



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

June 20, 2016

Trent Alder, Administrator
Franklin County Transitional Care
44 North First East
Preston, ID 83263-1326

Provider #: 135059

Dear Mr. Alder:

On **June 9, 2016**, a survey was conducted at Franklin County Transitional Care 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 a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 30, 2016**. Failure to submit an acceptable PoC by **June 30, 2016**, may result in the imposition of penalties by **July 29, 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 **July 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 **July 25, 2016**. A change in the seriousness of the deficiencies on **July 30, 2016**, may result in a change in

Trent Alder, Administrator
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the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 7, 2016** includes the following:

Denial of payment for new admissions effective **September 7, 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 **December 6, 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 **September 7, 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:

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<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:

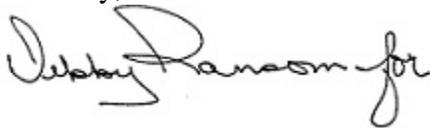
- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **June 30, 2016**. If your request for informal dispute resolution is received after **June 30, 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 that reads "David Scott for". The signature is written in a cursive style.

David Scott, RN, Supervisor
Long Term Care

ds/
Enclosures

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

PRINTED: 07/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/09/2016
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH FIRST EAST PRESTON, ID 83263		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from June 6, 2016 to June 9, 2016.</p> <p>The surveyors conducting the survey were:</p> <p>Brad Perry, BSW, LSW, Team Coordinator Ophelia McDaniels, RN</p> <p>Survey Definitions: ADL = Activities of Daily Living ALS = Amyotrophic Lateral Sclerosis BIMS = Brief Interview for Mental Status CHF = Congestive Heart Failure CM = Centimeter CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse LPM = Liters Per Minute LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment NC = Nasal Cannula O2 = Oxygen PRN = As Needed RN = Registered Nurse SQRS = Strategic Quality Report System</p>	F 000			
F 253 SS=B	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 253		7/13/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/29/2016

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

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F 253	<p>Continued From page 1</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure 1 of 2 (#6) residents' refrigerators was kept clean and maintained under sanitary conditions. Findings include:</p> <p>On 6/6/16 at 4:55 pm, Resident #6's room refrigerator was observed to have a 3-inch by 1-inch food spill which had a 10-inch long trail of dried liquid which came from the spill. There were also several small flecks of an unidentified substance on the bottom shelf. The fridge had two gallons of milk and six bottles of Ensure supplement drink.</p> <p>On 6/6/16 at 5:10 pm, the MDS Coordinator said the refrigerator was "nasty inside" and said the large food spill appeared to be Ensure.</p>	F 253	<p>1-A root cause analysis was performed on 6/13/16 and it was determined that no process was in place to ensure that resident refrigerators would be safely maintained. Resident #6's refrigerator was cleaned and a thermometer was placed in it on 6/8/16. A maintenance schedule was placed on the refrigerator on 6/29/16 so that the temperature and cleanliness of the refrigerator could be checked daily by the evening charge nurse to ensure that the refrigerator is functioning properly. The refrigerator will be deep cleaned weekly and /or as necessary by housekeeping.</p> <p>2- A sweep of all residents rooms was performed by the Administer on 6/24/16 and it was determined that one other resident had a personal refrigerator at this time. This resident owned refrigerator was cleaned on 6/8/16 with a thermometer placed inside. A maintenance schedule was placed on the refrigerator on 6/29/16. This refrigerator will also be deep cleaned weekly by housekeeping and will be checked for cleanliness and proper functioning daily by the evening charge nurse.</p> <p>3-When a refrigerator is brought by a resident and/or their representative to the facility; a Refrigerator Checklist will be procured by the charge nurse. The charge nurse will then send an email to the Housekeeping Director or his designee to ensure that the refrigerator is placed on the cleaning schedule and to</p>		

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F 253	Continued From page 2	F 253	<p>the Maintenance Director or his designee so it can be checked to ensure that it is functioning properly. After it has been determined that the resident refrigerator is functioning adequately the maintenance representative will place a thermometer inside. The Charge Nurse will then place a cleaning and temp schedule on the outside of the refrigerator. The refrigerator will be checked daily by the evening Charge Nurse to make sure it is clean and that the refrigerator temperature is appropriate. She/he will then initial the maintenance schedule and write the temperature on the schedule. Housekeeping will add refrigerator maintenance to their current room checklist as a reminder to perform the weekly cleaning of the refrigerator and will initial the maintenance schedule each time they clean the refrigerator. The Administrator will ensure that an accurate procedure will be in policy manager for the staff to follow by 6/29/16. The procedure regarding the maintenance of resident's refrigerators will be explained to all Nursing Home Staff in Staff Meeting on 6/29/16. The Administrator explained these same procedures to the Housekeeping Director on 6/24/16 and the Maintenance Director on 6/28/16.</p> <p>4- The Administrator or his designee will conduct audits of each affected resident's refrigerator, to ensure the procedure is being followed correctly. The Administrator will perform this audit five times per week for two weeks, then</p>		

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F 253	Continued From page 3	F 253	three times per week for two weeks, then weekly for a month and then he will refer the process to the Quality Management Committee to determine further need for monitoring.		
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's hospice agreement, and staff interview, it was determined the facility failed to ensure a hospice care plan was available for staff. This was true for 1 of 1 (#3) residents reviewed for hospice care. This failure had the potential for more than minimal harm if the resident did not receive appropriate services based on the care plan. Findings include:</p> <p>The facility's Hospice Agreement, dated 3/3/99, documented:</p> <p>"Hospice Care Plan (1) Nursing Facility Residents. The Hospice shall develop, at the time an eligible resident is admitted into the</p>	F 309	<p>5-The facility will be in compliance with tag F253 by 7/13/2016.</p> <p>1-A Root Cause Analysis revealed that there was an insufficient protocol when dealing with hospice agencies that have a contract with Franklin County Transitional Care. It also was revealed that our care plan did not reflect the hospice care plan. On 6/8/16 the care plan for resident # 3 was corrected and a section for hospice was added to his care plan to include which hospice agency was providing services and the portion of the care the hospice workers will provide. The hospice plan of care was obtained from the hospice agency and placed in the resident's chart in the nursing home. Updated plans of care from the hospice</p>	7/13/16	

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F 309	<p>Continued From page 4</p> <p>Hospice program...which includes a written and detailed description of the services and supplies necessary to provide palliative care for the resident."</p> <p>Resident #3 was admitted to the facility on 12/16/15, with multiple diagnoses, including ALS.</p> <p>Resident #3's 12/31/15 physician's orders documented an order for hospice services.</p> <p>Resident #3's clinical record did not contain a hospice plan of care and the facility care plan for Resident #3 did not indicate which hospice provider served Resident #3.</p> <p>On 6/8/16 at 9:35 am, LN #2 said the hospice only provided assistance with lunch meals three or four times a week, depending on family involvement.</p> <p>On 6/8/16 at 2:20 pm, the DON said the hospice care plan was not in Resident #3's chart and the facility's care plan did not document which hospice provider served Resident #3.</p>	F 309	<p>were also obtained and placed in the nursing home chart. A discussion with hospice agency regarding what was needed for the future took place on 6/13/16.</p> <p>2-On 6/16/16 a sweep of all residents Physician Orders was conducted by the MDS Coordinator to ensure that no other residents have hospice services ordered. At this time there are no other residents with hospice services. Only resident #3 was affected.</p> <p>3- A protocol was developed to be used when any resident qualifies and selects hospice to help with their care in the nursing home. A checklist was created on 6/24/16 for each resident with a new hospice order. This checklist includes a line item to ensure that the care plan has been checked, and to ensure that there are directives on it to include; which hospice agency will be providing services and a list of services that they will provide. The MDS Coordinator will ensure that the hospice care plan is current in the Nursing Home (NH) chart bi-monthly. A hospice section has been created on the NH care plan template as a reminder to care plan any resident who chooses and/or qualifies for future services. The Quarterly Review Work Sheet was updated to include a section regarding the reviewing and updating of the residents hospice care plan. All staff will be trained related to the process at staff meeting on 6/29/16.</p>		

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F 309	Continued From page 5	F 309	4-The MDS Coordinator or designee will ensure that the care of resident #3 matches with Physician orders and the care plan for accuracy related to his hospice services. This review will occur bi-monthly by coordination with hospice after the hospice's bi-monthly IDT meeting. The DON will review hospice charts bi-monthly times three months then refer to the Quality Management Committee to determine further need for monitoring. 5-The facility will be in compliance with tag F309 on 7/13/16		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. 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 appropriate respiratory care as ordered by a	F 328	1-A Root Cause Analysis performed on 6/9/16 revealed that oxygen orders for some residents with oxygen were put in as a Nursing Order and not as a	7/13/16	

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F 328	<p>Continued From page 6</p> <p>physician. This was true for 2 of 6 (#6 & #9) residents reviewed for oxygen therapy. This deficient practice created the potential for more than minimal harm due to residents receiving oxygen therapy without physician orders and staff not following physician orders. Findings include:</p> <p>1. Resident #9 was admitted to the facility on 6/1/14 with multiple diagnoses, including CHF.</p> <p>Resident #9's medical record did not contain a physician's order for O2.</p> <p>Resident #9's care plan documented an intervention on 4/4/15 for continuous O2 at 2 LPM per NC.</p> <p>Resident #9's 4/23/16 "Nursing Orders" documented Resident #9 received O2 at 2 LPM per NC.</p> <p>Resident #9 was observed in his room on 6/8/16 at 1:40 pm, 2:40 pm, and 3:15 pm, with the oxygen wall unit set at 2 LPM via NC.</p> <p>Resident #9 was observed on 6/8/16 at 4:15 pm, and on 6/9/16 at 9:00 am and 11:10 am, with an oxygen companion on his wheelchair set at 2 LPM via NC.</p> <p>On 6/9/16 at 11:40 am, the DON said she could not find a physician's order for Resident #9's O2. She said she was not sure why there was a nurses order for the O2 without a physician's order.</p> <p>2. Resident #6 was readmitted to the facility on 5/11/16 with multiple diagnoses, including</p>	F 328	<p>Physician Order. It was discovered that some of the nursing staff did not recognize that the CPSI program (EHR) has a specific way of entering verbal orders given for oxygen by the Physician. A Physician's written order for resident #9 was obtained for oxygen on 6/9/16. The liter flow for the oxygen of resident #6 was clarified by the Physician on 6/9/16.</p> <p>2-A sweep was performed by DON of all of the residents Oxygen orders to ensure their correctness on 6/9/16. A sweep was performed of all care plans to make sure they match the order on 6/9/16. The necessary changes to the residents care plan and/or Physician orders relating to Oxygen were obtained on 6/25/16.</p> <p>3-The DON will review all new oxygen orders within 72 hours of the order. When a new order for oxygen is received, a copy of the order will be given to the DON. The DON or her designee will review all the orders related to oxygen for accuracy on a monthly basis and at every quarterly review. A List of residents with oxygen has been developed and will be updated from the review of all new orders and as new residents are admitted to the facility. This list will be used as an audit form for the DON to follow. Nursing staff will be educated in the process of entering a Verbal Physician Order and demonstrate knowledge of how to place an order into CPSI (EHR) by 6/29/16. Education will be documented in their individual education log by the unit</p>		

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F 328	Continued From page 7 asthma and CHF. Resident #6's 5/19/16 Physician's order documented an order for O2 at 4 LPM continuous per NC. Resident #6 was observed on 6/6/16 at 4:45 pm, 6/7/16 at 8:17 am, and 6/8/16 at 11:05 am, with an oxygen companion on his wheelchair set at 3 LPM via NC. Resident #6 was observed in his room on 6/7/16 at 9:20 am, and 6/8/16 at 10:20 am, with the oxygen wall unit set at 3 LPM via NC. On 6/8/16 at 11:05 am, LN #1 was observed in the hallway turning on Resident #6's O2 companion and setting it to 3 LPM. LN #1 said Resident #6's order was for 3 to 4 LPM. On 6/8/16 at 11:06 am, Resident #3 said he liked his O2 set at 3 liters. On 6/9/16 at 10:10 am, the DON said Resident #6's physician's order was for 4 LPM via NC. She was informed of the observations and said Resident #6 would let staff know what liter flow he preferred. The DON said she would get an order change to reflect Resident #6's needs and preferences.	F 328	secretary within one week of the education event. 4-The DON will perform random audits of the orders, care plans, and Med Act (EHR) regarding correct and matching oxygen orders. This will occur five times per week for two weeks, then three times per week for two weeks, then weekly for a month and then be referred to the Quality Management Committee to determine further need for monitoring. All orders for Oxygen will be reviewed during every quarterly review as a continual process. 5-The facility will be in compliance with tag F 328 by 7/13/16.		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	F 354		7/13/16	

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F 354	<p>Continued From page 8</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</p> <p>The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an RN was on duty 8 hours a day 7 days a week to provide care and treatment to the residents. This was true for 1 of the 21 days reviewed. This affected 9 of 9 (#1-#9) sampled residents and all other residents in the facility. It created the potential for more than minimal harm if residents' nursing needs went unmet. Findings included:</p> <p>The facility's Three-Week Nursing Schedule between 5/15/16 and 6/4/16 documented there was no RN coverage on 5/28/16.</p> <p>This created the potential for the routine and emergency nursing needs of Residents #1-#9 to go unmet.</p> <p>On 6/8/16 at 1:25 pm, the DON said there was no RN coverage for that day. She said one of the LPNs may have switched with the RN who was originally scheduled for that day, but she could not be sure.</p>	F 354	<p>1-A Root Cause Analysis performed on 6/10/16 found that the nursing staff were exchanging shifts and covering an RN with an LPN. The DON reviewed the current schedule to ensure that there is at least 8 hours of RN coverage per day for the remainder of the month.</p> <p>2-All of the residents were affected, since staffing affects all residents.</p> <p>3- The DON will assure that when making the schedule there is an RN scheduled 8 hours for every 24 hour period. If and/or when there is insufficient RN coverage the DON will make the appropriate changes or cover the shift herself. After the schedule is posted, the DON and/or her designee will review and approve the schedule on a daily basis. All changes to the schedule affecting RNs will be approved by the DON prior to the changes. At any time the staff realizes there is insufficient RN coverage, they will immediately notify the DON and/or Administrator. All nursing staff will be</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/09/2016
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F 354	Continued From page 9	F 354	trained regarding this policy on 6/29/16. They will be educated that any changes and/or problems with the nursing schedule will be communicated via text or phone call to the DON. 4-The DON and/or her designee will review the schedule and staffing daily to ensure RN coverage for the next 24 hour period. This will be a continual process 5-The facility will be in compliance with tag F 354 by 7/13/16		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		7/13/16	

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F 431	<p>Continued From page 10</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff and resident interview, it was determined the facility failed to ensure medications were not accessible to 2 of 2 (#11 & #12) random residents. This deficient practice created the potential for more than minimal harm if residents improperly used creams and ointments. Findings include:</p> <p>1. On 6/6/16 at 1:50 pm, a bottle of mentholatum ointment was observed on Resident #11's over bed tray table and within reach of Resident #11 who was alone in the room and asleep in bed. The warnings on the bottle included to avoid contact with the eyes.</p> <p>On 6/6/16 at 2:25 pm, CNA #2, with LN #6 present, said Resident #11's sister had brought in the ointment on several occasions for Resident #6. LN #6 said Resident #11 had not been determined safe to self-administer medications and did not have an order for the ointment. LN #11 then accompanied the surveyor to Resident #11's room. LN #11 removed the ointment from</p>	F 431	<p>1-A Root Cause Analysis revealed that a process was not in place to assure that all residents who had Over The Counter (OTC) Medications in their rooms had been assessed and had orders to self-administer and /or keep medications at the bedside. All medications were locked up for resident #2 and resident #12 on 6/8/16.</p> <p>2-A sweep of each resident's room was performed by the DON on 6/24/16 to ensure that all medications in the resident rooms had proper orders and was stored appropriately. An Assessment tool for self-administration of medication was obtained. All residents who had OTC medications in their room were assessed with the new assessment tool by the DON on 6/27/16. Each resident's self-administration assessment was reviewed by the IDT team on 6/29/16 to determine if it is appropriate for the resident to self-administer medications</p>		

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F 431	<p>Continued From page 11</p> <p>the tray table and gave it to Resident #11's sister, who was in the room at that time. LN #11 explained to Resident #11's sister that Resident #11 could not have the ointment.</p> <p>2. Resident #12 was admitted to the facility 7/17/15. Her diagnoses included weakness and peripheral neuropathy. Her quarterly MDS assessment, dated 4/14/2016, stated her cognitive patterns were not impaired.</p> <p>Resident #12's Physician Orders, dated 7/7/15, included Nystatin 100,000 Units per 1 Gram Topical Application Cream, 1 application transdermal twice a day. Nystatin Cream is a medication used for skin infections.</p> <p>Documentation in Resident #12's Skin Notes and Treatment Record, dated 3/29/16, stated her "groins [were] pink, closed but resident said they were sore, Nystatin Cream applied by skin nurse." The Multidisciplinary Meeting Record, dated 4/19/16, did not address open lesions.</p> <p>During observation of the Medication Pass on 6/7/16 at 9:00 am, LN #2 asked Resident #12 if she wanted her Nystatin Cream. Resident #12 responded, "No, I have some. They left it for me last night." Resident #12 picked up from her bedside table a clear graduated medicine cup with a yellowish cream substance which LN #2 acknowledged was Nystatin Cream.</p> <p>Resident #12's record did not include an assessment of her ability to self-administer medication. The DON stated on 6/8/16 that Resident #12 had not been assessed and approved for self-administration of medication.</p>	F 431	<p>and/or store their medications securely in the resident room. The IDT team then determined if it was safe for residents to self-administer some or all of their identified medications. Physician agreement was obtained 6/29/16.</p> <p>3-All nursing home staff will be educated to the policy of self-administration assessment, self-administration and appropriate storage of drugs by the residents on 6/29/16. All residents and /or their representative will be educated regarding self-administration laws and facility polices by letter or face to face by the DON before 6/30/16. All nursing staff will be educated by 6/29/16 regarding this procedure.</p> <p>4- DON will perform random audits of the resident rooms to assess for medications in resident's rooms and safe storage of said medications. She will also ensure that the self- administration of drugs policy is being followed appropriately. The DON will perform these audits five times per week for two weeks, then three times per week for two weeks, then weekly for a month and then refer to the Quality Management Committee to determine further need for monitoring. A regular assessment of medications in resident's rooms will be conducted quarterly by the DON and/or her designee on an ongoing basis.</p> <p>5-The facility will be in compliance with tag F483.60 by 7/13/16</p>		

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F 431	Continued From page 12 The facility's Admission Rules and Services policy included, "Residents are not permitted to keep medications in their possession except for lifesaving medication and medication that the Interdisciplinary team has determined safe to be self-administered. The nurses are not allowed to leave medications in the room unless the resident has self-administration privileges and never in common areas of the facility."	F 431			
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility failed to follow its policy and procedures for self-administration of medication and failed to implement procedures for the control and safe storage of medications. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of in-service records and residents' records, the facility failed to ensure that nurse aides were able to demonstrate competency in skills and techniques necessary to assist a resident with safe transfers. This was true for 1 of 10 sampled residents (#2). This created the potential for residents to sustain fractures or other serious injuries due to falls. Findings include: Resident #2 was admitted to the facility 1/15/16.	F 498	1-A Root Cause Analysis was preformed and revealed that training of CNA's was not being documented for CNA's when individual training was done by nurses. Root Cause Analysis also revealed that the CNA'S did not always have individual training done at the time of an incident. All CNA's and Nurses were re-educated by Physical Therapy relating to appropriate transfer techniques and assisted fall techniques to reduce the risk of falling and to avoid injury to the	7/13/16	

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F 498	<p>Continued From page 13</p> <p>Her diagnoses included dementia, insomnia, and lumbar disc degeneration. Her primary physician ordered Clonazepam 1.5 mgs by mouth at bedtime for anxiety. Side effects of Clonazepam include drowsiness, dizziness, and difficulty with walking and coordination.</p> <p>Resident #2's 1/21/16 MDS assessment documented she was "not steady, only able to stabilize with staff assistance" when walking. She used a four wheeled walker to assist her with walking and required the physical assistance of one staff person using a gait belt. A gait belt is a medical safety device used by caregivers to transfer a resident by assisting them to stand and ambulate; and to make transfers such as from a chair to a wheelchair.</p> <p>Documentation in the CNA Daily Flow Chart, dated 1/20/16 at 11:30 am, included, "Transfer 1 assist, limited assist, chair, bed, ambulation, walker and toilet." No fall precautions. A Fall Risk Assessment was conducted 1/20/16 and documented Resident #2 was at risk for falls.</p> <p>Resident #2's Care Plan, dated 1/21/16, documented she had sustained a fall and fall prevention measures were initiated. Documentation in the clinical record regarding the fall, and an assessment of Resident #2 after the fall, were lacking. LN #2 stated on 6/7/16 at 11:30 am, that she was unable to retrieve information regarding the fall. She stated "I can only fill out a new incident report. Only the Director of Nurses has access to the report."</p> <p>The DON stated, on 6/7/16 at 11:50 am, that documentation was kept in the SQRS and not in</p>	F 498	<p>resident or the employee. DON educated the staff relating to the effects of medication on resident stability by 6/29/16. Just-in-time training (Training done immediately at time of an incident with available staff) procedure was taught and implemented on 6/29/16.</p> <p>2-A sweep of the charts was performed on 6/27/16 by the DON. The staff was made aware of all residents at risk for falls including the major contributing factors associated with falls such as; dementia, medications, deterioration of health, etc. on 6/29/16. All residents can be affected.</p> <p>3- Annual competency training relating to correct transfers was held May 18, 2016. Staff was retrained in the 6/29/16 staff meeting regarding safe transfers. Competency training on safe transfers is done annually with all staff. The effects of mind altering substances will be discussed at the staff meeting on 6/29/16 and the identified residents who are at higher risk of falls will be identified and discussed. Just -in-time training will be done with the CNA's present at any time a fall occurs. This training will include interventions that could prevent falls relating to transfers or whatever occurred with that particular incident. This will be done by the charge nurse and/or Restorative Aide at the time of the incident. Training with CNA's at this just-in-time training will be documented in their individual training logs maintained by</p>		

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F 498	<p>Continued From page 14</p> <p>the clinical record. The SQRS maintained incident reports. The DON printed Resident #2's fall report. It showed that it was "created by Anonymous, created at Jan 21, 2016 (at) 0400" (4:00 am) and was submitted at the same time. The Occurrence Label stated Resident #2, "fell against the bathroom rail and opened up an old bruise." The Occurrence Description documented, "Resident was being taken to the bathroom when she turned to sit she missed the toilet and scrapped her elbow that already had a bruise there on the wall. Area was cleaned and bandaid applied. 1 cm triangle area."</p> <p>Resident #2 was observed during the survey to ambulate with a 4 wheeled walker, with a gait belt around her waist and one staff member assisting her. Her elbows did not have opened areas.</p> <p>Review of the in-service offered to staff for the previous year and following the fall, did not include safe ambulation and transfer of residents. The DON stated on 6/7/16 at 11:50 am, that staff did not receive training relative to falls and transfers before or following Resident #2's fall.</p> <p>Failure of the facility to ensure that nurse aides were able to demonstrate competency in skills and techniques necessary to assist a resident to transfer to a toilet resulted in a resident sustaining a fall and injuring her elbow.</p>	F 498	<p>the unit secretary. A record of the interventions discussed to prevent the fall identified will be kept and shared with rest of the staff on the 72 hour monitoring clip board and then shared with the fall team at the next fall meeting.</p> <p>4-Staff will pass off transferring skills on a quarterly basis. This will be done working directly with the restorative aides and documented in the employees individual training logs. The DON will perform random audits of the staff's skills, related to transferring residents, by working with the CNA's and or questioning the staff's knowledge. She will perform these audits five times per week for two weeks, then three times per week for two weeks, then weekly for a month and then refer to the Quality Management Committee to determine further need for monitoring.</p> <p>5-5-The facility will be in compliance with tag F483.75 by 7/13/16.</p>		