



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

RECEIVED
JUL 12 2016
FACILITY STANDARDS

June 13, 2016

Jon Smith, Administrator
Caribou Memorial Living Center
300 South Third West
Soda Springs, ID 83276-1559

Provider #: 135060

Dear Mr. Smith:

On **May 27, 2016**, a survey was conducted at Caribou Memorial Living 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 (XS) 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.

Jon Smith, Administrator
June 13, 2016
Page 2 of 4

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 **June 23, 2016**. Failure to submit an acceptable PoC by **June 23, 2016**, may result in the imposition of penalties by **July 23, 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 **August 25, 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 **August 25, 2016**. A change in the seriousness of the deficiencies on **July 11, 2016**, may result in a change in the remedy.

Jon Smith, Administrator
June 13, 2016
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The remedy, which will be recommended if substantial compliance has not been achieved by **August 25, 2016** includes the following:

Denial of payment for new admissions effective **August 25, 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 **November 23, 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 **August 25, 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>

Jon Smith, Administrator
June 13, 2016
Page 4 of 4

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

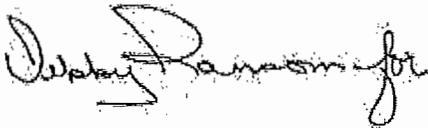
- BFS Letters (06/30/11)

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

This request must be received by **June 23, 2016**. If your request for informal dispute resolution is received after **June 23, 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,

A handwritten signature in black ink, appearing to read "David Scott for". The signature is written in a cursive style with a large initial "D".

David Scott, RN, Supervisor
Long Term Care

ds/pmt
Enclosures



**Caribou Memorial
Hospital**

July 6, 2016

Loretta Todd, RN
Idaho Department of Health & Welfare
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009

RECEIVED
JUL 12 2016
FACILITY STANDARDS

Dear Ms. Todd:

Enclosed you will find the revised Plan of Correction for Caribou Memorial Hospital required as part of our long-term care survey completed on May 27, 2016. Thank you for your assistance in identifying opportunities for us to improve the services which we provide to our Residents.

If you have any additional questions, please contact me at (208) 547-2765 or jon.smith@cmhlc.org.

Sincerely,

Jon Smith, CEO
Caribou Memorial Hospital

Enclosure

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

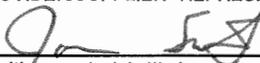
PRINTED: 06/13/2016
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/27/2016
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NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey from May 23 to May 27, 2016.</p> <p>The surveyors conducting the survey were: Presie C. Billington RN, Team Coordinator Nina Sanderson LSW Teresa Kobza RD, LD</p> <p>Definitions include: CNA - Certified Nursing Assistant DNR- Do Not Resuscitate DNS - Director of Nursing Services GERO - Gastroesophageal Reflux Disease GDR- Gradual Dose Reduction ICC- Infection Control Committee IDT- Interdisciplinary Team IM - Intramuscular LSW - License Social Worker MD - Physician MOS - Minimum Data set mg - Milligrams MOM - Milk of Magnesium NN - Nurse's Note PO - by mouth PRN - As Needed QD - Once a Day UTI - Urinary Tract Infection</p>	F 000	<p>RECEIVED JUL 12 2016 FACILITY STANDARDS</p>	
F 155 SS=D	<p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements</p>	F 155		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 7/6/16
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 155	<p>Continued From page 1</p> <p>specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents had the opportunity to formulate advanced directives. This was true for 1 of 10 (#1) residents sampled for notification of the right to refuse treatment. This failed practice increased the risk that residents' treatment wishes would not be honored. Findings included:</p> <p>Resident #1 was admitted to the facility on 3/20/15 with diagnoses which included depression, chronic kidney disease, heart failure, hyperlipidemia, pulmonary fibrosis, diabetes and pain.</p> <p>On 12/23/15, Resident #1's IDT Meeting Minutes documented his code status was reviewed with him and he wished his status to remain DNR. Resident #1 was not present at the IDT meeting.</p> <p>On 3/9/16, Resident #1's annual MOS</p>	F 155	<p>F155 Resident #1 will have a POST Form completed and placed in chart. This will be done by the PCP, Resident, and Social Services.</p> <p>Identification of other Residents Potentially Affected: The CNO/Designee will conduct a sweep of all resident charts to make sure that a completed POST form is located in each chart.</p> <p>Staff will be trained regarding Advanced Directives and the new admission checklist.</p> <p>The CNO/Designee has created an Admission Checklist which will be completed upon each admission. Included on this checklist is the completion of the POST and placement in the chart.</p> <p>The CNO/Designee will conduct a QA on every admission chart for six months to validate the completion of the checklist including the POST. The CNO/Designee will reassess the needed frequency of the QA after six months.</p>
	8/11/2016		

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F 155	Continued From page 2 assessment indicated he did not have cognitive impairments. Resident #1's May 2016 MD recapitulation orders stated Resident #1's code status was DNR. Resident #1's clinical record did not contain a signed POST form, or other document with his signature on it, that specified his scope of treatment preferences. On 5/25/16 at 2:00 pm, the DNS and the LSW stated the code status and/or POST form should be in Resident #1's chart and they would try to locate the document. On 5/27/16 at 9:30 am, the DNS provided Resident #1's admission Physician's Orders, which stated Resident #1's code status was DNR. There was no documentation to show Resident #1 was present with the MD, or the IDT, when his code status was discussed and determined. Signed confirmation from Resident #1 that he was in agreement with the DNR order, was not present in his record.	F 155			
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	F 309	F309 Resident #6 will be reassessed for any contributing factors causing constipation. Any pertinent assessment findings will be reported to the responsible party and attending physician. New physician orders obtained/clarified and noted. Care plan updated as applicable. Identification of other Residents Potentially Affected: The Noc nurse is responsible for printing off the No BM Sheet from the EHR each morning. The Sheet is then reviewed with the Day Medication Nurse. The sheet is then initialed by each nurse and submitted to the CNO/Designee. Staff will be trained regarding bowel protocols. The CNO/Designee will be responsible for conducting a review of each NO BM Sheet/interventions on Monday, Wednesday, and Friday during the interdisciplinary Stand-Up meeting. The CNO/Designee will conduct a monthly QA on each NO BM Sheet/Bowel Protocol Interventions for six months. The CNO/Designee will reassess the needed frequency of the QA after six months.	8/11/2016	

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F 309	<p>Continued From page 3</p> <p>by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure implementation of a bowel care protocol as order by the physician for 1 of 6 (Resident #6) residents whose elimination status was reviewed. The deficient practice created the potential for fecal impaction when the resident went 8 days without a bowel movement. Findings included:</p> <p>Resident #6 was readmitted to the facility on 12/1/14 with diagnoses which included cardiovascular accident and expressive aphasia.</p> <p>The facility's Physician Standing Orders for Resident #6 stated she was to receive:</p> <ul style="list-style-type: none"> * 10 ml MOM on the fourth morning after three consecutive days without a bowel movement, * A Dulcolax suppository on the fifth morning, and * A Fleets enema on the sixth day with no bowel movement. <p>The Standing Orders stated the physician was to be notified if Resident #6 did not have a bowel movement after the sixth day. The Standing Orders for the bowel protocol were listed on Resident #6's MAR.</p> <p>Resident #6's Completed Care Tasks documentation (AOL flow sheets) for the month of March 2016 showed she did not have a bowel movement from 3/15/16 at 11:26 am until 3/23/16 at 4:37 pm.</p> <p>Resident #6's MAR documented she received MOM on 3/20/16 at 8:54 am, a Dulcolax suppository on 3/21/16 at 8:56 am, and MOM on 3/23/16 at 9:11 am. The MAR did not show the</p>	F 309		
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NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(X4) 1D 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 309	Continued From page 4 physician's orders for Resident #6's bowel protocol were followed when she continued not to have bowel movements. Per the Standing Orders, Resident #6 should have received: * MOM on the morning of 3/19/16 (given 3/20/16), * A suppository on 3/20/16 (given 3/21/16), * An enema on 3/21/16 (not given), and * The physician should have been notified on 3/22/16 (not notified). A NN documented on 3/23/16 at 9:15 am, indicated Resident #6 had not had a bowel movement for 8 days, refused a suppository, but did accept MOM that day. There was no documentation the physician was notified Resident #6 had not had a bowel movement. On 5/26/16 at 8:30 am, the DNS stated the bowel protocol was not followed for Resident #6. F 314 SS=D 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to	F 309	F314 Resident #3 will be reassessed by the Certified Wound Care Nurse for any evidence of skin breakdown related to immobilization and a current Braden Score will be reviewed. Any pertinent assessment findings will be reported to the responsible party and attending physician. New physician orders obtained/clarified and noted. Care plan updated as applicable. A recliner was placed in room and resident is encouraged and assisted to reposition every two hours and offload every 30 minutes. If resident refuses, staff is to try again in 15 minutes. If resident continues to refuse, the nurse is notified for further intervention i.e. getting social worker involved, education from wound nurse regarding the effects of not repositioning and offloading, as well as getting family involved if need be. Identification of other Residents Potentially Affected: 1.) The CNO/Designee will conduct a sweep of all patients charts for identification of a high to very high Braden Score (≤ 15). These residents will be placed on a Repositioning/Offloading program. Once identified, Nursing/CNA staff will be responsible for repositioning every 2 hours and/or offloading every 30 minutes. This will be captured in the EHR documentation as specific point and click buttons have been created to indicate that repositioning/offloading occurred and the position the resident was placed in. 2.) The CNO/Designee will calculate Braden Scores weekly on all residents.	8/11/2016

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F 314	<p>Continued From page 5</p> <p>ensure residents were repositioned as needed. This was true for 1 of 9 (#3) residents sampled for positioning. This deficient practice created the potential for harm if residents developed skin breakdown when not moved or repositioned for extended periods of time. Findings include:</p> <p>Resident #3 was admitted to the facility on 4/26/16 with multiple diagnoses, including GERO and UTI.</p> <p>Resident #3's 5/9/16 Initial MOS assessment documented he had moderately impaired cognition, and was dependent on one staff member for transfers, ambulation, and bed mobility.</p> <p>Resident #3's current care plan documented he required repositioning at least every 2 hours.</p> <p>On 5/24/16 between 9:33 am and 11:37 am, Resident #3 was observed lying on his back in bed. Resident #3 was not observed to receive assistance to reposition or offload during that time.</p> <p>On 5/24/16 between 2:00 pm and 3:50 pm, Resident #3 was observed lying on his back in bed. Resident #3 was not observed to receive assistance to reposition or offload during that time.</p> <p>On 5/24/16 at 4:15 pm, the LTC Manager said it was Resident #3's choice to stay in bed but CNAs should have repositioned him at least every 2 hours.</p>	F 314	<p>3.) The CNO/Designee will assign the IDT to perform walking rounds observing for residents who have not been repositioned. This will be added to the current environmental rounds form. This will be done weekly. 4.) CNO/Designee will review the Recliner/Chair Request form, that has been created, with the family/resident on admit to indicate if the family will provide a recliner/chair for the resident or rather CMH will provide a recliner/chair for the resident. This form has been added to the Admission Checklist that is to be completed and placed in the chart with each new admit. 5.) CNO/Designee has written a policy and it has been reviewed by staff supporting the above plan.</p> <p>Staff will be trained regarding repositioning and off-loading.</p> <p>The CNO/Designee will conduct a monthly QA of the EHR documentation, as well as each resident Braden Score, for six months. The CNO/Designee will reassess the needed frequency of the QA after six months.</p> <p>The CNO/Designee will conduct a QA on every admission chart for six months to validate the completion of the checklist including the Recliner/Chair Request Form. The CNO/designee will reassess the needed frequency of the QA after six months.</p> <p>IDT weekly rounds will be reviewed monthly during the facility QA meeting.</p>	

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F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, observation, and record review, it was determined the facility failed to ensure residents at risk for falls were adequately monitored and supervised to prevent accidents. This was true for 2 of 2 (#4 and #6) residents sampled for falls. The deficient practice had the potential to cause harm when a) Resident #4 was left unattended and fell in the dining room, and b) Resident #6 experienced two falls after displaying symptoms of medical, behavioral, and cognitive changes, and received an injections of Ativan, without increased supervision. Findings include:</p> <p>1. Resident #6 was readmitted to the facility on 12/1/14 with diagnoses which included cardiovascular accident and expressive aphasia.</p> <p>a. Resident #6's Quarterly MOS, dated 9/16/15, noted she had severely impaired cognition; some difficulty making herself understood; was able to ambulate but needed physical assistance to steady herself with standing, walking, turning, and when moving herself on and off the toilet; and required limited assistance from staff with toileting.</p> <p>On 12/5/15 at 10:52 am, a NN documented /</p>	F 323	<p>F323</p> <p>Resident #6 will be reassessed for fall risk; appropriate interventions including increased supervision post PRN antianxiety medication administration, and care plan updated. Physical therapy evaluation will also be completed. Responsible party and attending physician notified and new orders noted as applicable.</p> <p>Resident #4 will be reassessed for fall risk; appropriate interventions including increased supervision while in dining room, and care plan updated to also reflect that call light is to be within reach while in room. Responsible party and attending physician notified and new orders noted as applicable.</p> <p>Identification of other Residents Potentially Affected: 1.) CNO/Designee will conduct a sweep of all residents to identify those that are a high falls risk (≥ 10). Identified residents will be encouraged to spend their time in the day room, outside of their rooms. 2.) CNO/Designee will establish Resident watch, meaning that a staff member will be assigned to the day room for their shift. This assignment is to ensure that a staff member is present in the day room/dining room at all times. 3.) The facility will institute IDT rounds to be completed 3 x week to identify those high falls risk residents that are continuing to stay in their rooms and the effectiveness of the resident watch. The rounds will also be used to identify any possible contributing factors related to falls. 4.) Any time a PRN Hypnotic/anxiolytic medication is given, psychotropic monitoring is to be implemented. This is to include visual checks on the resident every 30 minutes x 24 hours then every 60 minutes x 24 hours. This will be captured in the EHR documentation as</p>	8/11/2016
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F 323	<p>Continued From page 7</p> <p>Resident #6 was "acting differently" with changes in her ability to respond to questions. At 3:12 pm, a NN documented Resident #6 had been sent to the ER for a grand mal seizure, received an injection of 2 mg of Ativan, and had returned to the facility at 2:40 pm. At 5:40 pm, Resident #6 was noted to be trying to get out of bed, and required assistance to use the bathroom and dress at that time. The NN further stated Resident #6 was noted to stumble during ambulation and was instructed to use her call light for assistance.</p> <p>At 9:30 pm, a NN indicated Resident #6 was in her room standing at bedside with her pants and adult brief at her knees. Resident #6 responded, "Yes," when asked if she needed help, but did not respond when asked if she needed to use the bathroom. Resident #6 was noted to be "unsteady and confused." The nurse assisted Resident #6 to pull her pants back up and return into bed. The NN documented that at 11:58 pm, Resident #6 had an unwitnessed fall in her room. The NN stated Resident #6 had a "change in mentation post seizure this AM." There was no documentation of an increase in the level of supervision provided to Resident #6 in response to the noted changes throughout the day.</p> <p>A Resident Incident Followup report, documented on 12/10/15 at 12:58 pm, indicated the root cause of Resident #6's fall was determined to be staffs' failure to assist her to the bathroom when she was discovered with her pants and adult briefs down after her seizure, when she had been identified as weak and confused, and had received an Ativan injection in the ER.</p> <p>b. A NN documented on 5/22/16 at 8:14 pm,</p>	F 323	<p>specific point and click buttons have been created to indicate that a visual check occurred.</p> <p>Staff will be trained regarding supervision and fall prevention.</p> <p>The CNO/Designee will conduct a QA on every fall to include completion of the falls risk assessment and root cause analysis. This will occur for six months then the CNO/designee will reassess the needed frequency of the QA after six months.</p> <p>The CNO/Designee will conduct monthly QA on psychotropic monitoring to validate the documentation of the visual checks. This will occur for six months then the CNO/designee will reassess the needed frequency of the QA after six months.</p> <p>IDT weekly rounds will be reviewed monthly during the facility QA meeting.</p>	

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F 323	<p>Continued From page 8</p> <p>noted that at 4:30 pm Resident #6 became agitated, non-pharmacological interventions were ineffective, and the physician ordered a single injection of Ativan to calm her while her medical status was further assessed. There was no of increased supervision related to her behavioral status or suspected changes in her health status. The NN indicated Resident #6 was assisted to bed after the Ativan was administered.</p> <p>At 8:29 pm, the NN documented Resident #6 tripped over her slippers and fell while ambulating in her room.</p> <p>On 5/23/16 at 3:20 pm, Resident #6 was observed sitting in a recliner in her room. Her call light was clipped to the armrest of the recliner near her right hand. Resident #6's overbed table was in front of her, with a soda, ice water, Gatorade, and a bag of potato chips within her reach. A CNA was in the room. Within 5 minutes of the CNA leaving, Resident #6 stated, "Where is everybody?" and began to rise from the chair. The surveyor cued her to ask for assistance. Resident #6 did not respond to the cue, and continued to stand while the surveyor stepped to the hallway to summon assistance. Her feet became tangled in the base of the overbed table. Resident #6 sat back down, pushed the table away from the recliner, then stood. She teetered as she took her first four steps, then steadied somewhat, left the room, and approached the activity room across the hall. Once in the hall, the AD approached Resident #6, steadied her, and guided her into a chair to participate in the activity.</p> <p>On 5/25/16 at 4:35 pm, the DNS stated the facility should have provided additional supervision after</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>Resident #6's fall in December due to her seizure, mental status change, and use of Ativan. The DNS stated the facility had not yet completed its root cause analysis of the 5/22/16 fall, but it was likely the facility would find that Resident #6 should have had increased supervision related to her behavioral changes and the administration of Ativan.</p> <p>2. Resident #4 was admitted to the facility on 12/01/14 with multiple diagnoses, including epilepsy and organic brain syndrome.</p> <p>Resident #4's 5/04/16 Quarterly MOS assessment documented Resident #4 was cognitively intact, required extensive assistance of two staff for ambulation, and had 2 or more falls with one injury (laceration) prior to the assessment.</p> <p>Resident #4's 7/24/14 care plan documented Resident #4 was at risk for falls related to a seizure disorder and not requesting assistance. Interventions included staff completing hourly rounds to assess needs (pain, toileting, positioning, etc.), observing for seizure type activity, and reminding Resident #4 to ask for assistance for all ambulation.</p> <p>A 4/6/16 Fall Scene Investigation Report documented Resident #4 was found on the floor in the dining room at 1:35 pm. Staff were unable to determine the circumstances involved with Resident #4's fall. CNAs were taking other residents to the activity bus for a ride and Resident #4 was left alone in the dining room at the time of the fall. Staff all thought that someone else was in there in the dining room. They were not sure what was the resident doing when he</p>	F 323		

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F 323	Continued From page 10 fell. They could not tell if Resident had a seizure and resident said he cannot remember what he was trying to do when he fell. On 5/26/16 at 11:25 am, the Director of Performance Improvement stated Resident #4 had a history of multiple falls and said staff should not have left Resident #4 alone in the dining room.	F 323		8/11/2016	
F 329 SS=E	483.25(1) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329	Resident #1 will have a GDR of scheduled Ativan 3 mg q day. GDR will be Ativan .5 mg q AM and Ativan .5 mg 2 tablets q PM. Celexa 60 mg q day will remain the same per physician order with Documentation of a formalized evaluation of the potential risks of the high dose. Scheduled EKG and labs (particularly K+ and Magnesium) are scheduled q six months. Responsible party and attending physician notified and new orders noted as applicable. Sleep monitoring clarified: Slept most of shift = \geq 4.5 total hours per shift. Slept all of shift = \geq 8 total hours per shift. Awake most of Shift = \geq 4.5 total hours per shift. Awake all of shift = \geq 8 total hours per shift. Resident #4 All orders for PRN Haldol will be d/c'd. Behavior Monitoring Sheet will be started to list target behaviors, side effects and non-pharmacological interventions. This is to be completed per shift by nursing staff. Responsible party and attending physician notified and new orders noted as applicable. Resident #5 will have a GDR of scheduled Citalopram 30 mg q day. GDR will be Citalopram 20 mg q day. GDR of scheduled Lorazepam 1 mg q HS to 0.5 mg q HS. Abilify 2 mg PRN will be d/c'd. Responsible party and attending physician notified and new orders noted as applicable. Sleep monitoring clarified: Slept most of shift = \geq 4.5 total hours per shift. Slept all of shift = \geq 8 total hours per shift. Awake most of shift = \geq 4.5 total hours per shift. Awake all of shift = \geq 8 total hours per shift.		

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F 329	<p>Continued From page 11</p> <p>by:</p> <p>Based on observation, record review, and staff, resident, and family member interviews, it was determined the facility failed to ensure adequate indications for use and monitoring of residentspecific target behaviors for the use of psychotropic medications; failed to ensure dosages of psychotropic medications were not excessive; and failed to ensure physician's orders clearly identified the dose to be administered. This was true for 4 of 7 residents (#1, #4, #5, and #8) sampled for psychotropic medication use. The failed practice created the potential for residents to experience adverse reactions to medications for which there were no clear indications for their use. Findings include:</p> <p>The 2015 Nursing Drug Handbook states the recommended maximum dose of Celexa for those greater than 60 years of age should be 20 mg per day, with 40 mg being the recommended maximum dose for other adults. F329 documented a maximum daily dose for Ativan at 2 mg per day, and that "it is important to evaluate and document the indications, specific circumstances for use, andthe desired frequency of administration."</p> <p>On 5/25/16 at 2:00 pm, the LSW stated the facility's behavior monitoring process involved CNA observations each shift. The behaviors monitored were determined by trigger items on the MDS and were the same for all residents. The CNA would note, for the entire shift, that a behavior had either occurred or not occurred. The LSW stated that if the behavior occurred, it was to be reported to the nurse, who should document an assessment of the resident's behavior. The LSW stated the facility's computer system did not</p>	F 329	<p>Resident #8 will have a GDR of scheduled Seroquel 50 mg TID. GDR will be Seroquel 50 mg q AM & q HS, Seroquel 25 mg q Noon. Behavior Monitoring Sheet will be started to list target behaviors, side effects and non-pharmacological interventions. This is to be completed per shift by licensed nursing staff. Responsible party and attending physician notified and new orders noted as applicable.</p> <p>Identification of other Residents Potentially Affected: 1.) Pharmacy will conduct a sweep of all residents on psychoactive medication to identify those that exceed geriatric recommended doses. 2.) Pharmacy will conduct a sweep of all residents on psychoactive medications to identify orders that are potentially written/prescribed inappropriately. 3.) Pharmacy will complete a Physician Action Report for all psychoactive medications monthly. The original will be forwarded to the PCP and a copy placed in the resident chart and a copy forwarded to the IDT. 4.) Pharmacy will institute a new policy for automatic 3 day stop order on all psychotropic PRN medications. 5.) Individual Behavior Monitoring Sheets will be instituted for all residents on psychoactive medications. These are to include the # of episodes of target behaviors, side effects and non-pharmacological interventions per shift. To be completed by licensed nursing staff. 6.) CNA/Nursing staff to be in-serviced on Sleep Monitoring parameters. Sleep monitoring clarified: Slept most of shift = ≥ 4.5 total hours per shift. Slept all of shift = ≥ 8 total hours per shift. Awake most of shift = ≥ 4.5 total hours per shift. Awake all of shift = ≥ 8 total hours per shift.</p> <p>Staff will be trained regarding geriatric dosing, GDR's, sleep monitoring, and behavior monitoring assessments.</p> <p>The CNO/Designee will conduct a QA on the Physician Action Reports monthly to determine physician response and appropriate documentation. This will occur for six months then the CNO/Designee will reassess the needed frequency of the QA after six months.</p>	

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F 329	<p>Continued From page 12</p> <p>allow for the facility to identify a specific target behavior for which a resident was receiving a psychotropic medication. The LSW stated the computer system allowed for resident sleep patterns to be tracked only in general terms of whether during the entirety of the CNA's shift, the resident was:</p> <ul style="list-style-type: none"> * awake all shift * awake most of shift * asleep all shift * asleep most of shift <p>1. Resident # 1, an 85 year old, was admitted to the facility on 3/20/15 with diagnoses which included chronic kidney failure, heart failure, depression, pulmonary fibrosis, and anxiety.</p> <p>Resident #1's May 2016 physician recapitulation orders noted he received:</p> <ul style="list-style-type: none"> * Celexa at 60 mg daily, beginning 3/20/15; * 1 mg of Ativan every morning and 2 mg of Ativan at bedtime beginning 4/1/15; and * 1 mg of Ativan at night as needed if his anxiety prevented him from sleeping, beginning 9/22/15. <p>The 2015 Nursing Drug Handbook documented the maximum dose for Celexa for those greater than 60 years of age should be 20 mg per day.</p> <p>Resident #1's 3/9/16 Annual MDS assessment documented he had no behaviors, no cognitive or decision making impairments and no signs and symptoms of depression. Quarterly MDS assessments dated 7/2/15, 9/23/15, and 12/23/15, stated the same findings.</p>	F 329	The CNO/Designee will conduct a QA on the Behavior Monitoring Sheets to validate completion of documentation. This will occur for six months then the CNO/Designee will reassess the needed frequency of the QA after six months.		

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F 329	<p>Continued From page 13</p> <p>Resident #1's care plan, dated 3/25/15, stated staff were to monitor and record if Resident #1 had adverse side effects with the use of the psychotropic medications, and staff were to monitor and record possible mood symptoms with the use of psychotropic medications. Resident #1's record did not contain documentation of monitoring for the potential adverse reactions to psychotropic medications. Resident #1's record did not include documentation of his specific target symptoms as identified by the physician for the use of Celexa and Ativan. Evidence of ongoing monitoring for the presence of the symptoms was not found in Resident #1's record.</p> <p>The IDT reviewed Resident #1's psychotropic medication usage on 11/9/15, 12/23/15, and 3/17/16. The MD declined dosage reductions on all three occasions due to Resident #1's history of anxiety. The MD did not document clinical justification for the ongoing use of Celexa and Ativan in doses which exceeded the recommendations of nationally recognized professional guidance.</p> <p>On 5/1/16, a NN documented Resident #1 told the nurse he no longer wanted the Ativan in the morning and he only wanted it at night for sleep. He stated he did not realize he received it twice a day and thought he only received it when he needed it.</p> <p>On 5/25/16 at 2:00 pm, the LSW and DNS stated residents receiving psychotropic medications were reviewed quarterly during the Psychotropic Interdisciplinary Medication review and IDT meetings, where GDR and other recommendations were discussed. They stated</p>	F 329		
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F 329	<p>Continued From page 14</p> <p>the Ativan was given to Resident #1 in the morning to "get him through the day" in terms of his respiratory status. They stated they had not realized the diagnosis for Resident #1's Ativan use at night included difficulty sleeping, but when Resident #1 requested his PRN dose of Ativan, he usually identified air hunger as the underlying cause of sleeplessness. When asked for documentation of Resident #1's sleeping pattern, the facility provided shift-by-shift documentation from CNAs as to whether Resident #1 "Slept Most of Shift/ "Slept All of Shift," was "Awake All of Shift" or "Awake Most of Shift". Those terms were not clearly defined and it could not be determined how often the resident was sleeping or how long he was awake on any given day.</p> <p>On 5/26/16 at 10:45 am, the MD and Resident #1's wife stated Resident #1 had been receiving Celexa and Ativan at the current doses for years. The MD stated Resident #1's dosages of these medications had been the same since the resident had been admitted to the facility. The MD stated Resident #1 had struggled with depression and anxiety for the previous 10 years and multiple medication adjustments had been made to manage symptoms prior to the current regimen. The MD stated he did not believe he had documented a formalized evaluation of the potential risks of the high doses of the resident's Ativan and Celexa, but would do so if required.</p> <p>2. Resident #5 was admitted to the facility on 3/23/15 with diagnoses which included bipolar disorder, depression, anxiety, insomnia, and dry mouth.</p> <p>Resident #S's May 2016 recapitulation orders documented she received Celexa 30 mg daily for</p>	F 329			

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F 329	<p>Continued From page 15</p> <p>depression beginning 3/24/15, Abilify at 5 mg daily and 2mg PRN (no frequency ordered) for psychosis/depressive episodes beginning 3/24/15, and Ativan at 1 mg at bedtime for insomnia beginning 4/24/15.</p> <p>On 4/13/16, Resident #5's Annual MDS assessment documented she had no behaviors; no cognitive or decision making impairments; and no signs and symptoms of depression. MDS assessments dated 8/5/15, 10/28/15 and 1/20/16 documented similar findings with no behaviors or cognitive/decision making impairments. Resident #5 reported mild depressive symptoms on 8/5/15 and 10/28/15 MDS assessments.</p> <p>Resident #5's care plan, dated 4/21/16, documented staff were to monitor and record if Resident #5 had adverse side effects with the use of the psychotropic medications and report to the MD as needed, and to monitor and record possible mood symptoms with the use of psychotropic medications. Her record did not contain documentation of monitoring for the potential adverse reactions to psychotropic medications. The record did not include documentation of resident-specific target symptoms as identified by the physician for the use of Celexa, Ativan, or Abilify or ongoing monitoring of the presence of these symptoms. The care plan also documented the Abilify PRN was to be administered within 10 minutes of an "episode" to help Resident #5 regain control over her emotions and behaviors, per psychiatrist recommendations. There was no documentation as to what specifically constituted an "episode" which warranted medication use.</p> <p>On 3/27/16, the IDT recommended a GDR of</p>	F 329			

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(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 329	<p>Continued From page 16</p> <p>Celexa from 30 mg to 20 mg per day; no need for a GDR of the PRN Ability; and to keep the 5 mg Ability the same due to clinical stability. The MD declined dosage reductions on this occasion due to Resident #S's lack of aggressive behavior and Resident #S's decreased self-reported depression episodes. The MD did not document clinical justification for the ongoing use of Celexa in a dose that exceeded the manufacture's recommendations. Resident #S's sleeping patterns were documented by the CNAs as "Slept Most of Shift," "Slept All of Shift," "Awake All of Shift" or "Awake Most of Shift" with no further specific information available. There were no IDT recommendations regarding the use of Ativan.</p> <p>On 5/24/16 at 4:04 pm, Resident #5 stated her depression was much better than it used to be, and if she experienced an occasional depressive episode, listening to Scripture on tape helped.</p> <p>On 5/25/16 at 2:00 pm, the LSW and DNS stated Resident #S's psychotropic medication use was reviewed quarterly during the Psychotropic Interdisciplinary Medication review and the IDT meetings on 7/6/15, 10/2/15/ 11/8/15 & 3/27/16, where GDR and other recommendations were discussed. They reported the Abilify PRN for Resident #5 had not been discussed because it was a psychiatrist recommendation from 12/26/14.</p> <p>3. Resident # 8 was admitted to the facility on 12/1/14 with diagnoses which included dementia and depression.</p> <p>Resident #S's May 2016 recapitulation orders documented Seroquel at 50mg three times a day, beginning 12/29/15, for psychosis, and Ativan 1</p>	F 329			

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F 329	<p>Continued From page 17 mg, as needed for agitation, beginning 3/1/15.</p> <p>On 4/27/16, Resident #S's most recent quarterly MOS assessment documented Resident #8 was severely cognitively impaired; had no psychosis; did not reject of cares; experienced mild depression, and exhibited occasional physical or verbal aggression.</p> <p>Resident #S's care plan, dated 5/16/16, documented staff were to monitor and record if Resident #8 had adverse side effects with the use of the psychotropic medications and report to the MD as needed, and monitor and record behaviors and non-pharmacological interventions. The resident's record did not contain documentation of monitoring for the potential adverse reactions to psychotropic medications. The record did not include documentation of resident-specific target symptoms as identified for the use of Seroquel or ongoing monitoring of the presence, persistence, and alterability of those symptoms.</p> <p>The IDT reviewed the resident's psychotropic medication usage on 12/16/15. The MD and IDT team agreed not to try a dosage reduction of the Seroquel on this occasion due to persistent psychosis with presence of aggressive behaviors and previous unsuccessful GDR. It was not clear from the review how the resident's behaviors were determined to be evidence of psychosis, or how the facility's generic behavior documentation monitored the frequency, persistence, or alterability of that psychosis.</p> <p>Physician notes from 9/12/15, 11/16/15, 1/12/16, 3/16/16, 5/14/16, and 5/24/16 all documented Resident #8 tended to refuse her medications and that was when her behaviors were present.</p>	F 329		

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F 329	<p>Continued From page 18</p> <p>The MD progress note from January 2016 documented a new diagnosis of bipolar disorder. In May 2016, the MD progress note documented a new diagnosis of Schizo-Affective disorder. The notes did not document, and the facility could not provide, evidence of which diagnostic criteria were used to diagnose either Bipolar disorder or Schizo-Affective disorder after the resident had been diagnosed with dementia.</p> <p>On 5/25/16 at 2:00 pm, the LSW and the DNS stated there was a current performance improvement project in the works to improve the facility's behavior monitoring documentation.</p> <p>On 5/26/16 at 3:00 pm, the LSW stated a GDR was attempted and it failed after a few months because Resident #8 had increased physical behaviors towards staff during cares. The LSW stated Resident #8 would spit out her pills or refuse them at a more frequent rate. When she refused her pills, the LSW said, Resident #S's behaviors tended to increase during cares. The LSW stated Resident'#8's refusal of medications and cares could not be altered with non-pharmacological interventions, including being left alone and reapproached. The LSW stated the resident expressed fear and "paranoia" as her reasoning for refusing care and treatment and placed herself at risk of infection, odor, and skin breakdown due to the persistence of her refusals. The LSW stated Resident #8 was at further risk of social isolation, as she would become disruptive in social situations such as meals and groups, which caused other residents to tell her to "shut up," "sit down," or avoid her altogether. The LSW reported the facility would reassure Resident #8 by talking to her, gentle touch and warm blankets, which could help her</p>	F 329		
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F 329	<p>Continued From page 19</p> <p>not to be disruptive. The LSW stated she hoped the current performance improvement project regarding behavior monitoring would result in the facility having more accurate data on which to base recommendations to the MD.</p> <p>4. Resident #4' was admitted to the facility on 12/01/14 with multiple diagnoses, including epilepsy and organic brain syndrome.</p> <p>Resident #6's 5/22/16 physician's telephone order documented staff were to administer Haldol 10 mg IM QD PRN for agitated behavior, and Haldol 2 mg PO BID PRN for agitated behavior.</p> <p>On 5/25/16 at 9:30 am, the physician's telephone order was shown to the Unit Manager. The Unit Manager said the order was not written clearly and the nurse who received the order should have clarified with the physician as to when to administer Haldol 2 mg PO BID PRN and when to administer Haldol 10 mg IM QD PRN to the resident.</p> <p>Resident #4 was ordered to receive Haldol 2 mg BID PRN and Haldol 10 mg IM QD PRN without adequate an assessment, indication for use and failure of non-pharmacological interventions.</p>	F 329	
F 461 SS=D	<p>483.70(d)(1)(vi)-(vii), (d)(2) BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET</p> <p>Bedrooms must have at least one window to the outside; and have a floor at or above grade level.</p> <p>The facility must provide each resident with-- (i) A separate bed of proper size and height for the convenience of the resident; (ii) A clean, comfortable mattress;</p>	F 461	

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F 461	<p>Continued From page 20</p> <p>(iii) Bedding, appropriate to the weather and climate; and</p> <p>(iv) Functional furniture appropriate to the resident ' s needs, and individual closet space in the resident ' s bedroom with clothes racks and shelves accessible to the resident.</p> <p>CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1)(i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations--</p> <p>(i) Are in accordance with the special needs of the residents; and</p> <p>(ii) Will not adversely affect residents' health and safety.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and family member interview, it was determined the facility failed to ensure necessary furniture was provided for a resident's needs. This was true for 1 of 9 (#3) residents sampled for homelike environment in the facility. This deficient practice had the potential to negatively effect Resident #3 if he had to always lay in bed rather than sit on a chair. Findings include:</p> <p>Resident #3 was admitted to the facility on 4/26/16 with multiple diagnoses, including GERO and UTI.</p> <p>Resident #3's 5/9/16 Initial MDS assessment documented moderately impaired cognition and</p>	F 461	<p>F 461</p> <p>Resident #3 will be reassessed by the Certified Wound Care Nurse for any evidence of skin breakdown related to immobilization and a current Braden Score will be reviewed. Any pertinent assessment findings will be reported to the responsible party and attending physician. New physician orders obtained/clarified and noted. Care plan updated as applicable. A recliner was placed in room and resident is encouraged to reposition every two hours and offload every 30 minutes.</p> <p>Identification of other Residents Potentially Affected: 1.) The CNO/designee will conduct a sweep of all patients charts for identification of a high to very high Braden Score (≤ 15). These residents will be placed on a Repositioning/Offloading program. Once identified, Nursing/CNA staff will be responsible for repositioning every 2 hours and/or offloading every 30 minutes. This will be captured in the EHR documentation as specific point and click buttons have been created to indicate that repositioning/offloading occurred and the position the resident was placed in. 2.) The CNO/designee will conduct a sweep of all patients' rooms to make sure there is an adequate chair for resident/visitor. 3.) The CNO/Designee will calculate Braden Scores weekly on all residents. 4.) The CNO/Designee will assign the IDT to perform walking rounds observing for residents who have not been repositioned. This will be added to the current environmental rounds form. This will be done weekly. 5.) CNO/Designee will review the Recliner/Chair Request form, that has been created, with the family/resident on admit to indicate if the family will provide a recliner/chair for the resident or rather CMH will provide a recliner/chair for the resident. This form has been added to the Admission Checklist that is to be completed and placed in the chart with each new admit. 6.) CNO/Designee has written a policy and it has been reviewed by staff supporting the above plan.</p>	8/11/2016

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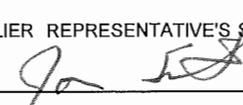
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F 461	<p>Continued From page 21</p> <p>dependenGe on one staff for transfers, ambulation and bed mobility.</p> <p>On 5/23/15 at 4: 10 pm, Resident #3's family member said whenever she visited the resident he was always in bed and the only time she saw the resident out of his bed was when he was in the dining room eating his meal or when he was doing his physical therapy. The family member also said she had previously asked nurses for a chair or recliner so Resident #3 could sit instead of always lying in bed, but there was no chair or recliner provided. The family member said whenever she visits Resident #3 the resident she could only sit on the side of resident's bed.</p> <p>On 5/24/16 at 9:00 am, another family member visited Resident #3 and expressed her concern for the resident being always in bed and not able to sit in a chair or recliner in his room.</p> <p>On 5/24/15 at 5: 10 pm, the LSW said it was not brought to her attention that Resident #3's family requested a recliner inside his room. She said Resident #3's family were welcome to bring in their recliner from home and that the facility would provide one if the family could not.</p>	F 461	<p>Staff will be trained regarding the requirement for a chair to be in each resident room.</p> <p>The CNO/Designee will conduct a monthly QA of the EHR documentation, as well as each resident Braden Score, for six months. The CNO/Designee will reassess the needed frequency of the QA after six months.</p> <p>The CNO/Designee will conduct a QA on every admission chart for six months to validate the completion of the checklist including the Recliner/Chair Request Form. The CNO/designee will reassess the needed frequency of the QA after six months.</p> <p>IDT weekly rounds will be reviewed monthly during the facility QA meeting.</p>		

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the state licensure survey from May 23 to May 27, 2016.</p> <p>The surveyors conducting the survey were: Presie C. Billington RN, Team Coordinator Nina Sanderson LSW Teresa Kobza RD, LO</p> <p>Definitions include: ICC - Infection Control Committee</p>	C 000		
C 666	<p>02.150,02,c Quarterly Committee Meetings</p> <p>c. Meet as a group no less often than quarterly with documented minutes of meetings maintained showing members present, business addressed and signed and dated by the chairperson. This Rule is not met as evidenced by: Based on staff interview and review of Infection Control Committee records, it was determined the facility failed to ensure a representative from each department attended the Infection Control Meetings at least quarterly. The lack of participation of all departments created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings included: On 5/26/16 at 2:53 pm, the facility's Infection Control Program was reviewed with the Infection Control Nurse. The Infection Control Nurse provided the sign-in sheets from the monthly ICC meetings. Upon review of the sign-in sheets, it was determined the following departments were not represented: * Maintenance, Medical Director, Housekeeping and Pharmacy for January 2016 meeting</p>	C 666	<p>RECEIVED JUL 12 2016 FACILITY STANDARDS</p>	

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 7/6/16
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Bureau of Facility Standards

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C 666	Continued From page 1 * Maintenance, Housekeeping, Administrator, and Pharmacy for February 2016 meeting * Maintenance and Housekeeping for March 2016 meeting * Maintenance, Medical Director, Housekeeping and Dietary Services Director for April 2016 meeting * Maintenance, Medical Director and Housekeeping for May 2016 meeting The Infection Control Nurse acknowledged the lack of participation in the meetings.	C 666	C666 Monthly Facility QA/Infection Control meeting is to be held the third Tuesday of each month. All disciplines will be in attendance at least quarterly. Those in attendance are to include: CEO, CNO, Pharmacy, Social Services, Restorative, Maintenance, Dietary, Infection Control, Medical Director, Wound Care, Nursing Informatics, Compliance Officer, MDS Coordinator, LTC Manager, Activities, Housekeeping, and Staff Development. The CEO/Designee will provide education to the QA attendees on the responsibility and requirements of attendance to the monthly meeting. Attendance will be taken and monitored each meeting to ensure that all regulatory requirements are being met. Any further action needed will be addressed by the CEO.	8/11/2016