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 29, 2016

Steve Gannon, Administrator
Quinn Meadows Rehabilitation & Care Center
1033 West Quinn Road
Pocatello, ID 83202-2425

Provider #: 135136

Dear Mr. Gannon:

On **April 15, 2016**, a survey was conducted at Quinn Meadows Rehabilitation & Care 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. The survey found that the most serious deficiency in your facility to be pattern in nature. The deficiency cited reflects no actual harm with potential for more than minimal harm that is not immediate jeopardy (Severity/Scope = E).

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid 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 **May 9, 2016**. Failure to submit an acceptable PoC by **May 9, 2016**, may result in the imposition of penalties by **June 3, 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 **May 31, 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 **July 14, 2016**. A change in the seriousness of the deficiencies on **May 31, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 14, 2016** includes the following:

Denial of payment for new admissions effective **July 14, 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 **October 12, 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 **July 14, 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:

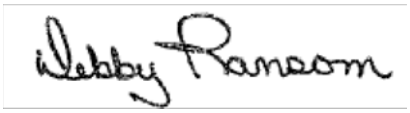
- BFS Letters (06/30/11)

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

This request must be received by **May 9, 2016**. If your request for informal dispute resolution is received after **May 9, 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

dr/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135136	A. BUILDING _____ B. WING _____	C 04/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUINN MEADOWS REHABILITATION & CARE CENTER	1033 WEST QUINN ROAD POCATELLO, ID 83202

(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 April 11, 2016 to April 15, 2016. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Sherrie McElwain, RN Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide CVA = Cerebrovascular Accident DNS = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment OT = Occupational Therapist PRN = As Needed QHS = Every Night recap = recapitulation ROM = Range of Motion TAR = Treatment Administration Record	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 164		5/20/16

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

Electronically Signed | 05/04/2016

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F 164	Continued From page 1 Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, it was determined the facility failed to ensure personal medical information was protected for 5 of 9 sampled residents (#s 1, 3, 4, 6, & 7) and 11 random residents (#s 12-22) who had diabetes. This failure created the potential for a negative effect on the residents' psychosocial well-being. Findings included: On 4/13/16 at 3:10 pm, a snack cart was observed unattended in the 100 hallway outside of room 107. On the second shelf of the cart was a piece of paper with the words facing up and in plain sight of anyone walking down the hallway. The paper documented, "Please make sure that every diabetic is offered a snack" and included a column of resident names with a "Y" next the	F 164	Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority. Accordingly, the facility has drafted this Plan of Correction in accordance with Federal and State Laws which mandate the submission of a Plan of Correction as a condition for participation in the Medicare and Medicaid program. This Plan of Correction shall constitute this facility□s credible allegation compliance with this section.	

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F 164	Continued From page 2 residents who had diabetes. The list identified Resident #s 1, 3, 4, 6, 7, and 12-22 as having diabetes. On 4/13/16 at 3:12 pm, CNA #2 approached the cart and said she was just assigned to take over the snack cart duties from a different CNA and the list should have been covered. On 4/13/16 at 4:20 pm, the DNS said the 'Y' next to the resident names meant they were diabetic and the list should have been covered.	F 164	F- 164 SS=E ¿483.10(e), 483.75(l)(4) □ Personal Privacy/Confidentiality of Records The facility does ensure that Residents□ personal medical information is protected. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: By 5/12/16, the Administrator or Designee will provide a 1:1 in-service education to C.N.A. #2 regarding F-164 on Personal Privacy/Confidentiality of records with emphasis on ensuring that Resident(s) personal medical information such as the diabetic list is protected on the snack cart when passing the afternoon snack. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following: Resident(s) who are diabetic that receives afternoon snack from the snack cart may have the potential to be affected by this deficiency therefore; By 5/12/16, a visual observation will be done by the Administrator or Designee during the passing of snack cart to ensure that Resident(s) personal medical information such as the diabetic list is	

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F 164	Continued From page 3	F 164	protected on the snack cart when passing the afternoon snack. Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure that the deficient practice does not recur, By 5/12/16, all C.N.A.s will be provided an in-service education by the Administrator or Designee with regards to F-164 on Personal Privacy/Confidentiality of records with emphasis on; The importance of ensuring that Resident(s) personal medical information such as the diabetic list is protected on the snack cart when passing the afternoon snack. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through: The Administrator or Designee will do a random visual observation during the afternoon passing of the snack cart to ensure that Resident(s) personal medical information such as the diabetic list is protected on the snack cart.	

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F 164	Continued From page 4	F 164	Monitoring will start on 5/19/16. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. The Administrator or Designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money	F 278		5/20/16

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F 278	Continued From page 5 penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and review of the medical records, it was determined the facility failed to ensure accurate assessments were completed for 3 of 9 sampled residents (#1, #2 and #7). The facility failed to assess; Resident #1 for self-administration of eye medications, Resident #2 for intermittent urinary self-catheterizations and failed to accurately assess a dialysis access device for Resident #7. This resulted in the potential for residents' health care needs to go unmet. Findings include: 1. During an interview with Resident #2, at 2:30 p.m. on 4/11/16, he indicated he performed his own intermittent self-catheterizations every few days due to hypertrophy of the prostate. Resident #2 stated, "I didn't tell anybody and they (staff) didn't ask until one of them (staff) helped me in the bathroom. It was a few days after I got here." The DON was interviewed on 4/13/16 at 8:25 am. The DON said "(Resident #2) has been assessed to self-cath. We were not aware until days later." Review of Resident #2's medical record indicated an admission date of 2/23/16, with the diagnoses including: aftercare of a wedge compression fracture of first lumbar vertebra sequel,	F 278	F- 278 SS=D ¿483.20(g)-(j) □ Assessment Accuracy/Coordination/Certified The facility does ensure that assessment(s) accurately reflect the Resident□s status. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident #2 is no longer a Resident of the facility. Resident #7 is no longer a Resident of the facility. Resident #1 is no longer a Resident of the facility. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following: This deficiency is an isolated deficiency	

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F 278	Continued From page 6 unspecified fracture of the left clavicle, and weakness. The 2/23/16 admission MDS assessment signed by nursing staff, noted under "Elimination" section, that Resident #2 did not have bladder problems, pain or burning, frequency/nocturia issues, or a history of urinary retention. In the section of the assessment related to appliances and programs, there were 10 options to select from including "Intermittent catheter." This option was not selected; instead "Pads/briefs used" was chosen. The MDS indicated Resident #2 did not have a deficit of short or long term memory and was able to make himself understood to others. Resident 2's Nurses' Notes indicated he was taking fluids, however, there was no mention of him performing intermittent self-catheterizations until 3/9/16. A Nurses' Note documented on 3/9/16 at 8:00 am, indicated Resident #2 reported he was self-catheterizing a 'couple' times a day when it was needed. Resident #2's admission MDS assessment did not include an accurate assessment of his urinary status. 2. During an observation on 4/13/16 at 1:30 p.m., it was noted that for dialysis Resident #7 had a subclavian access tubing with a clear dressing to the right upper chest. There was no evidence of an A-V fistula. An interview was completed with LPN #1 on 4/13/16. She could not recall receiving dialysis related training at the facility. LPN #1 stated, "I've taken care of dialysis patients before, just not	F 278	as reflected in the Statement of deficiencies-form CMS-2567. However, all Resident(s) in the facility may have the potential to be affected by this deficiency therefore; By 5/12/16, the Director of Nursing or LN Designee will; Create a form for Licensed Nurses to utilize during admission assessment to ask alert Resident(s) if they performed intermittent self-catheterization prior to admission to the facility. Perform a Return Demonstration, with all License Nurses regarding how to differentiate between a central line and an AV fistula and how to appropriately assess the central line used for dialysis access; as well as the importance of understanding the requirement of completing Dialysis Communication Form when Resident(s) attend dialysis appointments. Perform a visual round of all Residents rooms to ensure that there are no eye drop medications in the Residents rooms without being assessed for safe self-administration of medications. Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following: By 5/12/16, the Director of Nursing or LN Designee will provide an in-service	

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F 278	Continued From page 7 here." An interview was completed with the charge nurse on 4/13/16 at 1:00 pm. The charge nurse indicated communication with the dialysis unit was to be documented in the Nurses' Notes. She then said communication was documented in the progress notes. The charge nurse examined Resident #7's medical record. The charge nurse could not find documented communication between the facility and the dialysis unit before or after Resident #7's 4/12/16 dialysis session. When the DON was interviewed on 4/13/16, she was unsure of the training given to nursing staff regarding residents receiving dialysis. The DON provided a blank, "Dialysis Communication Form." Resident #7's record included an admission date of 4/6/16, with diagnosis of chronic kidney disease, stage 4. An MDS assessment, dated 4/6/16, was signed by an LPN. Section 11 of the assessment documented Resident #7 had a "Central Line: (handwritten) Dialysis Access Type: subclavian site: (sic- Right)." A Nurses' Note dated 4/12/16, written by an LPN, contained the statement, "Rt. Clavicle AV fistula intact. (No) bleeding, bruit felt." Licensed staff was not aware of the difference between a central line and an AV fistula and how to appropriately assess the central line used for dialysis access. 3. On 4/11/16 at 2:25 pm, Resident #1 was awake in his bed. On the bedside table and within reach of the resident was a small bottle of	F 278	education to all Licensed Nurses regarding F 278 with emphasis on: The importance of the new form created for Licensed Nurses to utilize during admission assessment to ask alert Resident(s) if they performed intermittent self-catheterization prior to admission to the facility. The importance of asking alert Resident(s) during admission assessment with regards to whether the alert Resident(s) performs intermittent self-catheterization prior to admission to the facility. Dialysis and the importance of understanding the difference between a central line and an AV fistula and how to appropriately assess the central line used for dialysis access. The importance of understanding the requirement of completing Dialysis Communication Form when Resident(s) attend dialysis appointments. By 5/12/16, the Director of Nursing or LN Designee will provide an in-service education to all C.N.As regarding F278 with emphasis on: The importance of understanding that when a family member brings in eye drop medication(s) that the Licensed Nurse be notified to ensure that the Resident(s) will be assessed for safe self-administration of medications.	

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F 278	Continued From page 8 store brand eye drops without a medication label. CNA #6 came into the room and said the eye drops were brought in by the resident's family and were used for dry eyes. On 4/11/16 at 2:35 pm, LN #5 was shown the eye drops and said the eye drops container should have been labeled and not left on the bedside, because Resident #1 had not been assessed to self-administer medications safely.	F 278	How the corrective action(s) will be monitored to ensure the deficient practice will not recur; Monitoring will be done through: The Director of Nursing or LN Designee will: Review at least three (3) new alert Resident(s) to ensure that alert Resident(s) are asked upon admission if they perform intermittent self-catheterized prior to admission to the facility. Review at least three (3) Resident(s) on dialysis to ensure that proper assessment of access line used for dialysis was completed by the Licensed Nurse. Review at least three (3) Resident(s) on dialysis to ensure that the Dialysis Communication Form was completed by the Licensed Nurse when Resident(s) attends Dialysis appointment(s). Observation of at least three (3) Resident(s) rooms to ensure that no eye drops are at bedside without assessment for Resident□s ability to self-administer medications. Monitoring will start on 5/19/16. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. The facility Director of Nursing or LN Designee will submit to the QA&A Committee any findings and/or corrective actions taken during the quarterly QA&A	

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F 278	Continued From page 9	F 278	Committee Meeting. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure care plans for 2 of 9 sampled residents (#1 & #8) were updated to reflect their current needs. Care plans did not document how many staff were needed for	F 280	F- 280 SS=D ¿483.20(d)(3), ¿483.10 (k)(2) □ Right to Participate Planning Care-Revise CP The facility does ensure that Care Plans identify the number of staff needed for	5/20/16

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	135136	A. BUILDING _____ B. WING _____	C 04/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUINN MEADOWS REHABILITATION & CARE CENTER	1033 WEST QUINN ROAD POCATELLO, ID 83202

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F 280	Continued From page 10 transfers and ADLs and that a resident wore hand splints for contractures. This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in their respective care plans. Findings included: 1. Resident #1 was readmitted to the facility on 2/24/16 with multiple diagnoses, including muscle weakness. The resident's Fall and ADL care plans documented on 12/31/15 the resident was "at risk for falls related to impaired balance...generalized weakness...history of previous falls." Interventions included: *"Will receive extensive assistance with transfers to reduce risk of falls," *"Will receive limited assistance with locomotion," and *"Encourage and remind resident to seek assistance with ADLs as needed. He requires extensive assist for all ADLs with the exception of eating." Resident #1's 3/18/16 significant change MDS assessment documented the resident required extensive two-person assistance for transfers and extensive one-person assistance with ambulation, dressing, and hygiene. This information was not included on Resident #1's care plan dated 12/31/15. On 4/13/16 at 10:35 am, CNA #3 said she would transfer the resident with two-person assistance. When asked where that information would be	F 280	transfers and ADLs & that Care Plans are formulated for Resident(s) who wear hand splints for contractures. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident #1 is no longer a Resident of the facility. Resident #8: By 5/12/16, Resident□s Care Plan will be updated to include Resident□s hand splints for hand contractures. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following: This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, all Resident(s) in the facility who need assist with transfers and ADLs and/or Resident(s) who wear hand-splints for hand contractures may have the potential to be affected by this deficiency therefore; By 5/12/16, the Director of Nursing or LN Designee will; Review all Fall and ADL Care Plans on Resident(s) who need assistance with transfers and ADLs to ensure the number	

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F 280	Continued From page 11 found for all staff members, she said the resident's closet contained a white dry-erase board where the information was documented. When the CNA opened the resident's closet the board did not contain the information. CNA #3 said she could also check the care plan for the information. On 4/13/16 at 4:25 pm, the DNS said the care plan should document how many staff members were needed to assist the resident with transfers and other ADLs and Resident #1's care plan did not document that information. 2. Resident #8 was admitted to the facility on 1/28/14 with multiple diagnoses, including spinal stenosis. Resident #8's 1/24/16 annual MDS assessment documented the resident had upper extremity contractures. The resident's 5/29/15, 8/27/15 and 3/27/16 physician progress notes documented she had flexion contractures to both hands. The resident's current care plan did not document the resident wore hand splints for the hand contractures. On 4/13/16 at 1:30 pm, Resident #8 was observed in her room in her wheelchair with two hand splints on the tray table next to her. She said she used the splints at night when she went to bed and she put them on herself. On 4/14/16 at 9:55 am, OT #4, with the Director of Therapy present, said the splints were for the	F 280	of staff members needed to assist the Resident is included in the interventions section of the Care Plan. Review all Resident(s) that utilize hand splints for contractures to ensure that they have a Care Plan in place regarding the use of hand splints. Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following: By 5/12/16, the Director of Nursing or LN Designee will provide an in-service education to all Licensed Nurses regarding F 280 with emphasis on: The importance of making sure that all Fall and ADL Care Plans on Resident(s) who need assistance with transfers and ADLs identify the number of staff members needed to assist the Resident in the interventions section of the Care Plan. The importance of making sure that all Resident(s) that utilize hand splints for contractures have a Care Plan in place regarding the use of hand splints. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; Monitoring will be done through:	

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F 280	Continued From page 12 resident's hand contractures. On 4/14/16 at 10:20 am, the DNS said the hand splints were not on the care plan.	F 280	The Director of Nursing or LN Designee will: Review at least three (3) Resident(s) to ensure that the Fall and ADL Care Plans on Resident(s) who need assistance with transfers and ADLs identify the number of staff members needed to assist the Resident in the interventions section of the Care Plan. Review at least three (3) Resident(s) that utilize hand splints for contractures to ensure that the Resident(s) have a Care Plan in place regarding the use of hand splints. Monitoring will start on 5/19/16. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. The facility Director of Nursing or LN Designee will submit to the QA&A Committee any findings and/or corrective actions taken during the quarterly QA&A Committee Meeting. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION 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	F 318		5/20/16

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F 318	Continued From page 13 decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure residents received interventions to prevent a decrease in range of motion. This was true for 2 of 3 (#3 & #8) residents reviewed for ROM. This practice had the potential to harm residents when they did not receive services necessary to prevent the deterioration of existing ROM limitations. Findings included: 1. Resident #3 was readmitted to the facility on 4/3/15 with multiple diagnoses, including CVA (stroke). The resident's 1/17/16 quarterly MDS assessment documented she: *Had upper extremity contractures, *Was moderately cognitively impaired, and *Required extensive assistance with dressing and personal hygiene. Resident #3's Physician orders dated 11/29/15 and 2/9/16 included, "Place carrot prosthesis in right hand QHS & as she will allow during the day due to contractures of 3rd, 4th & 5th fingers" and "Wash right hand in a bowl with warm soapy water, dry & replace carrot. Wear at all times except when eating." Resident #3's ADL care plan included an intervention on 2/10/16, which stated "Update:	F 318	F- 318 SS=D ¿483.25(e)(2) □ Increase/Prevention Decrease in Range of Motion The facility does ensure that Resident(s) receive interventions to prevent a decrease in range of motion. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident #3: By 5/12/16, the Director of Nursing or LN Designee will provide 1:1 in-service to CNA #3 with regards to F318 on the importance of offering the carrot orthotic as ordered and letting the LN know of any refusals by the Resident. Resident #3: By 5/12/16, the Director of Nursing or LN Designee will provide 1:1 in-service to LN #1 with regards to F318 on the appropriate place on the TAR to document refusals and to ensure refusals are documented. Resident #8: By 5/12/16, the Administrator or Designee will provide 1:1 in-service to Resident #8□s Physician with regards to F318 on the importance of writing an order for OT evaluation and/or	

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F 318	Continued From page 14 Place carrot orthotics R[ight] hand at all times except when resident is eating as she allows." From 4/11/16 to 4/13/16 the following observations were made: 4/11/16: *2:12 pm-Resident #3 was asleep in bed without a carrot orthodic to her right hand and two carrot orthodics were on the resident's bedside table. CNA #3 came into the room to adjust Resident #3's call light and left the room without offering or placing a carrot orthodic in the resident's hand. *2:20 pm-Resident #3 was asleep in bed without a carrot orthodic. LN #1 came into the room to remove two items from the bedside table and left the room without offering or placing a carrot orthodic in the resident's hand. *3:20 pm-Resident #3 was asleep in bed without a carrot orthodic and two carrot orthodic were on the resident's bedside table. 4/12/16: *10:22 am-Resident #3 was asleep in her recliner chair without a carrot orthodic in her hand and two carrot orthodic were on the resident's bedside table on the opposite side of the bed. *2:30 pm-Resident #3 was in her wheelchair in a music activity in the dining room and did not have a carrot orthodic in her hand. *4:00 pm-Resident #3 was awake in her wheelchair in her room with a visitor and did not have a carrot orthodic in her hand. One carrot orthodic was on the resident's bedside table.	F 318	intervention when Resident(s) with contractures are assessed by the physician to be more noticeable. Resident #8: By 5/12/16, Physicians order will be obtained regarding the hand splints for contractures and Resident s Care Plan will be updated to include Resident s hand splints for hand contractures. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following: This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, all Resident(s) in the facility who utilize hand splints and/or carrot orthotics for their contractures may have the potential to be affected by this deficiency therefore; By 5/12/16, the Director of Nursing or LN Designee will; Do a visual observation of all Resident(s) who utilize carrot orthotics for their hand contractures to ensure that they are offered the carrot orthotic as ordered and that refusals are being documented. Review current Physician Progress Note(s) for Resident(s) utilizing hand splints for contractures to ensure OT evaluation and/or intervention is ordered by the physician when Resident(s) with	

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F 318	Continued From page 15 *4:40 pm-Resident #3 was in her wheelchair in her room watching TV and did not have a carrot orthodic in her hand. One carrot orthodic was on the resident's bedside table. 4/13/16: *9:30 am-Resident #3 was in her wheelchair near the fireplace in the common area and did not have a carrot orthodic in her hand. *2:10 pm-Resident #3 was in her wheelchair in her room watching TV and did not have a carrot orthodic in her hand. Two carrot orthodics were on the resident's bedside table. On 4/13/16 at 3:25 pm, CNA #3 said Resident #3 was to be offered the carrot orthodic and staff were to let the nurse know about any refusals by the resident. On 4/13/16 at 3:27 pm, LN #1 said Resident #3 often refused the carrot orthodic, but said there was not a place on the TAR to document the refusals. On 4/13/16 at 4:30 pm, the DNS was informed of the observations and she said Resident #3's family did not want staff to push the carrot orthodic on her. 2. Resident #8 was admitted to the facility on 1/28/14 with multiple diagnoses, including spinal stenosis. Resident #8's 4/25/15, 7/27/15, and 10/27/15 quarterly MDS assessments documented she had upper extremity contractures.	F 318	contractures are assessed by the physician to be more noticeable. Review current Resident(s) utilizing hand splints for contractures to ensure Physicians order is obtained regarding the hand splints for contractures and Resident's Care Plan includes Resident's hand splints for hand contractures. Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following: By 5/12/16, the Director of Nursing or LN Designee will provide an in-service education to all Licensed Nurses regarding F318 with emphasis on: The importance of offering the carrot orthotic as ordered. The importance of understanding the appropriate place on the TAR to document refusals and ensuring that refusals are documented. The importance of ensuring Resident(s) utilizing hand splints for contractures have Physicians order obtained regarding the hand splints for contractures and Resident's Care Plan includes Resident's hand splints for hand contractures. By 5/12/16, the Director of Nursing or LN Designee will provide an in-service education to all C.N.A.s regarding F318	

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F 318	Continued From page 16 Resident #8's 5/29/15 and 8/27/15 physician progress notes documented, "Her flexion contractures of the hands limit their use" and "He[r] contractures of the hands are more noticeable." Resident #8's care plan and the April 2016 Physician recap orders did not document an intervention or orders related to her hand contractures. On 4/13/16 at 1:30 pm, the resident was observed in her room in her wheelchair with two hand splints on the tray table next to her. She said she had not been involved in therapy for the contractures for almost two years. She said she was given the hand splints by the therapy department when she was discharged from therapy. She said she used the splints at night when she went to bed and she put them on herself. On 4/14/16 at 9:55 am, OT #4, with the Director of Therapy present, said the splints were for the Resident #8 hand contractures. When shown the 8/27/15 physician's note regarding a possible decline in the resident's contractures, OT #4 said she was not aware of the note and had not received a referral for a new evaluation. On 4/14/16 at 10:20 am, the DNS said she would have expected to see a referral for an evaluation to therapy. She said Resident #8 was not in a restorative program.	F 318	with emphasis on: The importance of offering the carrot orthotic as ordered and letting the LN know of any refusals by the Resident. By 5/12/16, the Administrator or Designee will notify all attending physicians via letter regarding F318 with emphasis on: The importance of writing an order for OT evaluation and/or intervention when Resident(s) with contractures are assessed by the physician to be more noticeable. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; Monitoring will be done through: The Director of Nursing or LN Designee will: Review at least three (3) current Resident(s) who utilize carrot orthotics for their hand contractures to ensure that carrot orthotic(s) are offered as ordered and that refusals are being documented. Review at least three (3) current Physician Progress Note(s) for Resident(s) utilizing hand splints for contractures to ensure OT evaluation and/or intervention is ordered by the physician when Resident(s) with contractures are assessed by the	

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F 318	Continued From page 17	F 318	physician to be more noticeable. Review at least three (3) current Resident(s) utilizing hand splints for contractures to ensure Physicians order is obtained regarding the hand splints for contractures and Resident's Care Plan includes Resident's hand splints for hand contractures. Monitoring will start on 5/19/16. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. The facility Director of Nursing or LN Designee will submit to the QA&A Committee any findings and/or corrective actions taken during the quarterly QA&A Committee Meeting. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 323	F- 323 SS=D	5/20/16

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F 323	Continued From page 18 interview, it was determined the facility failed to ensure harmful chemicals were secured and out of reach of a resident who was cognitively impaired. This was true for 1 of 2 sample residents (#3) who were cognitively impaired. This failure created the potential for harm to the resident who could access the unsecured chemicals. Findings included: Resident #3 was readmitted to the facility on 4/3/15 with multiple diagnoses, including dementia. Resident #3's 1/17/16 quarterly MDS assessment documented the resident was moderately cognitively impaired. On 4/11/16 at 2:05 pm, Resident #3 was observed asleep in her bed and within reach of the resident was a bedside table with a spray bottle of Peri-wash and a tube of Calmoseptine ointment on top of the table. Both items had a hazard warning to "Avoid contact with eyes." On 4/11/16 at 2:12 pm, CNA #3 came into Resident #3's room to readjust the resident's call light then looked around the room and left. On 4/11/16 at 2:20 pm, LN #1, who was informed of the hazards, removed the items from the table and said they should not have been there.	F 323	¿483.25(h) □ Free of Accident Hazards/Supervision/Devices The facility does ensure that harmful chemicals are secured and out of reach of resident(s) who are cognitively impaired. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident #3: On 4/11/16 at 2:20 pm, the LN#1 removed the peri-wash and Calmoseptine from the Resident□s bedside table. Resident #3: By 5/12/16, the Director of Nursing or LN Designee will provide 1:1 in-service to CNA #3 to ensure that cognitively impaired Resident(s) do not have peri-wash or Calmoseptine within reach on bedside table. Resident #3: By 5/12/16, the Administrator will notify Heritage Hospice Nursing Service Coordinator (Director of Nursing) via letter regarding F323 with emphasis on the need to ensure Hospice staff do not leave peri-wash and Calmoseptine within reach of cognitively impaired Resident on bedside table. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:	

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F 323	Continued From page 19	F 323	This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, all Resident(s) in the facility who are cognitively impaired whom peri-wash and Calmoseptine are utilized during cares may have the potential to be affected by this deficiency therefore; By 5/12/16, the Director of Nursing or LN Designee will; Do a visual observation of all current Resident(s) room(s) who are cognitively impaired whom peri-wash and Calmoseptine are utilized during cares to ensure peri-wash and Calmoseptine are not within reach on bedside table. Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following: By 5/12/16, the Director of Nursing or LN Designee will provide an in-service education to all nursing staff regarding F323 with emphasis on: The importance of ensuring that Resident(s) who are cognitively impaired whom peri-wash and Calmoseptine are utilized during cares, such care items are not within reach on bedside table. How the corrective action(s) will be	

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F 323	Continued From page 20	F 323	monitored to ensure the deficient practice will not recur; Monitoring will be done through: The Director of Nursing or LN Designee will: Do a visual observation of least three (3) current cognitively impaired Resident(s) room(s) whom peri-wash and Calmoseptine are utilized during cares to ensure that peri-wash and Calmoseptine are not within reach on bedside table. Monitoring will start on 5/19/16. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. The facility Director of Nursing or LN Designee will submit to the QA&A Committee any findings and/or corrective actions taken during the quarterly QA&A Committee Meeting. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		5/20/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135136	A. BUILDING _____ B. WING _____	C 04/15/2016

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F 329	Continued From page 21 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a resident's medication was not duplicated. This was true for 1 of 9 sample residents (#4). This failure created the potential for harm if residents were to receive unnecessary medications and/or to experience adverse consequences related to duplicate therapy. Findings included: Resident #4 was admitted to the facility on 2/26/16 with multiple diagnoses, including depression. Resident #4's February, March and April 2016 MARs documented orders for daily use of Amitriptyline and Sertraline for depression and	F 329	F- 329 SS=D §483.25(i) – Drug Regimen is Free from Unnecessary Drugs The facility does ensure that Resident(s) drug regimen is free from unnecessary drugs. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident #4 is no longer a resident in this facility.	

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F 329	Continued From page 22 were administered as ordered. The resident's March and April 2016 depression behavior monitors documented zero incidents of "verbalizations of sadness" for 126 shifts. Resident #4's care plan documented an intervention on 3/16/16, "Assess need for a dose reduction, to achieve a minimum effective level of medication." The resident's 3/29/16 Pharmacy Consultation Report documented: "Comment: [Resident #4] receives two antidepressants...Recommendation: Please re-evaluate the need for both agents...Use of two or more antidepressants simultaneously may increase risk of side effects; in such cases, there should be documentation of expected benefits that outweigh the associated risks and monitoring for any increase in side effects..." The report documented the report had been faxed on 4/1/16 with a note "out to be signed." The physician's response and signature area was blank. On 4/14/16 at 10:10 am, the DNS said the consultation report had been sent to the physician on 4/1/16 but the facility had just received the physician's response back on 4/12/16 with the diagnosis of insomnia for the Amitriptyline. She was not sure why there was a delay for the new diagnosis.	F 329	Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following: This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, all Resident(s) in the facility who have a diagnosis of Depression whom are on Amitriptyline and Sertraline may have the potential to be affected by this deficiency therefore; By 5/12/16, the Pharmacist Consultant will review all current Resident(s) who have a diagnosis of Depression whom are on Amitriptyline and Sertraline to ensure that a resident(s) medications are not duplicated. Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following: By 5/12/16, the Administrator or Designee will notify all attending physicians via a letter regarding F329 with emphasis on: The importance of responding to monthly drug regimen review requests from Pharmacy Consultant regarding Resident(s) who have a diagnosis of Depression whom are on Amitriptyline and Sertraline in a timely manner to	

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F 329	Continued From page 23	F 329	ensure a resident(s) medications are not duplicated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; Monitoring will be done through: The Director of Nursing or LN Designee will: Review at least three (3) current Resident(s) who have a diagnosis of Depression whom are on Amitriptyline and Sertraline to ensure that current monthly drug regimen review from Pharmacy Consultant are signed by the physician and returned in a timely manner. Monitoring will start on 5/19/16. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. The facility Director of Nursing or LN Designee will submit to the QA&A Committee any findings and/or corrective actions taken during the quarterly QA&A Committee Meeting. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		5/20/16

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F 371	Continued From page 24 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 and interview, it was determined the facility failed to ensure foods were stored in a manner that prevented cross-contamination. This negative practice placed 36 of 36 residents who received their meals from the kitchen, at risk food-borne illness. Findings include: During an observation of the kitchen, on 4/11/16 at 11:10 am, a carton of liquid eggs was standing in blood leaking from a meat package in the same tray. The Dietary Manager (DM) was present during this observation and agreed this was not appropriate. An observation of the same refrigerator on 4/11/16 at 1:05 pm, found the meat package and the carton of liquid eggs continued to be stored in the same tray. There was no obvious blood in the tray but there was blood on the bottom seam of the liquid egg container. The DM stated that she wiped out the tray but did not inspect the bottom of the egg carton. The DM stated the eggs had not been used and disposed of them.	F 371	F- 371 SS=F ¿483.35(i) □ Food Procure, Store/Prepare/Serve - Sanitary The facility does ensure that foods are stored in a manner to prevent cross-contamination. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: The carton of liquid eggs was disposed of by the Dietary Manager on 4/11/16 at 1:05 pm. By 5/12/16, the Administrator will provide 1:1 in-service with Dietary Manager regarding F-371 with emphasis on the importance of ensuring the prevention of cross-contamination of food in the kitchen refrigerator through proper storage between liquid eggs and a meat package	

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F 371	Continued From page 25	F 371	& the disposal of such items should a leak occur. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following: All Resident(s) in the facility who receive their meals from the kitchen have the potential to be affected by this deficiency therefore; By 5/12/16, the Administrator or Designee will do a visual observation regarding the proper storage of food in the kitchen refrigerator to prevent cross-contamination through proper storage between liquid eggs and a meat package & the disposal of such items should a leak occur. Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following: By 5/12/16, the Administrator or Designee will provide in-service to all kitchen staff regarding F371 with emphasis on preventing cross-contamination in the kitchen refrigerator through proper storage between liquid eggs and a meat package & the disposal of such items should a leak occur. How the corrective action(s) will be	

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F 371	Continued From page 26	F 371	monitored to ensure the deficient practice will not recur; Monitoring will be done through: The Administrator or Designee will: Perform a visual observation to ensure prevention of cross-contamination in the kitchen refrigerator through proper storage between liquid eggs and a meat package & the disposal of such items should a leak occur. Monitoring will start on 5/19/16. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. The facility Administrator or Designee will submit to the QA&A Committee any findings and/or corrective actions taken during the quarterly QA&A Committee Meeting. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425		5/20/16

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F 425	Continued From page 27 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure pain medication was available in the facility, to provide pain control for 1 of 11 (Resident #10) sample residents. This resulted in a lack of ordered pain medication available to a resident following admission to the facility for aftercare for hip replacement surgery. Findings include: Resident #10's "Medication Record" for 10/8/15, indicated Resident #10 requested pain medication at 8:00 pm, midnight, and again at 4:00 am on 10/9/15. On the back of the "Medication Record" was a handwritten entry by LPN that stated "Percocet 5/325 ii po due 0000-not received from pharmacy." A second handwritten entry was documented by the same LPN, which stated "Percocet 5/325 ii po due 2000 not received-none in PIXIS." There was no evidence of other interventions to reduce Resident #10's pain.	F 425	F- 425 SS=D ¿483.60(a),(b) □ Pharmaceutical SVC-Accurate Procedures, RPH The facility does ensure that pain medication is available in the facility to provide pain control for Residents. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident #10 is no longer a resident in this facility. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:	

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F 425	Continued From page 28 The "Record of Admission" for Resident #10 specified an admit date and time of 10/8/15 at 2:03 pm, with the diagnosis of aftercare following joint replacement and the presence of right artificial hip joint. A physician's order, dated 10/08/15, read, "Percocet 5/325 po (orally) Q (every) 4 (hours) unless asleep scheduled. May refuse dose may ask for ii (2) tabs." A phone interview was completed with the facility's pharmacist on 4/14/16 at 11:45 am. The pharmacist indicated medication needs were communicated to the pharmacy. The pharmacist said the pharmacy checked medications, especially frequently used medications, approximately 2 times a week and replaced those used from the PIXIS. The pharmacist also stated, "the facility could obtain a first dose supply from a provisional pharmacy such as Walgreens." An interview was conducted with the DON on 4/14/16 at 10:18 am. The DON indicated that if a patient was admitted that day, medications would be in the facility the same day, unless it was late in the day. If it was late in the day, they would get approval to retrieve the medication from the PIXIS (a secured storage system with minimal medications used for immediate supply needs). The DON indicated they would then get the medication from (pharmacy names), the next day." Review of the list of medications in the PIXIS, provided by the DNS on 4/14/16 at 9:05 am, showed the pain medications that were prescribed for Resident #10 were to be	F 425	This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, all new Resident(s) in the facility who have pain medication may have the potential to be affected by this deficiency therefore; By 5/12/16, the Director of Nursing or LN Designee will review all current Resident(s) who have an order for pain medications to ensure that pain medication is available for administration when necessary. Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following: Administrator and Director of Nursing had a meeting with the Pharmacy Sales Representative on 10/16/15 regarding the importance of Pharmacy timely delivery of pain medication upon receipt of new order. Pharmacy installed new Omnicell medication disbursement machine on 2/22/16 which increased capacity of storage of pain medications for first dosing. By 5/12/16, the Administrator or Designee will in-service all licensed nursing staff regarding F425 with emphasis on	

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F 425	Continued From page 29 maintained in the PIXIS system. The DON mentioned there was a problem with the PIXIS at the time of Resident #10's admission, but it had been resolved. Pain medication needed by Resident #10 was not available at the time of his admission.	F 425	ensuring when new order(s) for pain medication(s) are sent to the Pharmacy that Pharmacy delivers first dosing or authorization is provided by Pharmacy to pull pain medication from Omnicell medication disbursement machine in a timely manner. If pain medication(s) are not delivered via first dosing or authorization to pull pain medication from Omnicell medication disbursement machine is not received in a timely manner, the nurse must contact the Pharmaceutical Representative immediately for resolution. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; Monitoring will be done through: The Director of Nursing or LN Designee will: Review at least three (3) new current Resident(s) who have new order(s) for pain medication sent to the Pharmacy to ensure that Pharmacy delivered first dosing or authorization was provided by Pharmacy to pull pain medication from Omnicell medication disbursement machine in a timely manner. If pain medication(s) were not delivered via first dosing or authorization to pull pain medication from Omnicell medication disbursement machine was not received in a timely manner, the nurse contacted	

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F 425	Continued From page 30	F 425	the Pharmaceutical Representative immediately for resolution. Monitoring will start on 5/19/16. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. The facility Director of Nursing or LN Designee will submit to the QA&A Committee any findings and/or corrective actions taken during the quarterly QA&A Committee Meeting. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it	F 514	F- 514 SS=D	5/20/16

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F 514	Continued From page 31 was determined the facility failed to ensure physician recap orders for of 1 of 9 sampled residents (Resident #1) were accurate. As a result, a resident was placed at risk of not receiving medication as ordered. Findings include: Resident #1 was readmitted to the facility on 2/24/16, with multiple diagnoses including anxiety. Resident #1's 2/24/16 physician orders included an order for Alprazolam for anxiety PRN. Resident #1's April 2016 Physician recap orders did not include the order for Alprazolam. Resident #1's April 2016 MAR documented the resident received Alprazolam for anxiety six times from 4/1/16 to 4/12/16. On 4/13/16 at 4:25 pm, the DNS said the order should have been on the recap orders.	F 514	¿483.75(l)(1) □ Res Records-Complete/Accurate/Accessible The facility does ensure that physician recap orders are accurate. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident #1 is no longer a resident in this facility. As reflected in the Statement of deficiencies-form CMS-2567, Resident□s Alprazolam was printed on the MAR and Alprazolam was given as ordered with no delay or missed medication dosage. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following: This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, all Resident(s) in the facility who have and order for Alprazolam may have the potential to be affected by this deficiency therefore; By 5/12/16, the Director of Nursing or LN Designee will review all current Resident(s) who have an order for Alprazolam to ensure that the medication is listed on the monthly physician order recapitulation.	

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F 514	Continued From page 32	F 514	Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following: By 5/12/16, the Administrator or Designee will in-service the Licensed Nurse assigned to the monthly physician order recapitulation and Medical Records Director regarding F514 with emphasis on ensuring that all Alprazolam orders are listed on the monthly physician order recapitulation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; Monitoring will be done through: The Administrator or Designee will: Review at least three (3) current Resident(s) who have an order for Alprazolam to ensure that Alprazolam is listed on the monthly physician order recapitulation. Monitoring will start on 5/19/16. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. The facility Administrator or Designee will submit to the QA&A Committee any	

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F 514	Continued From page 33	F 514	findings and/or corrective actions taken during the quarterly QA&A Committee Meeting. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	

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

May 20, 2016

Steve Gannon, Administrator
Quinn Meadows Rehabilitation & Care Center
1033 West Quinn Road,
Pocatello, ID 83202-2425

Provider #: 135136

Dear Mr. Gannon:

On **April 15, 2016**, an unannounced on-site complaint survey was conducted at Quinn Meadows Rehabilitation & Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006860

Several meals were observed during the survey. Staff was observed for verbal and written communication and for follow through with residents. Call light response times were observed. Resident rooms and beds were observed. Residents were observed for proper dressing and hygiene needs. Staff were observed for illness.

The identified resident and six other residents' medical records were reviewed. The facility's grievance file,which included a grievance and an investigation for the identified resident,were reviewed. Resident council minutes from January to March 2016 were reviewed.

Six residents in the Group Interview, three individual residents and two family members were interviewed regarding Quality of Care and Quality of Life concerns. Several staff, including Certified Nursing Assistants (CNAs), nurses, Social Worker, Dietary Manager, Occupational Therapist, Business Office Manager and a housekeeper were interviewed for Quality of Care and Quality of Life concerns. The Director of Nursing Services and Administrator were interviewed.

Allegation #1: The Reporting Party said there was a lack of communication between departments regarding an identified resident's care plan and a care conference was not completed in a timely manner.

Findings #1: The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from April 11, 2016 to April 15, 2016.

The identified resident was no longer in the facility at the time the complaint was investigated.

Similar allegations were investigated during a Recertification and State Licensure survey conducted from January 12, 2015 to January 16, 2015 and the facility was cited at F280. See the Recertification and State Licensure survey results regarding these deficient practices.

Conclusion #1: Substantiated. No deficiencies related to the allegation are cited.

Allegation #2: The rules of the facility, including visiting hours and expectations, were not explained on admission.

Findings #2: The identified resident's medical record documented admission paperwork was not completed on admission.

The Business Office Manager said she did not have a documented reason for the delay.

Based on the record review and staff interview, it was determined the allegation was substantiated.

Conclusion #2: Substantiated. No deficiencies related to the allegation are cited.

Allegation #3: Upon admission, family was encouraged to eat with the resident but were given the impression the facility was not prepared when family asked to dine with the resident.

Findings #3: Several meals were observed and family members were observed to eat with residents without a concern.

Six residents in the Group Interview, three individual residents and two family members said family eating with residents was not a concern. A nurse and a CNA said family members are encouraged to eat with residents and family meal trays are available.

Based on the observations and resident, family and staff interviews, it was determined the allegation could not be substantiated.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: A therapist left a note for the identified resident with instructions, but the resident had vision impairments which made it difficult to read. Also, staff members did not take into account the resident's hearing deficits when communicating with the resident.

Findings #4: Several staff including CNAs, nurses, Occupational and Physical Therapists, were observed communicating with residents and no concerns were identified.

The identified resident's record and six other residents' records were reviewed and no concerns were identified. Resident council minutes did not identify communication was an issue.

Six residents in the Group Interview and three individual resident interviews did not identify communication was a concern. An Occupational Therapist said she enlarges instructions via the copier for residents with visual deficits to see and speaks loudly enough for residents with hearing deficits. The Administrator said the allegation was investigated, but no evidence was found to substantiate the allegation.

Based on observations, record review and resident and staff interviews it was determined the allegation could not be substantiated.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Staff told the resident they would do something for him/her, but would not follow through.

Findings #5: Resident and staff interactions were observed and no concerns with follow through were observed.

Grievances and Resident Council Minutes did not document follow through was a concern.

Six residents in the Group Interview and three individual residents said staff followed up on their concerns. A nurse said if a resident requests something, then staff follow up with the request.

Based on the observations, record review and resident and staff interviews, it was determined the allegation could not be substantiated.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: Ill staff were observed caring for the resident.

Findings #6: Similar allegations were investigated during a Recertification and State Licensure survey conducted from January 12, 2015 to January 16, 2015 and the facility was cited at F441. See the Recertification and State Licensure survey results regarding these deficient practices.

Conclusion #6: Substantiated. No deficiencies related to the allegation are cited.

Allegation #7: Staff did not pay attention to soft-spoken residents while in the dining room and when other residents tried to intervene they were told to mind their own business.

Findings #7: Several meals were observed and staff were attentive to all the residents' needs.

Six residents in the Group Interview and three individual residents said staff listened to the residents while dining. A nurse and the Dietary Manager said staff were aware of those who speak softly, ensure their needs are met, and treat all residents with respect.

Based on observation and resident and staff interviews, it was determined the allegation could not be substantiated.

Conclusion #7: Unsubstantiated. Lack of sufficient evidence.

Allegation #8: The identified resident's bed was not made and the room was not cleaned.

Findings #8: Residents' beds were observed to be made, rooms were observed to be clean and housekeepers were observed to clean rooms thoroughly.

Six residents in the Group Interview, three individual residents and two family members said there were no concerns with beds being made or cleanliness of rooms. A CNA said resident beds were made each morning. A housekeeper was interviewed and she said rooms were cleaned daily.

Based on observation and resident and staff interview, it was determined the allegation could not be substantiated.

Conclusion #8: Unsubstantiated. Lack of sufficient evidence.

Allegation #9: The identified resident was not dressed one the morning, which delayed the resident's therapy.

Findings #9: Residents were observed to be dressed in a timely manner.

Six residents in the Group Interview, three individual residents and two family members said assistance with dressing and grooming was not a concern. A nurse and a CNA said residents dressing and grooming was performed each morning as residents requested.

Based on observations and resident and staff interview, it was determined the allegation could not be substantiated.

Conclusion #9: Unsubstantiated. Lack of sufficient evidence.

Allegation #10: Call lights were not answered in a timely manner.

Findings #10: Call lights and response times were observed throughout the survey and no concerns were identified.

Call light audits for the entire stay of the identified resident were reviewed and call light times were within acceptable limits. Resident Council Minutes did not document call light response time was a concern.

Three individual residents and two family members said call light response time was not a concern. Two CNAs said call lights were answered in a timely manner and when they were busy, the nurses would also assist with call lights. One nurse said it is every staff member's responsibility to answer call lights in order to assist residents in a timely manner. The Director of Nursing services said call light audits were conducted weekly to ensure call lights were being answered in a timely manner.

Based on the record review and staff interview, it was determined the allegation could not be substantiated.

Conclusion #10: Unsubstantiated. Lack of sufficient evidence

Allegation #11: The identified resident was not checked on an identified day, the resident's vital signs were not taken, and the identified resident was not assisted to the bathroom or to meals.

Findings #11: Residents were observed to receive nursing services, assistance with their toileting needs and assisted to meals.

The identified resident's medical record was reviewed and it documented medications were given, call lights answered, vital signs taken, and other nursing services were performed. Six other residents' records did not document concerns with these issues.
Six residents in the Group Interview and three individual residents had no concerns with assistance or nursing services. A nurse and a CNA said residents received all the ordered services and were assisted with toileting and to meals.

Based on observation, record review and resident and staff interview, it was determined the allegation could not be substantiated.

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Conclusion #11: Unsubstantiated. Lack of sufficient evidence.

Allegation #12: An identified day's lunch meal was late.

Findings #12: Several meals, including two lunch meals, were observed for timeliness and meals served in the dining room and hall trays were served within an acceptable time frame.

Six residents in the Group Interview and three individual residents had no concerns with meal delivery times. The Dietary Manager and Director of Nursing Services said all meals are served in a timely manner.

Based on the record review and staff interview, it was determined the allegation could not be substantiated.

Conclusion #12: Unsubstantiated. Lack of sufficient evidence.

Allegation #13: The identified resident's family was not informed of a delayed discharge for the resident.

Findings #13: The identified resident's clinical record documented the resident was able to make his/her own needs known. The identified resident's clinical record documented discharge planning and instructions had taken place in a timely manner. One other resident's record did not document a delay in his/her discharge.

The Social Worker said she does not remember if there was a delay for the identified resident at discharge and said when there was a delay the resident and a family member were always informed.

Based on the record review and staff interview, it was determined the allegation could not be substantiated.

Conclusion #13: Unsubstantiated. Lack of sufficient evidence.

Three of the allegations were substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

D. L Scott

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt

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
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May 20, 2016

Steve Gannon, Administrator
Quinn Meadows Rehabilitation & Care Center
1033 West Quinn Road,
Pocatello, ID 83202-2425

Provider #: 135136

Dear Mr. Gannon:

On **April 15, 2016**, an unannounced on-site complaint survey was conducted at Quinn Meadows Rehabilitation & Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007193

Medication pass was observed during the survey. Six residents were observed for pain control.

The identified resident's medical record and six other residents' records were reviewed. The facility's Grievance file for 2015 and 2016 were reviewed. Resident Council Minutes from January to March 2016 were reviewed. The facility's Incident and Accident reports from October 2015 to April 2016 were reviewed.

Six residents in the Group Interview and three individual residents were interviewed for Quality of Care concerns. Two nurses and the Director of Nursing services were interviewed regarding Quality of Care concerns. A Pharmacist was interviewed regarding medication concerns.

Allegation #1: The Reporting Party said an identified resident did not receive pain medications in a timely manner because the medication was not available in the facility, or may have been given to a different resident.

Findings #1: The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from April 11, 2016 to April 15, 2016.

The identified resident was no longer in the facility at the time the complaint was investigated.

Based on record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F309 and F425.

Conclusion #1: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #2: The identified resident was not appropriately assessed for a urinary tract infection and a possible leg infection.

Findings #2: The identified resident's medical record did not document inappropriate infection assessments. Two other residents' records were reviewed for assessments for infections and no concerns were identified.

One nurse and the Director of Nursing Services said nurses assess residents for possible infections.

Based on record review and staff interview, it was determined the allegation could not be substantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Some medications were almost given incorrectly and the identified resident's medication may have been given to a different resident.

Findings #3: Medication pass was observed with two different nurses administering 29 medications without any medication errors.

The identified resident's medical record and six other residents' records did not identify an issue with incorrect administration of medications.

Two nurses and the Director of Nursing Services said medications were administered as ordered.

Based on the record review and staff interview, it was determined the allegation could not be substantiated.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt