accident records documented the resident fell on: 10/13/15; 11/20/15; 12/10/15; and 1/24/16.</p> <p>The resident 's Restorative Exercise Program care plan, dated 5/29/15, identified the resident had lack of safety awareness and required assistance for ambulation with a FWW. Approaches included sit-to-stand and marches(marching in place) using FWW or bathroom sink for balance with increases in repetitions as tolerated.</p> <p>Restorative Administration Records documented</p>	F 318	<p>Restorative Nurse Manager educated to review resident who refuse and/or missed restorative exercises and ensure appropriate restorative exercises are care planned, and completed. Restorative Nurse Manager also educated to refer any resident refusing restorative exercises and/or residents lacking participation for a period of two weeks to the Director of Nursing and Therapy Department. Restorative Nurse Manager referrals to Director of Nursing and Therapy department to also include residents in the restorative program who demonstrate a decline in condition.</p> <p>MONITORING: Residents receiving restorative exercises will have their programs monitored by the Director of Nursing or designee weekly x 8 weeks, and monthly x 3 months to ensure appropriate programs being are completed. Monthly Performance Improvement Meeting, to review audits and implement system changes as necessary.</p>	4-20-16	

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F 318	<p>Continued From page 20</p> <p>the following:</p> <p>*December records documented that since 10/23/15 the resident was to ambulate 50-150 feet with increases in the distance as tolerated 5-7 days a week. The record documented the resident had been ambulated 5 of 31 days. The record further documented the "program was not completed," 16 of 31 days, and the resident had refused to participate on 2 days. The record further revealed that after 12/23/15, the resident had not ambulated, and ambulation exercises were no longer part of the resident ' s restorative program.</p> <p>*January records documented the resident completed sit-to-stand exercises and standing marches 8 of 31 days, but she either refused or did not complete the nu-step exercises that had been planned. The record ' s weekly summary documented the resident had been tired and ill for two weeks and that there had been four days when the "program was no completed."</p> <p>*February records documented the nu-step exercises were discontinued on 2/10/16. Sit-to-stand and standing marches were "programs not completed " 7 of 29 days, and the resident refused to participate in the therapy 2 days.</p> <p>*March records from 3/1/16 to 3/13/16, documented the " program [was] not completed, " 5 of the 13 days reviewed.</p> <p>On 3/14/16 and 3/15/16, the resident was observed to not leave her room. On 3/16/16 at 8:30 am, the resident was taken to the small dining room by staff to participate in an activity. The resident stated "They [activity aides] just came and got me. "</p> <p>On 3/16/16 at 1:05 pm, RNA #18 stated that</p>	F 318		4-20-16	

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F 318	Continued From page 21 "program not completed" either meant the resident was in an activity or that the RNA did not have time to perform the resident ' s restorative program. She stated the resident was usually available for restorative therapies as she typically did not leave her room. The RNA stated she had 22 residents on the restorative program and sometimes did not get to everyone. The RNA stated Resident #7 did not ambulate anymore; was unsteady with the FWW and all restorative exercises were done in the resident ' s bathroom using the sink. On 3/17/16 at 8:30 am, the resident stated the RNA did not " get to her every day, but usually once a week. " She stated that she had asked [staff], " How do you expect me to get stronger if sit here? " She stated she spent most of the day in her recliner and needed help to go anywhere. The resident stated she did not believe she was getting stronger. On 3/17/16 at 3 pm, PT #20 stated Restorative nursing needed to push the resident to capacity within the limits of safety. She stated that PT was not aware the resident was no longer walking, and the RNA should be trying to walk the resident. She further stated that although the resident needed encouragement, she rarely refused to participate in therapies. On 3/17/16 at 4:45 pm, the resident was observed ambulating down the corridor using a FWW with stand-by assistance from PT.	F 318			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive	F 325	F325 SPECIFIC RESIDENT: Resident # 1's meal tray card and care plan updated to read 1 carton of 2% milk. Resident # 1 meal service observed to ensure 1 carton of 2% milk being delivered.	4/20/16	

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F 325	<p>Continued From page 22</p> <p>assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure an intervention was consistently implemented for a resident identified with weight gain. This was true for 1 of 14 (#1) sampled residents. This practice created the potential to impact the resident's health status. Findings included:</p> <p>Resident #1 was admitted to the facility on 10/29/15 with multiple diagnoses including TBI.</p> <p>The resident's 1/5/16 quarterly MDS assessment documented the resident:</p> <ul style="list-style-type: none"> *was severely cognitively impaired, *experienced significant weight gain, and *required limited one-person assistance with meals. <p>The resident's 12/22/15 nutritional note documented:</p> <ul style="list-style-type: none"> *The resident experienced a "significant weight gain" of 8.67 percent in 42 days with a weight of 213 pounds and BMI of 28.8, *A family member requested weight loss for the 	F 325	<p>OTHER RESIDENT(s): Residents with weight gain interventions were reviewed by the Dietary Manager to ensure appropriate weight gain interventions documented in their care plan and tray card. Dietary manager reviewed resident with weight gain interventions to ensure appropriate drinks are provided per care plan and meal tray cards.</p> <p>SYSTEMATIC CHANGES: Residents at Risk Committee, and staff educated regarding the necessity to update care plans and meal tray cards when residents require weight gain interventions. Direct care staff educated regarding the necessity to check meal tray cards prior to providing meals to residents.</p> <p>MONITORING: Dietary Manager, or designee to audit twice weekly reviews x 8 weeks, and monthly reviews x 3 months of residents with weight gain interventions to ensure beverages served are consistent with care plans, and meal tray cards. Monthly Performance Improvement Meeting to review audits and implement system changes as necessary.</p>	4-30-16

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F 325	<p>Continued From page 23 resident, and</p> <p>*New interventions included reducing calories with changes from two 8-ounce containers of whole milk to two 2% containers of milk per meal and a change to small lunch and dinner meal portion sizes.</p> <p>The resident's 2/23/16 nutritional note documented:</p> <p>*The resident weighed 218 pounds- a 2.29 percent weight gain in 60 days with an increased BMI of 29.5,</p> <p>*The family and resident requested weight loss, and</p> <p>*New interventions included reducing calories by providing only one 2% container of milk per meal and changing all meal sizes to regular-sized portions.</p> <p>A weight monitor documented the following weights:</p> <p>*2/14/16-218 lbs *2/22/16-220 lbs *2/28/16-226 lbs *3/6/16-222.8 lbs *3/13/16-222.4 lbs.</p> <p>The resident's 3/1/16 Diet Order & Communication documented, "1-2% milk each tray..."</p> <p>The resident's 3/1/16 faxed physician's order documented, "1 carton of 2% milk" to reduce calories with a goal of weight loss.</p> <p>The resident's nutritional care plan intervention on 12/23/15 of "2 2% milks each tray" was crossed out with a discontinued date of 3/1/16. There was no other intervention on the nutritional care plan</p>	F 325		4-20-16	

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F 325	<p>Continued From page 24 regarding milk.</p> <p>The resident's meal tray card used by dietary/kitchen staff preparing meals documented under beverages, "2% 8 oz."</p> <p>On 3/14/16 from 12:12 pm to 12:45 pm, during the lunch meal observation, the resident was observed in the 400 hallway day room with two half pint (8 ounces each) cartons of 2% milk. CNA #15 provided the resident with the second carton without asking if he wanted more milk. The resident drank both milks.</p> <p>On 3/15/16 at 8:20 am, the resident was observed in the 400 hallway day room eating breakfast. The resident had a carton of whole milk on his tray. At 8:45 am, CNA #16 opened another carton of whole milk without asking the resident if he wanted more and the resident drank both milks. At 1:07 pm, the resident was observed to have drunk another 8-ounce carton of whole milk.</p> <p>On 3/15/16 at 3:40 pm, CNA #16 said the resident was to receive one carton of 2% milk.</p> <p>On 3/16/16 at 8:40 am, LN #17 delivered the resident his breakfast tray and, without checking the meal tray card, asked CNA #16 what type of milk Resident #1 drank. CNA #16 said, "2%," and LN #17 then opened a carton of 2% milk for the resident. At 12:12 pm, CNA #15 assisted the resident with his lunch and opened two cartons of whole milk for the resident without asking the resident if he wanted the second carton.</p> <p>On 3/16/16 at 12:17 pm, CNA #15 said Resident #1 usually drank two cartons of either 2% or</p>	F 325		4-20-16	

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F 325	Continued From page 25 whole milk. On 3/16/16 at 1:40 pm, the RD said due to the resident's weight gain one of the several interventions was to provide two 8-ounce cartons of 2% milk, which was later changed to only one carton of 2% milk, unless the resident asked for more. The RD verified a carton of whole milk contained 160 calories with 70 fat calories, while 2% contained 130 calories with 45 fat calories. When informed of the observations, she said she expected staff to give the resident what was ordered and follow the meal card, otherwise the resident received too many calories.	F 325			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of kitchen cleaning schedules, and interview, it was determined the facility failed to store and prepare foods under sanitary conditions, and failed to follow proper hand hygiene and appropriate use of gloves. These failures of the facility to store, prepare, and handle food under sanitary conditions had the potential to place all residents who dined in the	F 371	F 371 SPECIFIC RESIDENTS: Specific residents not identified. OTHER RESIDENTS: Dietary staff educated regarding storing and preparing food under sanitary conditions, proper hand hygiene, and proper use of gloves.	4/20/16	

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F 371	<p>Continued From page 26 facility at risk for more than minimal harm from food contamination. All residents dined in the facility at the time of survey and the resident census was 84. Findings include:</p> <p>1. On 3/14/16 at 9:00 am, during the initial tour of the kitchen, the following was observed in the walk-in refrigerator:</p> <ul style="list-style-type: none"> -Two half sandwiches of ham salad wrapped in cellophane on a metal food rack. There were no dates on the sandwiches indicating when they were prepared or stored. -A peeled and cut onion was wrapped in an undated cellophane wrapper. - A half-full gallon container of lemon wedges that were undated and the lid was not on tight. -Two packages of pre-prepared ribs on the shelf above the non-meat items. -An opened package of flour tortillas was not dated to indicate when it was opened. <p>From 9:15 am to 10:30 am, the following was observed in the food preparation area:</p> <ul style="list-style-type: none"> -Multiple pans with heavy grease buildup. -An inoperable light on the venti-hood. -An unidentified staff was cutting meat on a food preparation counter. A large trashcan with a soiled lid was placed at the same level of the food preparation counter and was within a few inches of the meat that was being cut. 	F 371	<p>SYSTEMATIC CHANGES: Dietary Manager to educate and review individual dietary staff compliance to ensure dietary staff practice: 1) sanitary food handling, 2) proper use and maintenance of a food thermometer, 3) labeling food items and storage of food, 4) proper use of gloves when handling food, 5) proper hand washing, 6) proper washing of pots and pans, and 7) proper dining practices to prevent the contamination of residents food and utensils during meal service.</p> <p>MONITORING: Registered Dietician or designee to review twice weekly x 8 weeks, and monthly x 3 months the staff's competency regarding storing and preparing food under sanitary conditions, proper hand hygiene, and proper use of gloves. Monthly Performance Improvement Meeting, to review audits and implement system changes as necessary.</p>	4-20-16

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F 371	<p>Continued From page 27</p> <p>-A metal bread storage shelf to the right of the toaster had large plastic bins that were covered in bread crumbs from the toaster. The FSM stated "Those are new; we have not found a good place to store them."</p> <p>-The top shelf of the bread rack had an opened loaf of wheat bread and an opened bag of hamburger buns that did not have a date of when they were opened.</p> <p>-The underside of a rubber mat on the floor in front of the pan storage area had a heavy buildup of black dirt and debris. The FSM stated, "They should have cleaned the floor last night."</p> <p>-A open, undated container of instant thickener.</p> <p>-Cook #1 was using the blender to puree rice when the blade of the blender fell off into the rice. The cook lifted and replaced the blade, touching the rice with an ungloved hand, and stated, "It was a true accident, I just realized what I did. I should have put on gloves."</p> <p>At 9:25 am, the following was observed in the dish room:</p> <p>- Ceiling tiles over the handwashing sink were coated with a buildup of black dust and dirt. The fire system sprinkler head near the ceiling tiles also had dust buildup and the ceiling tiles above the cooks' preparation area were heavy with black grease and dust buildup.</p> <p>-Ceiling tiles over the food tray line area were heavy with grease and dust buildup.</p> <p>On 3/16/16 at 9:00 am, the FSM provided a</p>	F 371		4-20-16	

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F 371	<p>Continued From page 28</p> <p>kitchen cleaning schedule; the schedule did not direct staff to mop the floor under the mats near the pan storage area.</p> <p>The FSM said, "Mopping the floors is not on the cleaning schedule, [but] the staff know they are supposed to mop the floors every day on the evening shift. It's in their job description and the evening shift does it."</p> <p>2. On 3/16/16 at 12:10 pm, Cook #2 was observed preparing residents' plates with food from the steam table. Cook #2 left the steam table area and went to the convection oven where he/she grabbed the door handle of the convection oven with a gloved hand. The cook then used the same gloved hand to reach into her uniform pocket from which he/she removed a food thermometer. Cook #2 then inserted the thermometer into a pan of broccoli that was heating in the convection oven without first sanitizing the thermometer. Without first changing his/her gloves, Cook #2 then returned to the steam table and with the same soiled glove picked up sliced tomatoes and lettuce that he/she then put on a resident's lunch plate. At 12:25 pm, Cook #2 placed a gloved hand on the handle of a metal food cart and pulled it closer to the steam table. The cook then used the same gloved hand to remove a pizza from the convection oven and place it on a plate that was being prepared on the tray line. Cook #2 did not perform hand hygiene during the entire observation.</p> <p>On 3/16/16 at 12:30 pm, in an interview regarding Cook #2 not sanitizing the food thermometer and other observations, the FSM stated, "Yes, I saw her do that."</p>	F 371		4-20-16	

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F 431 F 431 SS=F	Continued From page 29 483.60(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. 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. 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. 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. This REQUIREMENT is not met as evidenced by:	F 431 F 431	F 431 SPECIFIC RESIDENTS: Specific residents not identified. OTHER RESIDENTS: Pharmacy consultant nurse reviewed med carts to ensure medications were properly labeled/dated, expired medications discarded, and narcotics properly stored. SYSTEMATIC CHANGES: Licensed Staff educated to properly label/date eye drops, inhalers, debrox, QVar, Advair, insulins, nasal spray, and other multi-dose medications when opened. Licensed Staff also educated to reconcile, log, and store narcotics per policy. Pharmacy consultant to complete monthly reviews of med carts to ensure medications were properly labeled/dated, expired medications discarded, and narcotics properly stored. MONITORING: Director of Nursing or designee to review medication carts twice weekly x 2 weeks, then weekly x 6 weeks, and monthly x 3 months to ensure proper labeling/storing/discarding/reconciling medications.	4/20/16	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/18/2016
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COEUR D'ALENE			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST AQUA AVENUE COEUR D ALENE, ID 83815		
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F 431	<p>Continued From page 30</p> <p>Based on observation, interview and record review, it was determined the facility failed to ensure narcotics were safely stored, properly reconciled, and accurately labeled in 4 of 4 medication carts. These failures places all 84 residents who received medications at risk of ingesting medications with compromised integrity. Findings include:</p> <p>a. On 3/15/16 at 8:45 am, the following opened and undated medications were observed on Medication Cart 2:</p> <ul style="list-style-type: none"> * Two containers of Travatan (medication to reduce eye pressure) 0.0004% * Two containers of Brimonidine 2% (eye medication to treat glaucoma) * Dorzolamide timolol (medication to treat elevated intraocular eye pressure) <p>b. On 3/15/16 at 8:57 am, Medication Cart 2 was observed with 49 tablets of Clonazepam 1mg that were not logged into the narcotic record book, and an opened, undated multi-dose Advair inhaler.</p> <p>c. On 3/16/16 at 10:10 am, Medication Cart 5A was observed with the following opened, undated medications: ProAir HFA (inhaled medication to treat bronchospasms) and Advair 250/50 (inhaled medication to treat asthma/chronic obstructive pulmonary disease).</p> <p>d. On 3/16/15 at 10:15 am, the following medications were observed on Medication Cart 5B:</p> <ul style="list-style-type: none"> * Lantus insulin, opened and dated 2/4/16 * Two opened, undated bottles of Debrox ear drops (ear wax removal drops) * Qvar (medication to treat shortness of breath), 	F 431	<p>Performance Improvement Meeting to review audits and implement system changes as necessary.</p>	4-20-16	

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F 431	Continued From page 31 opened and undated * Advair250/50, opened and undated. e. On 3/15/16 at 10:20 am, the following medications were observed on the 400 Hall medication cart: * Humalog insulin, opened and undated * Novolog insulin, opened and dated 1/30/16 * Fluticasone (anti-inflammatory nasal spray) opened and undated * Two containers of Lantanoprost (anti-glaucoma eye drops), opened and undated. On 3/15/16 at 8:45 am, LN #10 said LNs were responsible for ensuring multi-dose medications should be dated when opened. LN #10 said she did not reconcile the Clonazepam during the narcotic count with the previous shift's nurse. LN #10 said she should reconciled the Clonazepam by count and then logged that information in the narcotic book. On 3/15/16 at 10:43 am, LN #2 said multi-dose medications should be dated when opened, which she said was the nurses' responsibility. On 3/17/16 at 3:15 pm, the DON said she expected nurses to date multi-dose medications and that medications should be reconciled by the receiving nurse.	F 431			
F 441 SS=F	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.	F 441	F 441 SPECIFIC RESIDENTS: Resident # 3, # 15 & #17 have discharged. Resident # 1 does not currently have an infection, and staff feeding Resident # 1 are following proper infection control procedure.	4/20/16	

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F 441	Continued From page 32 (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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment for 4	F 441	OTHER RESIDENTS: Staff are following infection control procedures. Residents with communicable infections audited for proper isolation. House wide 2-step PPD audit to ensure appropriate TB testing in place. All active infections have an appropriate organism identified, or McGeer criteria for infections met. Facility map updated with all current infections. SYSTEMIC CHANGES: Staff educated regarding infection control guidelines including protecting residents from coughs, hand washing techniques, TB control plan, isolation for communicable disease, and organism tracking. MONITORING: Director of Nursing or designee to audit 3 times weekly x 8 weeks and monthly x 3 months: a. Protecting residents from coughs, b. Hand hygiene throughout the facility, c. Resident TB tracking to ensure 2-step or chest x-ray completed, and d. Acute infections with organisms appropriately identified, and e. Use of necessary isolation precautions.	4-30-16	

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F 441	<p>Continued From page 33</p> <p>of 6 residents (#s 1,3,15 and 17) sampled for infections. This deficient practice also had the potential to affect all residents in the facility.</p> <p>* Resident #1 was provided care by a CNA who coughed in her hand and then failed to wash her hands before continuing cares.</p> <p>* Resident #3's clinical record did not indicate he/she received a two-step TB test during the stay from 1/19/16 to 3/20/16.</p> <p>* Resident #15 was diagnosed with MRSA on 3/11/16 and had no isolation precautions in place on 3/14/16.</p> <p>* Resident #17's clinical record did not document administration of a TB test during the stay from 2/1/16 to 2/16/16.</p> <p>* The ICP monthly tracking and trending logs from October 2015 to March 2016 failed to indicate tracking and trending of organisms.</p> <p>Findings include:</p> <p>1. The facility's Infection Control Logs documented:</p> <p>* October 2015: 19.79 % HAI and a 30.27 % total infection rate.</p> <p>* November 2015: 26.59 % HAI and a 41.63% total infection rate</p> <p>* December 2015: 38.92 % HAI and a 48.65 % total infection rate</p> <p>* January 2016: 41.30 % HAI and a 55.47% total infection rate</p> <p>* February 2016: 25% HAI and a 36.41 % total infection rate</p> <p>* March 2016 (current infections) at 15.47 % HAI and a 20.23 % total infection rate.</p> <p>The Infection Control Logs for October 2015 through March 2016 did not document the facility</p>	F 441		4-30-16

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F 441	<p>Continued From page 34</p> <p>had tracked any of the infections' infectious organisms.</p> <p>2. The Infection Control Log for 3/1/16 to 3/17/16 failed to document that Resident #3 was currently diagnosed with a C-diff infection, and instead contained documentation that the resident's infection was resolved.</p> <p>On 3/14/16 at 12:00 pm, the door to Resident #3's room was observed with a sign that instructed visitors to see a nurse prior to entering. Resident #3 was not in the room.</p> <p>On 3/15/16 at 8:10 am, Resident #3 was observed sitting in her room with the signage still on the door. At 2:00 pm, Resident #3 said she did not know why she was on isolation precautions.</p> <p>On 3/16/16 at 8:15 am, LN #10 said Resident #3 was on isolation precautions related to VRE. At 8:45 am, LN #9 said staff were informed of current infections through the 24 hour report and care directives instruct the specific process staff are to use with infected residents.</p> <p>Clinical records for Resident #3, who was admitted to the facility on 1/19/16, and readmitted on 1/28/16, with diagnoses that included renal failure, Stage V chronic kidney disease, anemia, Crohn's disease, did not reflect any current acute infections.</p> <p>A laboratory record dated 2/25/16 indicated Resident #3's stool culture result identified staphylococcus aureus MRSA and a positive C-difficile. The resident's TB screen record also revealed only one administration of the TB test on 2/9/16. The record did not include documentation</p>	F 441		4-30-16	

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F 441	<p>Continued From page 35 that a TB vaccination had been administered.</p> <p>3. A hospital progress note, dated 2/8/16, documented Resident #15 was previously admitted to the hospital for pneumonia and meningitis (infection of the meninges).</p> <p>Resident #15 was admitted to the facility on 2/10/16 with diagnoses of anemia, thrombocytopenia (decreased number of platelets), unstageable pressure ulcer, dysphagia, B-cell lymphoma, and chronic kidney disease. The comprehensive care plan, dated 2/22/16, did not document pneumonia on admission or the presence of an acute MRSA respiratory infection.</p> <p>A laboratory report, dated 3/11/16, documented Resident #15 had staphylococcus aureus MRSA and Enterobacter aerogenes (pathogenic bacteria causing opportunistic infections) in his sputum.</p> <p>On 3/14/16 at 11:55 pm, Resident #15, who was diagnosed on 3/11/16 with respiratory MRSA, was observed resting in his bed. There were no respiratory isolation precautions in place outside the door. At 12:30 pm, the resident's spouse was at bedside without PPE. She stated she was unaware of the need to wear any special isolation clothing or equipment. At 2:00 pm, Resident #15 was observed resting in bed with his spouse at bedside and without any respiratory precautions in place.</p> <p>The facility's "Droplet Precautions" policy, dated 5/21/2004, documented "a mask should be worn when within three feet of the resident whom has a droplet transmitted infection."</p> <p>4. Resident #17 was admitted to the facility on</p>	F 441		4-20-16

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F 441	<p>Continued From page 36</p> <p>2/1/16 with diagnoses of foot ulcer, cellulitis, and osteomyelitis.</p> <p>Physician orders, dated 2/1/16, documented Resident #17 required monitoring of the left lower extremity for symptoms of infection.</p> <p>The Infection Control Log for February 2016 did not include documentation that Resident #17's admitting diagnoses of cellulitis and osteomyelitis were community acquired infections.</p> <p>The facility's mapping of infections for February 2016 did not document Resident #17's room as one with a current infectious process requiring precautions.</p> <p>The February 2016 MAR did not document that the administration of an initial TB test for Resident #17 had been completed.</p> <p>On 3/17/16 at 3:30 pm, the DON said she did not have help with infection control on a regular basis. The DON said she was unaware Resident #15 had a MRSA respiratory infection without respiratory isolation precautions in place. The DON said she expected the nurses to ensure multi-dose medications were dated when opened. The DON stated organisms were not tracked on the Infection Control Log.</p> <p>On 3/18/16 at 12:40 pm, MD #14 said he addresses the infections of his residents and indicated he had approximately 90% of the residents in the facility. MD #14 also said he had attended some infection control meetings, but there had not been any meetings scheduled due to a vacancy for an infection control nurse. MD #14 said the facility followed corporate guidelines</p>	F 441		4-20-16	

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F 441	<p>Continued From page 37</p> <p>for infections and he would expect the facility to track organisms. MD #14 said tracking organisms was the only "true way" to determine an infectious outbreak.</p> <p>6. On 3/14/16 during the lunch meal observation from 12:12 pm to 12:35 pm in the 400 hallway dayroom, CNA #15 was observed assisting Resident #1 with his lunch meal. CNA #15 coughed into her right hand, retrieved a mask from her pocket and placed it over her mouth and nose. The CNA, without first washing her hands or using hand sanitizer, then handled one of the resident's milk cartons, which the resident then picked up. CNA #15 left the room temporarily and returned with another CNA, who adjusted the resident's position in his wheelchair, while CNA #15 readjusted a pillow to the left of the resident. Without first washing her hands or using hand sanitizer, CNA #15 then grabbed the resident's fork and spoon and a second carton of milk with her right hand before the resident then handled the same fork, spoon and second milk carton.</p> <p>On 3/14/16 at 12:35 pm, CNA #15 said she was not sick, but had coughed so she placed a mask on her face. She said she coughed into her hand, adjusted the resident's pillow, and handled the utensils and both milk cartons without washing her hands.</p> <p>On 3/17/16 at 8:35 am, when informed of the observation, the DON said CNA #15 should not have coughed into her hand and should have washed her hands or used hand sanitizer before touching the resident's milk cartons and utensils.</p>	F 441		4-30-16	

Bureau of Facility Standards

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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 Evelyn Floyd, JD, MSN, RN Linda Close, RN-BC, RAC-CT Tina Hicks, RN	C 000	<p>RECEIVED</p> <p>OCT - 7 2016</p> <p>FACILITY STANDARDS</p>	
C 762	02.200,02,c,ii When Average Census 60-89 Residents ii. In SNFs with an average occupancy rate of sixty (60) to eighty-nine (89) patients/residents a registered professional nurse shall be on duty for each a.m. shift (approximately 7:00 a.m. - 3:00 p.m.) and p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) and no less than a licensed practical nurse on the night shift. This Rule is not met as evidenced by: Based on review of a three-week nursing schedule provided by the facility, it was determined the facility did not meet the State requirement for registered professional nurse (RN) coverage when the resident occupancy rate was between 60 and 89 residents for each of the days reviewed. Inadequate RN coverage had the potential to negatively affect all residents living in the facility. Findings included: The three-week nursing schedule for 2/21/16 through 3/12/16 for RN coverage on the Day Shift (approximately 7:00 am to 3:00 pm) and the Evening Shift (approximately 3:00 pm to 11:00 pm) documented the following:	C 762	C 762 SPECIFIC RESIDENT(s) Specific residents not identified. Licensed nurse daily staffing schedule corrected to include a minimum of one RN during day shift, one RN during evening shift, and one LPN on the night shift. OTHER RESIDENT(s): Licensed nurse daily staffing schedule corrected for future schedules to include a minimum of one RN during day shift, one RN during evening shift, and one LPN on the night shift. SYSTEMATIC CHANGES: Staffing coordinator educated to ensure a minimum of one RN during day shift, one RN during evening shift, and one LPN on the night shift are scheduled daily. Staffing coordinator education also included notification to Executive Director and/or Director of Nursing of any RN staffing issues not in compliance with regulations.	4/20/16

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Wafar M. Zohair</i>	TITLE <i>Executive Director</i>	(X6) DATE 04/13/16
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Bureau of Facility Standards

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C 762	<p>Continued From page 1</p> <p>*2/21/16-An RN worked from 7:03 am to 4:29 pm, but there was no RN coverage for the Evening Shift hours of 4:29 pm to 11:00 pm. The resident census was 85.</p> <p>*3/6/16-An RN worked from 6:00 pm to 8:00 am and another RN worked from 2:08 pm to 10:18 pm, but there was no RN coverage for the Day Shift hours of 8:00 am to 2:08 pm. The resident census was 75.</p> <p>On 3/17/16 at 2:15 pm, the Payroll Manager confirmed there were not eight hours of RN coverage for the shifts above.</p>	C 762	<p>MONITORING: Director of Nursing or designee to review licensed nurse staffing schedules weekly x 8 weeks, and monthly x 3 months to ensure a minimum of one RN during day shift, one RN during evening shift, and one LPN on the night shift are scheduled daily.</p>	4-20-16