IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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3232 Elder Street
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April 8, 2016

Monte Jones, Administrator
Rexburg Care & Rehabilitation Center
660 South Second Street West
Rexburg, ID 83440-2300

Provider #: 135105

Dear Mr. Jones:

On **April 1, 2016**, a survey was conducted at Rexburg Care & Rehabilitation Center 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. 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) and on or before the "Opportunity to Correct." **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 18, 2016**. Failure to submit an acceptable PoC by **April 18, 2016**, may result in the imposition of penalties by **May 13, 2016**.

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*.

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 **June 30, 2016 (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 **June 30, 2016**. A change in the seriousness of the deficiencies on **May 16, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 30, 2016** includes the following:

Denial of payment for new admissions effective **June 30, 2016**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, 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 **September 28, 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.

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.

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 **June 30, 2016** 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 non-compliance 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 **April 18, 2016**. If your request for informal dispute resolution is received after **April 18, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135105	A. BUILDING _____ B. WING _____	C 04/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REXBURG CARE & REHABILITATION CENTER	660 SOUTH SECOND STREET WEST REXBURG, ID 83440

(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 federal recertification and complaint survey conducted at the facility from March 28, 2016 to April 1, 2016. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Presie Billington, RN Survey Definitions: ADL = Activities of Daily Living ASAP = As soon as possible BIMS = Brief Interview for Mental Status BIPAP = Bi-Level Positive Airway Pressure cm = Centimeters CNA = Certified Nurse Aide COPD = Chronic Obstructive Pulmonary Disease CPAP = Continuous Positive Airway Pressure DON = Director of Nursing HCL = Hydrochloride LN = Licensed Nurse MAR = Medication Administration Record MCO = Manager of Clinical Operations MDS = Minimum Data Set assessment PO = By Mouth POC = Plan of Care PRN = As Needed Q = Every UM = Unit Manager	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		5/15/16

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

Electronically Signed | 04/18/2016

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F 241	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure residents were treated with dignity and respect during their dining experience when staff did not respond to residents while talking amongst themselves and when a resident's breast, torso and adult brief were exposed while in the facility hallways. This was true for 2 of 9 sampled residents (#s 6 & 9) and 2 random residents (#s 12 & 13). This practice created the potential to negatively affect residents' sense of self-worth and self-esteem and cause embarrassment for a resident who was exposed to onlookers. Findings included: 1. On 3/31/16 from 12:07 pm to 12:15 pm, Resident #13 was observed in her wheelchair outside of the Targee Dining Room and next to the medication cart. The resident's blouse which tied in the back was pulled opened which exposed her bare skin from her right armpit to her buttock. Her adult brief could be seen and when she lifted her right arm, the lower portion of her right breast was also exposed. LN #4 and LN #5 were standing near her; LN #4 commented to the resident on the color of her blouse and slightly adjusted the blouse near her right shoulder, but the resident's right side was still exposed. LN #5 then assisted the resident down the hallway to the nurses station. From the nurses station, CNA #6 assisted the resident further down the hallway to her room, CNA #6 said something inaudible and then assisted the resident back to the nurses station, where she then left the resident. On 3/31/16 at 12:15 pm, the Activity Director was	F 241	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Rexburg Care and Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts and conclusions that form the basis for the deficiency. F241 1. Resident #13 was assessed by the Center Nurse Executive or designee on or before with no adverse effects related to partial exposure in hallway. New clothes were purchased on or before 5/15/16 by the Center Nurse Executive or designee. Resident #9 was assessed by the Support Services Director for adverse psychosocial effects related to dining experience conversation on or before 5/15/16. No negative psychosocial effects noted related to dining experience. 2. Other residents residing in the center, had clothing assessed by the Center Nurse Executive or designee to ensure clothing fit without risk of exposure on or before 5/15/16. Other residents residing in the center that dine in the center's dining	

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F 241	Continued From page 2 observed assisting the resident to the Activity Room, where she readjusted the resident's blouse to cover the exposed area. On 3/31/16 at 12:22 pm, LN #5 said she did not notice the resident was exposed. On 3/31/16 at 12:29 pm, CNA #6 said she did not notice the resident was exposed. On 3/31/16 at 12:30 pm, LN #4 said she adjusted the blouse because the resident's shoulder was exposed, but did not notice the rest of her side was also exposed. 2. On 3/29/16 at 5:16 pm, CNA #7 was observed assisting Resident #9 with her meal. No other residents were at the resident's table at the time of the observation. Van Driver #8 asked CNA #7 questions about a class they had taken together and CNA #7 began to discuss that topic with him. CNA #9, who was seated at a table nearby assisting Resident #s 6 and 12, joined the discussion with CNA #7 and Van Driver #8; none of the staff members engaged or included the residents in the conversation. On 3/31/16 at 3:25 pm, the DON with the MCO present said dining room conversations that do not include the residents were not appropriate.	F 241	rooms were observed by center Interdisciplinary Team (IDT) for interaction from staff and dining experience on or before 5/15/16. No issues were noted at the time of observations. Resident council meeting with Recreational Director and Administrator on or before 5/15/16 and discussed dining experiences. No negative comments from members of the council in attendance. 3. Nursing staff were re-educated by the Center Nurse Executive or designee on or before 5/15/16 on resident dignity and respect. Resident dignity and respect training to be completed during new employee orientation. Licensed nurse assigned to the dining room on or before 5/15/16 will assist and observe dining experience. Any issues observed will be immediately corrected with education and discussed during daily IDT stand up meeting for ongoing education. Members of the nurse management team and licensed staff will observe residents to validate they are covered and not exposed. Corrections will be immediately corrected as indicated through observations. 4. Beginning the week of 5/16/16 the Center Nurse Executive or designee will review 5 residents per week times 4 weeks and then monthly for 2 months to ensure resident's clothing is appropriate to maintain dignity. 5 meals will be observed weekly for 4 weeks and monthly for 2 months to validate staff are interacting with residents during meal to enhance the	

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F 241	Continued From page 3	F 241	dining experience. Results to be discussed at monthly Performance Improvement Committee for review for a minimum of 3 months or until substantial compliance is achieved. The Center Nurse Executive is responsible for monitoring and follow up.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure residents had set-up assistance with their meals. This was true for 2 random residents (#s 13 & 14) who needed set-up assistance. The deficient practice had the potential to cause harm if the resident's nutritional needs were not met. Findings included: a. Resident #13 was admitted to the facility on 5/30/12 with multiple diagnoses, including muscle weakness. Resident #13's care plan documented an intervention on 10/10/14 of, "Eats independently with set-up assist."	F 246	F246 1. Residents #13 and #14 were assessed related to difficulty cutting food by the Center Nurse Executive or designee on or before 5/15/16 with no adverse effects noted. 2. Other residents requiring set up of meals were observed to validate assistance is offered when meal tray is delivered. Care plan was updated to reflect current needs by the Center Nurse Executive or designee on or before 5/15/16. 3. Nursing staff were re-educated by the Center Nurse Executive or designee on or	5/15/16

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F 246	Continued From page 4 Resident #13's 3/8/16 quarterly MDS assessment documented the resident was severely cognitively impaired and required set-up assistance with meals. b. Resident #14 was readmitted to the facility on 11/27/15 with multiple diagnoses, including osteoarthritis. Resident #14's care plan documented an intervention on 1/24/15 of, "Independent with set-up assist with meals." Resident #14's 12/21/15 annual MDS assessment documented the resident was severely cognitively impaired and required set-up assistance with meals. On 3/29/16 from 12:00 pm to 12:15 pm, in the Targee assisted dining room, LN #4 was observed placing meals in front of Resident #s 13 and 14 and without offering to assist the residents with preparing their meal so they could eat independently. Resident #13 was observed using a spoon in a saw type motion to cut the calzone. Resident #14 was observed using her fork to stab the calzone into separate small pieces. Resident #14 left the dining room with 75 percent of the calzone still intact and uneaten. On 4/1/16 at 8:40 am, the DON with the MCO present said residents who dine in the Targee dining room need assistance with their meals. When informed of the observation, the DON said LN #4 should have offered to cut up the residents' calzones.	F 246	before 5/15/16 on resident meal assistance. Licensed nurses assigned to the dining rooms will review each resident to ensure that resident's needs are met during meal times. 4. Beginning the week of 5/16/16 the Center Nurse Executive or designee will audit the dining rooms 3 times per week for 4 weeks and then monthly for 2 months to ensure resident receive assistance with meals as care planed. Results to be discussed at monthly Performance Improvement Committee for review for a minimum of 3 months or until compliance is achieved. The Center Nurse Executive is responsible for monitoring and follow up.	
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE	F 252		5/15/16

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F 252	Continued From page 5 ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to maintain resident rooms and the weight scale in the Activity Room in good condition. This failure had the potential to affect residents' sense of comfort. Findings included: On 3/28/16 during the initial tour of the facility from 7:00 pm to 7:15 pm, the following were observed: 1. Room 228: * Privacy curtain with three large stains * Missing corner base board near the restroom * Scraped paint on the wall near the bed * Scraped paint on the bottom inside left wall of the bathroom facing the toilet bowl 2. Room 222: * Scraped paint paint on the wall near the TV stand * Cracked bathroom door at the bottom left corner On 3/30/16 at 10:30 am, black tape covering the weighing scale ramp in the Activity Room was observed with several tears, and the protective covering of the Activity Room door was peeling away at the bottom. On 3/31/16 at 2:20 pm, the Maintenance	F 252	F252 1. Room #228 privacy curtains were replaced, missing corner base board near the restroom was installed, scraped paint on the wall near the bed was touched up, scraped paint on the bottom inside left wall of the bathroom facing the toilet bowl was touched up. Room #222 scraped paint on the wall near the TV stand was touched up and cracked bathroom door at the bottom left corner was replaced. Weighing scale nonskid/nonslip ramp covering in the Activity Room was replaced or repaired. Patient shower room on side 2 where the old hand paper dispenser was located was painted. 2. A facility wide audit was performed to identify other areas that needed paint touchups, door repair and base board repairs. 3. Maintenance staff were re-educated by the Administrator or designee on or before 5/15/16 regarding facility standards for resident rooms and equipment. Our systematic change is that we will include a facility review of facility standards for resident rooms and equipment in our	

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F 252	Continued From page 6 Supervisor said he was aware that some of the rooms needed to be repainted. On 3/31/16 at 2:30 pm, the "Patient Bath Side 2" where the hand paper dispenser was previously located was observed in need of repainting and shown to the Maintenance Supervisor.	F 252	monthly Performance Improvement Committee meetings. 4. Beginning the week of 5/16/16 the Administrator or designee will perform a facility wide audit for paint touch ups on walls, base board repairs, door repairs and weighing scale covering condition weekly for 4 weeks and then monthly for 2 months to ensure facility standards are met. Audit results will be reported to the Performance Improvement Committee for a minimum of 3 months or until compliance sustained. The Administrator is responsible for monitoring and compliance.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to ensure coordination and communication of care for residents receiving hospice care was provided as care planned for 2 of 2 sampled residents (#s 8 and 9) reviewed for hospice care. The facility also failed to clarify the Oxycodone order for 1 of 1 Random Resident (#15). These failures created	F 309	F309 1. On or before 5/15/16 resident #15 was assessed by the Center Nurse Executive or designee with no adverse effects noted with pain management. New orders received by physician on 3/28/16 to include pain parameters for Oxycodone administration. Orders processed and	5/15/16

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F 309	Continued From page 7 the potential for missed or inadequate care by the facility and hospice provider, and inappropriate pain management for Random Resident #15. Findings included: 1. Random Resident #15 was admitted to the facility on 7/22/15, and readmitted on 3/16/16, with multiple diagnoses, including infection and inflammatory reactions due to internal right hip prosthesis. On 3/29/15 at 3:10 pm, during the medication pass observation, LN #3 asked Random Resident #15 if he was in pain and to describe its severity on a 10-point scale. The resident said he was in pain and it was at a level of "3." LN #3 then gave the resident 2 tablets of Oxycodone 5 mg and said he gives the resident either 2 or 3 tablets according to the resident's pain level at the time of administration. Random Resident #15's 3/22/16 Physician's Order documented, "Oxycodone HCL tablet 5 mg give one, two, three or four tablets PO Q4 hours PRN". The resident's March 2016 PRN Pain Management Flow Sheet documented inconsistencies in the administration of pain medication to Random Resident #15. The following was documented: *On 3/22/16 at 12:15 pm, the resident rated his right leg pain at "8" and he received 3 tablets of Oxycodone 5 mg. At 1:15 pm, the resident's pain was reassessed at "1." *On 3/23/16 at 1:30 pm, the resident rated his right leg pain at "6" and received 3 tablets of	F 309	care plan updated by center licensed nurse at time of order receipt. Resident #8 discharged form facility on 3/31/16. Resident #9 was assessed by the Center Nurse Executive or designee with no adverse effects related to facility and hospice coordination of care on or before 5/15/16. Residents hospice and facility care plans were revised to include resident specific problems, goals and interventions. 2. Residents currently residing in the facility that receive pain medications as needed, will have their pain management program clarified to support resident's pain level on or before 5/15/16 by the Center Nurse Executive or designee. Residents residing in the facility that receive hospice services were reviewed to ensure that hospice nurses notes are available for the center licensed nurses to review and care plans available for both hospice and the facility with delineation of cares on or before 5/15/16 by the Center Nurse Executive or designee. 3. Nursing staff were educated by the Center Nurse Executive or designee on or before 5/15/16 to ensure that residents with multiple doses of as needed (PRN) pain medications have parameters for pain management. Interdisciplinary Team to review new pain medication orders in daily clinical review to ensure that parameters for pain management are in place. Hospice licensed staff and facility licensed staff were educated by the Center Nurse Executive or designee on or	

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F 309	Continued From page 8 Oxycodone 5 mg. At 2:30 pm, the resident's pain was reassessed at "1." *On 3/24/16 at 11:15 am, the resident rated his right leg pain at "3" and received 2 tablets of Oxycodone 5 mg. At 12:15 pm, the resident's pain was reassessed at "0." *On 3/25/16 at 3:30 am, the resident rated his right leg pain at "8" and received 2 tablets of Oxycodone 5 mg. At 5:00 am, the resident's pain was reassessed at "2." *On 3/27/16 at 12:35 pm, the resident rated his pain at "8" and received 3 tablets of Oxycodone 5 mg. At 1:40 pm, the pain was reassessed at "4." On 3/29/16 at 3:55 pm, when asked about Random Resident #15's Physician's Order for Oxycodone 1 tablet, 2 tablets, 3 tablets or 4 tablets, the DON said the resident was cognitively intact and would specify the number of tablets he wanted. The DON was shown of the resident's PRN Pain Management Flow Sheet and said there was no parameter on the physician's order for pain and the order should have been clarified. 2. Resident #8 was admitted to the facility on 5/19/11, and readmitted on 11/18/14, with multiple diagnoses, including dementia and psychotic disorder. The resident's 12/19/15 Significant Change in Status MDS assessment coded the resident received hospice care services. Resident #8's Care Plan documented the hospice started on 12/14/15 due to end stage diagnosis of	F 309	before 5/15/16, that resident's receiving hospice therapy will have the plan of care reviewed quarterly and with any significant change during center's IDT resident care plan meetings to ensure that it includes resident specific area of concerns, goals and interventions. 4. Beginning the week of 5/16/16 the Center Nurse Executive of designee will audit 5 residents per week receiving multiple as needed (PRN) pain medications to ensure that resident's PRN pain medications are administered as ordered according to pain levels for 4 weeks and then monthly for 2 months. Results to be discussed at monthly Performance Improvement Committee for review for a minimum of 3 months or until compliance is achieved. The Center Nurse Executive is responsible for monitoring and follow up. Beginning the week of 5/16/16 the Center Nurse Executive or designee will audit 5 resident's receiving hospice services to ensure their hospice binders contain weekly hospice IDT notes and care plans are present. Results to be discussed at monthly Performance Improvement Committee for review for a minimum of 3 months or until compliance is achieved. The Center Nurse Executive is responsible for monitoring and follow up.	

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F 309	Continued From page 9	F 309		

failure to thrive.

There were no hospice progress notes found in the resident's clinical record.

On 3/31/16 at 12:10 pm, when asked how hospice staff visits were documented and communicated to the facility, the DON said the documentation was in the resident's clinical chart, which would be provided to the surveyors.

On 3/31/16 at 3:30 pm, referring to Resident #8's hospice's progress notes from 12/16/15 to 3/24/16, the DON said there was no documentation from the hospice provider in the resident's clinical record.

3. Resident #9 was admitted to the facility on 6/4/15 with multiple diagnoses, including dementia with behavioral disturbance.

The facility's Hospice Services Agreement, dated 8/1/15, documented:
*"Development and Implementation of Plan of Care...Hospice and Center shall jointly develop and agree upon the patient's POC..."
*"Each of Hospice and Center shall designate a responsible representative, responsible for coordinating the implementation of the POC for patient and ensuring communication between the Hospice and the Center."

The resident's 8/4/15 physician's order documented an order for hospice services.

The resident's record did not contain a hospice coordinated plan of care, delineation of duties or

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F 309	Continued From page 10 hospice visit notes beyond 11/9/15. On 3/31/16 at 11:55 am, UM #2 said the resident was receiving hospice services and said she would check whether there was a coordinated plan of care or more recent hospice notes in the chart. At 2:00 pm, UM #2 said the current hospice notes and "care plan" were found in the resident's overflow chart in the medical records office. When asked why they were not in the chart for staff to review, UM #2 said there was no room in the chart and said she did not know the hospice progress notes should be in the chart. The surveyor and UM #2 observed the chart, which appeared to have room for additional paperwork. At 2:45 pm, after review of the hospice "plan of care", UM #2 said there was no delineation of duties and the hospice care plan lacked goals and interventions. The hospice "care plan" for Resident #9 failed to identify resident-specific areas of concern, goals, and interventions. On 3/31/16 at 3:15 pm, the MCO with the DON and UM #2 present, said the hospice care plan had check boxes to indicate what the hospice and facility were responsible for. The MCO said there were some goals and interventions on the checked form, but the form was not resident-specific with individualized goals and interventions.	F 309		
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:	F 328		5/15/16

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F 328	Continued From page 11 Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure a resident's CPAP was set-up as required by facility policy. This was true for 1 of 2 residents (#4) sampled for CPAP use and created the potential for harm should the resident have her CPAP set-up incorrectly. Findings included: Resident #4 was admitted to the facility on 5/29/12, and readmitted on 7/7/15, with multiple diagnoses, including COPD. The resident's most recent Quarterly MDS assessment, dated 1/14/16, documented intact cognition with a BIMS of 15. Resident #4's 10/25/14 CP documented altered respiratory status, and shortness of breath/difficulty breathing related to COPD. Interventions included, "CPAP as ordered, provide oxygen as ordered, observe for alterations in respiratory status including shortness of breath..." On 3/29/16 at 10:33 am, Resident #4 stated she wished the CNA would be trained on how to set up the CPAP and said she would prefer the LN to	F 328	F328 1. Resident #4 was assessed by the Center Nurse Executive or designee on or before 5/15/16 with no adverse effects related to CPAP placement. 2. Other residents residing in the center receiving CPAP or BIPAP were reviewed by the Center Nurse Executive or designee on or before 5/15/16, to ensure proper placement of equipment according to policy and resident specifications. No issues were noted at time of observations. 3. Licensed nursing and nursing assistant staff were educated by the Center Nurse Executive or designee on or before 5/15/16 regarding CPAP and BIPAP setup and monitoring including but not limited to setup by licensed nurses only. Licensed nurses are to place and monitor residents with CPAP and BIPAP. 4. Beginning the week of 5/16/16 the Center Nurse Executive or designee will review 5 residents per week receiving CPAP or BIPAP for placement and	

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F 328	Continued From page 12 set-up her CPAP instead of the CNA. Resident #4 said when she checked her CPAP setting the previous night, she discovered the CNA connected the oxygen tubing to the adaptor but the CPAP tubing was not connected to the other end of the adaptor. Resident #4 said this was not the first time she had a problem with her CPAP being set-up by a CNA. She just said there had been two earlier incidences and that one time the adaptor was missing. On 3/29/16 at 4:40 pm, CNA #9 said, she set-up the CPAP for Resident #4 when she was on duty. On 3/30/16 at 4:15 pm, the DON provided the facility's policy for BiPAP/CPAP. The policy documented, "Bi-level Positive Airway Pressure (BiPAP) and/or Continuous Positive Airway Pressure (CPAP) is set up and monitored by a licensed nurse or respiratory therapist with a physician's/mid-level provider's order." When asked if she was aware of the policy regarding CPAP, the DON said, "Now I am aware and this will be corrected ASAP."	F 328	monitoring by the licensed nurse for 4 weeks and then monthly for 2 months. Results to be discussed at monthly Performance Improvement Committee for review for a minimum of 3 months or until compliance is achieved. The Center Nurse Executive is responsible for monitoring and follow up.	
F 431 SS=E	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	F 431		5/15/16

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F 431	Continued From page 13 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: Based on observations and staff interviews, it was determined the facility failed to ensure expired medications were removed from a medication room and medication cart. This was true for 1 of 2 medication carts and 1 of 1 medication room checked for expired medications. This failed practice created the potential for residents to receive expired medications with decreased efficacy. Findings included: On 3/29/16 at 2:20 pm, a bottle of Vit D3 2,000 IU which had expired February 2016 was discovered in the Back Hall Medication Cart. LN #1 said she	F 431	F431 1. Expired medications Vit D3 2,000 IU, Cetirizine Hydrochloride 10mg, Vancomycin Hydrochloride 1mg, Alendronate 70mg, and Influenza Vaccine 0.5cc Syringe were removed from storages and destroyed by the Center Nurse Executive on or before 3/31/16. 2. Medication storage areas were reviewed for outdated medications/supplies by the Center Nurse Executive or designee on 3/29/16 with any outdated medications or supplies	

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F 431	Continued From page 14 would remove the bottle from her cart. On 3/29/16 at 4:20 pm, during inspection of the Medication Room with the DON present, the following medications were found: * One box of 10 mg Cetirizine Hydrochloride with 90 tablets which had expired 6/20/15 * Two vials of 1 mg Vancomycin Hydrochloride which had expired February 2016 * Two tablets of 70 mg Alendronate which had expired 3/16/16 * Five boxes of Influenza Vaccine with 10 prefilled 0.5 cc syringes which had expired 3/2016 The DON said the medications were all expired and would be discarded.	F 431	removed at that time. 3. Licensed nursing staff were educated by the Center Nurse Executive or designee on or before 5/15/16 to check for medication expiration date prior to administration of medications. Interdisciplinary Team to review medication cart, medication stock room, treatment room and Pyxis machine monthly to ensure no outdated medications in stock. 4. Beginning the week of 5/16/16 the Center Nurse Executive of designee will review medication storage areas weekly for 4 weeks and then monthly for 2 months for outdated medications. Results to be discussed at monthly Performance Improvement Committee for review for a minimum of 3 months or until compliance is achieved. The Center Nurse Executive is responsible for monitoring and follow up.	
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure staff were	F 518	F518 1. Licensed nurse #5 was educated	5/15/16

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F 518	Continued From page 15 knowledgeable about what to do in the event of power failure. This was true for 1 of 2 (LN #5) staff interviewed for emergency preparedness. This deficient practice created the potential for more than minimal harm should power failure occur that threatened the delivery of resident care. Findings included: On 3/31/16 at 5:00 pm, LN #5 was said she was unsure if the facility had an emergency generator. When asked about the location of the emergency power outlet. The LN said she was not sure where it was. When shown a red outlet in the Back Hall, the LN said, "It's red, I guess that's the emergency power outlet." On 4/1/16 at 10:05 am, the ADM said the policy and procedures for emergency preparedness and the staff-inservices for emergency procedures for December 2015, January 2016 and February 2016 could not be located.	F 518	regarding what to do during a power outage specifically the location of the generator and emergency power outlets. 2. Facility staff were educated regarding what to do during a power outage specifically the location of the generator and emergency power outlets. 3. Maintenance staff were re-educated by the Administrator or designee on or before 5/15/16 regarding facility standards for training staff on what to do during a power outage. Our systematic change is that we will have additional training included in our new hire orientation. Periodic training for current staff to be performed regarding what to do during a power outage. 4. Beginning the week of 5/16/16 the Administrator or designee will perform an audit of 5 staff members per week for 4 weeks, then monthly for 2 months to ensure facility standards are met. Audit results will be reported to the Performance Improvement Committee for a minimum of 3 months or until compliance sustained. The Administrator is responsible for monitoring and compliance.	