



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

July 6, 2016

Mark Teckmeyer, Administrator
Bingham Memorial Skilled Nursing & Rehabilitation
98 Poplar Street
Blackfoot, ID 83221-1758

Provider #: 135007

Dear Mr. Teckmeyer:

On **June 17, 2016**, a survey was conducted at Bingham Memorial Skilled Nursing & Rehabilitation 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 an isolated deficiency that constitutes actual 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.

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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 **July 18, 2016**. Failure to submit an acceptable PoC by **July 18, 2016** may result in the imposition of penalties by **August 5, 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 22, 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 **September 15, 2016**. A change in the seriousness of the deficiencies on **August 1, 2016**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **September 15, 2016** includes the following:

Denial of payment for new admissions effective **September 15, 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 14, 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 15, 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/NursingFa>

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[ilities/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 **July 18, 2016**. If your request for informal dispute resolution is received after **July 18, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

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/lj
Enclosures

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

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2016
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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221
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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 of your facility. The survey was conducted June 12, 2016 to June 17, 2016.</p> <p>The survey team included:</p> <p>Evelyn Floyd, JD, MS, RN - Team Coordinator Jennifer McCants, MS, RD, LN</p> <p>Survey Abbreviations:</p> <p>ADL= Activities of Daily Living SBAR = Situation, Background, Assessment and Recommendation cc = cubic centimeter CNA = Certified Nursing Assistant CVA = Cerebral Vascular Accident DNS = Director of Nursing Services DNR = Do Not Resuscitate g = grams I&A = Incident and Accident Report IDT = Interdisciplinary Team Kcal = Calories lbs = pounds LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set Assessment ml = milliliter mg = milligram OT = Occupational Therapy PT = Physical Therapy QAPI = Quality Assessment Performance Improvement RNP = Restorative Nursing Program ROM = Range of Motion TAR = Treatment Administration Record</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 07/18/2016
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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 000	Continued From page 1	F 000			
F 155 SS=E	<p>UTI = Urinary Tract Infection</p> <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 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 observation, record review and staff interviews, it was determined the facility failed to ensure staff received training necessary to understand and follow the facility's advanced directive policies. This was true for 7 of 24 sampled residents (#1, #4, #5, #21-#24) with DNR status, and had the potential to impact all residents who had established advanced directives. This failed practice created the potential for staff to initiate, or not initiate,</p>	F 155	<p>F TAG WITH SCOPE AND SEVERITY PLAN OF CORRECTION</p> <p>1. F Tag 155 E c/o of May Right to Refuse ;Formulate Advance Directives Guide: A. What corrective actions will be accomplished for those residents found to have been affected by the deficient</p>	7/22/16	

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F 155	<p>Continued From page 2 resuscitation, contrary to residents' wishes. Findings include:</p> <p>On 6/12/16 at 6:35 pm, during the initial tour of the facility, the rooms of Residents' #1, #4, #5, and #21 - #24 were observed to have a blue dot by the residents' names. At 6:40 pm on the 300 hallway, CNA #6 and CNA #7 were asked what the blue dots meant. CNA #7 stated she was not sure. CNA #6 stated she did not know, but believed it meant DNR. LN #1 stated the blue dot meant the resident was a DNR. At 6:45 pm on the 400 hallway, CNA #2 stated the blue dot meant the resident was a full code. CNA #3 stated she was not sure what the blue dot meant. LN #5 stated it was the residents' code status, but did not know which and would have to check. LN #9 stated she was not sure, it was probably a code status, but at a previous place she worked it referred to assistive devices.</p> <p>On 6/13/16, the medical records of Residents' #1, #4, #5, and #21 - #24 were reviewed. Each residents' medical record documented the resident's code status as DNR.</p> <p>On 6/14/16 at 12:00 pm, the DNS stated the blue dot by residents' names meant DNR, not a full code. The DNS stated she was in the process of changing the program because it was confusing. The DNS stated that usually a "code blue," means resuscitation. The DNS stated the policy was for staff to look in the chart at the actual advance directives. The code status of each resident was found in the first section of the resident's chart.</p>	F 155	<p>practice? B. Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken. C. Address what measures will be put in place and what systematic changes will be made to ensure that the deficient practice does not recur. D. Indicate how the facility plans to monitor performance to ensure that the corrective actions are effective and compliance is sustained? BE SPECIFIC ON AUDIT MONITORING E. Include dates when corrective action will be completed.</p> <p>*CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC: ¿ Residents # 1, 4, 5 were affected by this deficient practice. - The code status of resident #1, #4, and #5 were reviewed and verified with their advance directive, MD orders, and care plan to be accurate. -There were no resident 21 and 24 from the resident ID list during the survey that was stated to be affected.</p> <p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE : -All residents with advance directives has</p>	

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F 155	Continued From page 3	F 155	<p>the potential to be affected by this deficient practice. The residents with advance directives has been evaluated by the IDT, their Idaho POST, MD orders and care plan were accurate to ensure that they match the resident's wishes.</p> <p>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</p> <p>-The code status policy for BMH SNRC has been updated to reflect the new practice of checking the chart to verify a resident's code status. The practice of using blue dots has been discontinued. Staff has been educated on July 15, 2016 regarding the new code status policy. Staff will be audited to determine understanding of the new code status policy.</p> <p>*MONITORING A.WHO: - DNS /Designee -</p> <p>B.FREQUENCY: - will audit 3x a week for 1month , then 2x/week for 1 month ,weekly x 1 month for a period of 12 weeks .Any issue noted will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits.</p>		

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F 155	Continued From page 4	F 155	C.START DATE: -July 15,2016 *DATES WHEN CORRECTIVE ACTION IS COMPLETED: -July 22,2016		
F 221 SS=E	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews, it was determined the facility failed to ensure residents were not physically restrained. This was true for 3 of 10 sampled residents reviewed for side rails (#2, #3, and #10). This resulted in the use of half to full side rails for residents who did not have the ability to lower the side rails and had no identified medical symptoms that required restraint. Findings include:</p> <p>1. Resident #10's MDS assessment, dated 4/11/16, documented he was moderately cognitively impaired and required total assistance with mobility and cares. The MDS documented Resident #10 did not have any physical or mechanical device, or equipment, that could easily be removed.</p> <p>On 6/16/16 at 4:00 pm, Resident #10 was observed lying in bed. The bed was against the wall to his right side, with 4 side rails up.</p>	F 221	<p>Right to be Free from Physical Restraints</p> <p>*CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC: -Resident #2 side rail was discontinued and is currently in a SNF approved bed. -Resident #3 side rail was discontinued and is currently in a SNF approved bed. -Resident #10 side rails have been d/c. Currently in a SNF approved bed.</p> <p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE : -All residents has the potential of being affected by this deficient practice. Residents with side rails were evaluated according to their medical condition and their ability to use the bed control. Resident's side rail assessment, care plan and MDS assessment were verified</p>	7/22/16	

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F 221	<p>Continued From page 5</p> <p>Resident #10's left side was affected by a previous cerebral vascular accident. Resident #10 stated he felt "trapped."</p> <p>Resident #10 did have consents for use of side rails for use related to bed mobility, bed control and assistance with transfers, however, he did not have the ability to use the side rails for positioning and bed control.</p> <p>2. Resident #3's MDS assessment, dated 6/13/16, documented she was severely cognitively impaired, and required total assistance for mobility and cares. The MDS assessment documented Resident #3 did not have any physical or mechanical device, or equipment, that could easily be removed.</p> <p>On 6/16/16 at 4:00 pm, Resident #3 was observed in bed with bilateral lower side rails. Resident #3 was observed not to be able to lower her side rails.</p> <p>Resident #3 did have consents for use of side rails for use for assistance with repositioning in bed, however, she did not have the ability to use the side rails for positioning and bed control.</p> <p>3. Resident #2's MDS assessment, dated 4/22/16, documented she was severely cognitively impaired, and required total assistance with mobility and all cares. The MDS assessment documented Resident #2 did not have a physical or mechanical device, or equipment, that could easily be removed.</p> <p>On 6/16/16 at 4:00 pm, Resident #2 was observed in bed with bilateral, full upper and</p>	F 221	<p>and updated.</p> <p>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</p> <p>-The facility has audited all the current beds with bed control attached to the side rail, Engineering representative evaluated the beds and he is unable to modify the beds to re- situate the bed control away from the rail.</p> <p>-The residents with side rails has been assessed and their care plan has been updated to reflect any change .The Side rails that is not warranted for residents use has been zip tied to the bed with instructions labeled in the rail to not pull up.</p> <p>-Staff was educated regarding Physical restraint use on July 15, 2016.</p> <p>-The use of side rails on new admissions will be audited to ensure that no unnecessary side rail is used.</p> <p>-NHA is working with the hospital administration and hospital board at a future plan to purchase SNF approved beds.</p> <p>*MONITORING</p> <p>A.WHO: -The DNS/Designee</p> <p>B.FREQUENCY: - Will audit 3x a week for 1 month, then 2x/week for 1 month, weekly x 1 month for a period of 12 weeks. Any issue noted</p>		

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

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F 221	Continued From page 6 lower side rails. Resident #2 was observed to not be able to lower her side rails. Resident #2 did have consents for use of side rails for use related to proper positioning and bed control, however, she lacked the ability to use the side rails for positioning or bed control. On 6/16/16 at 6:20 pm, the DNS stated the facility had old beds that had the bed controls on the side rails. The DNS agreed the residents did not have the ability to remove their side rails or use the bed controls.	F 221	will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits and after the initial 12 weeks, make a determination related to changing the frequency of those audits. C.START DATE: - July 18,2016 * DATES WHEN CORRECTIVE ACTION IS COMPLETED: - July 22,2016		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		7/22/16	

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F 225	<p>Continued From page 7</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident, staff and family interview, it was determined the facility failed to ensure that for 1 of 2 investigations reviewed for abuse/neglect, the allegations were identified as potential neglect and investigated and processed as such. This was true for 1 of 2 residents (#7) whose allegations and investigations were reviewed. The facility failed to recognize an allegation as potential neglect and handled the investigation as a general care complaint. This compromised the ability of the facility to identify, thoroughly investigate, and initiate corrective actions necessary to protect residents from neglect. Findings include: Resident #7 was admitted to the facility on 6/3/16 for rehabilitation following a total knee replacement. She had an admission diagnosis of</p>	F 225	<p>Investigate/Report/allegations/Individuals *CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC: It is our Policy (1225, 625 & 392 attached) to investigate allegations of Abuse, Neglect and Misappropriation of Property. The Administrator was educated on July 13th of the three aforementioned policies. Likewise, policy 1225 & 625 our now current for review and effective dates. Resident #7 was safely and happily d/c to home on June 21, 2016. With that said the concerns of #7 were taken very seriously and each item address quickly and professionally.</p> <p>Our Bingham Memorial Hospital Concern Form was completed by the Administrator at the time of the complaints. New</p>		

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F 225	<p>Continued From page 8</p> <p>chronic obstructive pulmonary disease and required oxygen continuously. At the time of admission, Resident #7 required staff assistance for toileting and transfers.</p> <p>During an interview on 6/13/16 at 2:10 pm, Resident #7 stated that she had problems with her bladder when she was initially admitted after knee surgery. She stated it was hard for her to get to the bathroom on time. Resident #7 stated that initially, it took 2 to 3 staff to assist her with toileting because of her limited weight bearing status following surgery. She stated she was prescribed Lasix and was incontinent the first couple days because staff did not help her. Resident #7 stated she waited an hour to an hour and a half to be toileted. Resident #7 reported staff came to her room and turned off her call light and said they would come back, but did not come back. She stated she remained in wet incontinence briefs for extended timeframes. Resident #7 stated staff got angry when they had to come and assist her to the toilet. It took several staff to do so and reported one staff member stated, "Again?" when she needed assistance to toilet. Resident #7 suggested the surveyor speak with her family member, Family Member #1, because this family member reported these concerns to administration and could provide the details.</p> <p>Family Member #1 was interviewed on 6/14/16 at 3:00 pm. Family Member #1 stated Resident #7 was admitted to the facility for rehab about a week and a half ago. Family Member #1 stated Family Member #2 was with Resident #7 during the day she was admitted (6/3/16) to the facility following surgery. Family Member #1 stated he</p>	F 225	<p>complaints surfaced during the Annual Survey and were reviewed with the Administrator. These additional complaints were reviewed with the family member once the investigation was completed. Documentation attached to show continence level of patient #7 from day of admit to d/c. Patient was not continent when arriving @ our SNRC as a catheter was removed @ the hospital and a brief applied during the stay with the SNRC.</p> <p>Nurse interaction concerning the initial skin assessment with family #1 concerning the term BS was reviewed by the Administrator & Director of Nursing with subsequent disciplinary note. The initial skin assessment is attached as well as a skin assessment performed by our wound nurse on June 6th is attached also. Patient #7 was placed on our weekly skin protocols.</p> <p>At no time, other than the initial concerns, did the patient who is her own person complain about the additional concerns brought to us by a family member. There were care conferences held on June 8th in which none of the three family members chose to attend to talk about the patients care. Also, the patient did not offer any concerns for her care at the care conference. NHA met with the patient several times during the stay and was quite content and satisfied with her care.</p> <p>*CORRECTIVE ACTION FOR</p>		

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F 225	Continued From page 9 was with Resident #7 during the second day (6/4/16) following Resident #7's admission and that both he and Family Member #2 went and spoke with the Administrator due to their concerns. Family Member #1 stated Resident #7 had been completely continent prior to the surgery and was aware when she needed to use the toilet. Family Member #1 stated Resident #7 had a catheter in the hospital but it was removed prior to her coming to the facility. He stated Resident #7 was put into incontinent briefs when she was admitted to the facility even though she was continent. Family Member #1 stated both he and Family Member #2 observed Resident #7 waiting too long for assistance and Resident #7 was incontinent, urinating in her brief, as a result. He stated he had medical training and helped Resident #7 to the toilet twice when he was visiting because staff did not come timely and Resident #7 had already been incontinent. Family Member #1 stated he was concerned because Resident #7 had what looked like skin breakdown to her bottom. Family Member #1 stated he and Family Member #2 spoke with the Administrator on Monday 6/6/16. Concerns raised included Resident #7 being put in incontinence briefs, the long wait for toileting assistance, call light response time, and Resident #7 remaining in wet briefs for an extended time. Family Member #1 also reported an interaction with a nurse who forcefully stated, "Bullshit" when he reported a concern about whether Resident #7's skin had been assessed upon admission. Family Member #1 stated he was concerned when he observed Resident #7's skin as it looked like she had skin breakdown to her buttocks area. Family Member #1 stated the Administrator was concerned when the issues were reported	F 225	POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE : - All residents have the potential to be affected by this tag. The Administrator & the Social Worker, as outlined in our policy 1225 (attached) will review all resident/family concerns to determine if a Self-Report exists or if it can be handled with our BMH Concern Form (attached and only form on-site to use) *MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: - The review of grievances will be added during the facility stand up meetings weekly to ensure that grievances are addressed timely and for Administrator /Social worker to determine if a self-report to the State exists. Self-reports will be called in within 24 hours with the final report faxed to the state within 5 business days as mentioned by state law. A log with Grievances and Abuse/Neglect allegations will be kept and updated weekly. This data will be a part of our QAPI quarterly meetings for review and any recommendation for remediation that may present. *MONITORING A.WHO: NHA/LSW/Designee - B.FREQUENCY: - Daily for three months. Any issue noted		

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F 225	<p>Continued From page 10</p> <p>on 6/6/16 and told both he and Family Member #2 that it would be handled as a state level complaint. Family Member #1 stated the Administrator had not followed up with him regarding the outcome of the investigation.</p> <p>A BMH Concern Form, dated on 6/6/16 at 1:30 pm, documented the concerns raised by Family Member #1 and Family Member #2.</p> <p>A Bowel and Bladder Continence Evaluation, dated 6/8/16, documented Resident #7 was incontinent of urine a total of 4 times on 6/3/16 and on 6/4/16. On 6/5/16 and 6/6/16, there were no recorded incidents of incontinence; however, there was one incident of Resident #7 being wet. The SNRC Admission Assessment, dated 6/3/16, stated Resident #7's buttocks area were red and excoriated.</p> <p>Review of the Bingham Memorial Skilled Nursing and Rehabilitation Center and Bingham Memorial Hospital Abuse and Assault (Child Abuse/Neglect; Elder Abuse/Neglect; Domestic Battery, Sexual Assault) policy, created 1/25/13 and expired on 1/25/16, defined neglect as, "The failure of a caretaker to provide food, clothing, shelter, or medical care necessary to sustain the life and health of a vulnerable adult..." Examples of physical neglect were documented as, "Inadequate provision of care ...Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." The abuse/neglect policy stated if an allegation of neglect was made for a resident in the facility that did not reach the level of serious, life threatening injury or death, staff must notify the Administrator and DNS. The Administrator was responsible to</p>	F 225	<p>will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits.</p> <p>C.START DATE: - July 18,2016</p> <p>*DATES WHEN CORRECTIVE ACTION IS COMPLETED: -July 22,2016 Care and Environment ,Promotes Quality of Life</p> <p>*CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC: -Resident #20 was discharged on 7/06 to home as planned. -Res. # 3 who sits at a restorative table is to be served first during the large dining room meal service. -Res # 6 met with IDT to discuss the new dining process to improve wait times at meals. -Res. #8 met with IDT to discuss the new dining process to improve wait times at meals. RD met with the resident to review diet concerns. -Res. #9 who sits at a restorative table is to be served first during the large dining room meal service. Staff was in serviced to offer beverages be poured in a cup. IDT met with resident and she prefers her supplement to be served from the can with a straw. Her preference has been care planned.</p>		

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F 225	<p>Continued From page 11</p> <p>contact the SNRC Social Worker to proceed with reporting requirements of within 24 hours to the State Agency, Bureau of Facility Standards. The SNRC Social Worker or designee would then fax a written report to the Bureau of Facility Standards within 5 days.</p> <p>The Administrator was interviewed on 6/16/16 at 2:00 pm. He stated Family Member #1 and Family Member #2 came into his office on 6/6/16 and expressed their concerns regarding Resident #7's the lack of care. He stated he grabbed a complaint form and documented their concerns at that time. He stated he went to the charge nurse after the discussion and began investigating the concerns immediately. He stated that he found out Resident #7 was admitted with an incontinence brief on and that a skin assessment was completed upon admission. He stated he directed staff to respond timely to call lights and toileting assistance. He verified [nurse's name] said, "Bullshit" when Family Member #1 questioned whether an initial skin assessment was completed. The investigation did not include documentation of interviews with nursing staff members who worked with Resident #7 on 6/4/16 and 6/5/16 or any other method to determine whether adequate toileting assistance was provided. The investigation did not include interviews with other residents to determine whether their needs were met on those dates. The investigation did not include an interview with Resident #7 at that time; she was interviewed during the survey. When asked about reporting the incident as an allegation of potential neglect to the State Agency, the Administrator stated the incident should have been reported to the social worker. He stated he had not</p>	F 225	<p>-Res. #10 staff has been in serviced to offer water to all resident every meal.</p> <p>-Res. #14 was discharged to home on 6/28/16 as planned.</p> <p>-Res. #15 Staff was in serviced to offer beverages be poured in a cup. IDT met with resident and she prefers her supplement to be served from the can with a straw. Her preference has been care planned.</p> <p>Res #16 who sits at a restorative table is to be served first during the large dining room meal service. Staff has been in serviced to offer water to all resident every meal.</p> <p>Res. #17 is to be served first during the large dining room meal service. Staff has been in serviced to offer water to all resident every meal.</p> <p>Res. #18 is to be served first during the large dining room meal service.</p> <p>Res. #19 who sits at a restorative table is to be served first during the large dining room meal service.</p> <p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE :</p> <p>- All other residents have the potential to be affected by this deficient practice. The Director of Nutrition Services has provided department in-services to the dietary staff regarding meal service times. DNS has provided an in-service to all nursing staff regarding meal service times</p>		

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F 225	Continued From page 12 considered the allegation as potential neglect at the time, but could see how a failure to provide care and services (toileting) met the criteria. He verified the incident was not reported to the State Agency within 24 hours and a report was not faxed to the State Agency within 5 days.	F 225	and the correct procedure for the passing of fluids and beverages during meal services. *MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: - Facility meal service times will be adjusted and reposted. Director of Nutrition Services will purchase condiment holder for all tables for the large and small dining room and nursing staff will fill condiment holders. Care plan will be updated for residents who desire their beverage be served in a bottle or carton. DNS will provide assigned responsibilities to dining room CNA staff to ensure meals are served in a timely manner. Concerns noted during the audits will be addressed. Results of the audits will be reviewed during the QA meetings. *MONITORING A.WHO: RD/Designee - B.FREQUENCY -will audit 3x a week for 1 month, then 2x/week for 1 month, weekly x 1 month for a period of 12 weeks. Any issue noted will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits and after the initial 12 weeks make a determination related to changing the frequency of		

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F 225	Continued From page 13	F 225	those audits.		
F 240 SS=E	<p>483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE</p> <p>A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to ensure the dining experience in the main dining room promoted the enhancement of quality of life for residents. This directly impacted 12 of 20 sampled residents (#3, #6, #8 - #10, and #14 - #20) who resided in the facility at the time of survey and 6 of 7 residents in the group interview. It also had the potential to impact all residents who ate in the main dining room. Specifically: residents waited lengthy time frames to be served; meals were not always served on time; condiments such as salt and pepper and sugar were not easily accessible to residents who dined in the main dining room; a sufficient amount of beverages was not consistently served, including water; and beverages were served in cans, cartons and plastic bottles</p>	F 240	<p>C.START DATE: - July 18,2016</p> <p>*DATES WHEN CORRECTIVE ACTION IS COMPLETED: - July 22,2016</p> <p>Care and Environment ,Promotes Quality of Life *CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC: -Resident #20 was discharged on 7/06 to home as planned. -Res. # 3 who sits at a restorative table is to be served first during the large dining room meal service. -Res # 6 met with IDT to discuss the new dining process to improve wait times at meals. -Res. #8 met with IDT to discuss the new dining process to improve wait times at meals. RD met with the resident to review diet concerns. -Res. #9 who sits at a restorative table is to be served first during the large dining</p>	7/22/16	

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F 240	<p>Continued From page 14</p> <p>without residents being offered the option of having the beverages poured into cups. Findings include:</p> <p>1. Meal service start times were posted on the wall adjacent to the primary entrance into the main dining room as follows: breakfast 7:20 am, lunch 12:20 pm, and dinner 5:20 pm. Between 30 to 35 residents were observed to eat their meals in the main dining room during the survey.</p> <p>a. On 6/13/16, breakfast observations were made in the main dining room beginning at 7:05 am. At this time, approximately 20 residents were present in the dining room, sitting at their tables. The remaining residents (approximately 10 residents) arrived and were present in the dining room by 7:15 am. Although most residents had one beverage at their places on the tables, breakfast meal service did not start until 7:40 am. This was 20 minutes after the posted meal time and 40 minutes after two thirds of the residents had been present. Meal service concluded at 7:55 am. Approximately 20 of the residents had been in the dining room since prior to 7:05 am, when observations began. Specific examples include:</p> <p>* At 7:15 am, Resident #20 stated (in regards to meal service) "It takes a while."</p> <p>* At 7:45 am, 3 of the 4 residents sitting at the assistance table (Residents #9, #15 and #16), were observed with their heads slumped and their eyes closed. The remaining resident, Resident #3, was observed intermittently fidgeting with her silverware and sitting and staring off from the time she was first observed</p>	F 240	<p>room meal service. Staff was in serviced to offer beverages be poured in a cup. IDT met with resident and she prefers her supplement to be served from the can with a straw. Her preference has been care planned.</p> <p>-Res. #10 staff has been in serviced to offer water to all resident every meal.</p> <p>-Res. #14 was discharged to home on 6/28/16 as planned.</p> <p>-Res. #15 Staff was in serviced to offer beverages be poured in a cup. IDT met with resident and she prefers her supplement to be served from the can with a straw. Her preference has been care planned.</p> <p>Res #16 who sits at a restorative table is to be served first during the large dining room meal service. Staff has been in serviced to offer water to all resident every meal.</p> <p>Res. #17 is to be served first during the large dining room meal service. Staff has been in serviced to offer water to all resident every meal.</p> <p>Res. #18 is to be served first during the large dining room meal service.</p> <p>Res. #19 who sits at a restorative table is to be served first during the large dining room meal service.</p> <p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE :</p> <p>- All other residents have the potential to</p>		

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F 240	<p>Continued From page 15</p> <p>seated in the dining room at 7:05 am, until she was served her meal. This table was served last at 7:55 am.</p> <p>* Resident #17 was in the dining room sleeping with her tray in front of her at 8:02 am. She continued to sleep and ate nothing. She was aroused by staff at 8:15 am, and wheeled out of the dining room for a scheduled hair appointment.</p> <p>b. Almost all the residents were present in the dining room at 12:20 pm, when the observations began. Lunch meal service started at 12:25 pm. Service was finished at 12:40 pm. During meal service there were two dietary staff behind the tray line serving meals. One staff served hot items and the other cold items. There were 6 nursing staff members taking residents' trays from the tray line and serving the meals to the residents. There were frequently 4 to 6 nursing staff members waiting at the tray line for dietary staff to dish up the plates. Dietary staff did not keep up with the pace of the nursing staff who were available to serve the meals. Another factor that slowed the meal service had to do with the option for residents to walk, wheel, or be wheeled up to the tray line to select the specific foods they wanted. Four residents were observed to go to the tray line to select their meals; it took between 2 and 5 minutes each for the residents to get through the tray line with their food selected. Meal service backed up more during these times with up to 6 nursing staff waiting at the tray line for dietary staff to serve additional trays. Four residents complained about waiting too long for meals. Specific examples include:</p>	F 240	<p>be affected by this deficient practice. The Director of Nutrition Services has provided department in-services to the dietary staff regarding meal service times. DNS has provided an in-service to all nursing staff regarding meal service times and the correct procedure for the passing of fluids and beverages during meal services.</p> <p>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: - Facility meal service times will be adjusted and reposted. Director of Nutrition Services will purchase condiment holder for all tables for the large and small dining room and nursing staff will fill condiment holders. Care plan will be updated for residents who desire their beverage be served in a bottle or carton. DNS will provide assigned responsibilities to dining room CNA staff to ensure meals are served in a timely manner. Concerns noted during the audits will be addressed. Results of the audits will be reviewed during the QA meetings.</p> <p>*MONITORING A.WHO: RD/Designee - B.FREQUENCY -will audit 3x a week for 1 month, then 2x/week for 1 month, weekly x 1 month</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 240	<p>Continued From page 16</p> <p>* At 12:40 pm, Resident #19 was beginning to eat her meal. She stated, "All meals are a half hour late."</p> <p>* At 12:40 pm, Resident #18, who was sitting near Resident #19, agreed with Resident #19's statement that the meals were served a half hour late.</p> <p>* At 12:40 pm, Resident #6, newly admitted and sitting near Residents #18 and #19, stated she did not understand why they waited. She stated they (residents) were in the dining room and ready to go at noon.</p> <p>* At 12:43 pm, Resident #8 stated all meals were late and that she was just served her meal at 12:40 pm. She stated part of the problem was that staff brought residents to the dining room quite a while before the meals were served. She stated she no longer allowed staff to bring her to the dining room early.</p> <p>The Dietitian was interviewed on 6/15/16 at 9:40 am, and stated nursing and social services directed meal times/meal service. She stated residents were able to go through the tray line and select what they wanted and verified meal service took longer when residents did so. She stated the facility was brainstorming how to speed up meal service and still retain the ability of residents to go through the tray line to select food choices. When asked what her expectations were for how many trays per minute should be served, she stated 2 trays per minute was the goal.</p> <p>If two trays per minute were served, all residents</p>	F 240	<p>for a period of 12 weeks. Any issue noted will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits.</p> <p>C.START DATE: - July 18,2016</p> <p>*DATES WHEN CORRECTIVE ACTION IS COMPLETED: - July 22,2016</p>		

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F 240	<p>Continued From page 17</p> <p>would be served within approximately 15 minutes which was not observed to occur during the meal observations noted above.</p> <p>The DNS was interviewed on 6/16/16 at 5:50 pm, and stated that they had tried changing the serving order in the dining room to meet the needs of residents; however, were still in the process of figuring out the best meal service plan.</p> <p>2. Breakfast was observed on 6/13/16 in the main dining room from 7:05 am until 8:15 am. With the exception of 2 tables that had salt and pepper shakers (one set being provided after Resident #14 requested it), there were no condiments on the remaining 9 tables in the main dining room such as salt, pepper, sugar, etc. Condiments such as salt and pepper were not served unless residents asked for them. Specific examples include:</p> <ul style="list-style-type: none"> * Resident #14 asked for salt and sugar when his meal was served; staff went and got him a salt and pepper shaker for the table and sugar packets. * An anonymous resident asked for sugar at 7:59 am; a staff member went and retrieved sugar packets for the resident. <p>On 6/14/16 at 12:20 pm, the lunch meal dining room observations began and continued through 1:00 pm. No salt or pepper shakers or sugar was observed on the tables initially. At 12:15 pm, salt and pepper had been placed on one table; the other tables did not have it.</p>	F 240			

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F 240	<p>Continued From page 18 Specific examples include:</p> <p>* Resident #8 stated the food was bland; she stated there was no salt available for her to use. No salt and pepper shakers were observed on her table.</p> <p>* An anonymous resident was interviewed at 12:47 pm, and stated salt and pepper were not available on the tables. She stated she could ask for it if she wanted it.</p> <p>The Dietitian was interviewed on 6/15/16 at 9:40 am, and verified salt and pepper were not put on the tables customarily at meals. She stated residents could ask for salt if they wanted it.</p> <p>The Director of Nutrition services was interviewed on 6/16/16 at 11:15 am, and stated the facility used to provide salt and pepper shakers on the tables. She stated the previous Administrator instructed staff to remove the salt and pepper shakers to prevent residents that should not have sodium from accessing it. This practice had continued since that time.</p> <p>3. On 6/13/16, breakfast meal observations were made in the main dining room beginning at 7:05 am. At this time, approximately 20 residents were present in the dining room, sitting at their respective tables. A staff member was in the process of pushing a cart from table to table and pouring beverages for the residents. At 7:15 am, most residents had been served their beverages with the majority of them having only one beverage served to them. No water was observed to be present on the tables with the exception of 3 residents who had been served</p>	F 240			

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F 240	<p>Continued From page 19</p> <p>cups of water. Some residents were served additional beverages with their meals such as milk for cereal. Resident specific observations revealed the following beverages were served:</p> <ul style="list-style-type: none"> * Resident #10 was served one chocolate beverage only; no water was served. * Resident #14 was served a cup of water on the table when he arrived at 7:30 am. Resident #14 mumbled that he would like coffee when he was assisted by staff to the table. He asked staff again for coffee when they served his meal at 7:45 am; staff then brought him a cup of coffee. * Resident #16 was served one 4 ounce (oz) beverage. No water or additional beverage was served. * Resident #17 was served one 4 oz beverage with breakfast. No additional beverage was served. <p>The Dietitian was interviewed on 6/15/16 at 9:40 a.m. and stated water should be served at each meal and additional beverages in accordance with residents' preferences. She stated residents should be served a minimum of 2 beverages with meals.</p> <p>The Director of Nutrition services was interviewed on 6/16/16 at 11:15 am, and stated that CNAs served all the beverages to residents at meals. She stated dietary stocked and sent the beverages up in accordance with the menu and preferences from the kitchen in the basement to the first floor for meal service, but dietary staff did not serve beverages directly to residents. She</p>	F 240			

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F 240	<p>Continued From page 20</p> <p>stated she was not sure what the process was for nursing to determine the distribution of beverages to residents.</p> <p>4. During observation of the breakfast meal on 6/13/15, it was noted that none of the residents were observed with their canned supplements or milk (in plastic bottles/cartons) poured into cups. These beverages were either not opened, opened with straws placed in the containers, or were opened without a cup or straw being offered, which left the only method of drinking by lifting the can, carton or bottle up and drinking from the container. Specific observations from 7:05 to 8:15 am included:</p> <ul style="list-style-type: none"> * Resident #15 was served Glucerna supplement in a can, a straw or cup were not offered. She was observed, with some difficulty, lifting the can to her lips and drinking directly from it. Resident #15 sat at a table designated for residents who required meal assistance. * Resident #9 was served Nepro supplement in a can. A straw was placed into the can; Resident #9 was not offered the option of having the supplement poured into a cup. * Resident #14 was served Ensure Clear in the carton. A straw was placed in the carton; Resident #14 was not offered the option of having the supplement poured into a cup. He was also served milk in a plastic bottle with his meal; he was not offered the option of having it poured into a cup. * The table for residents requiring meal assistance was observed at the end of the meal 	F 240			

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F 240	<p>Continued From page 21 with 2 unopened plastic bottles of milk, that had not been opened during the meal, remaining on the table.</p> <p>During observation of the lunch meal on 6/13/16, it was noted that none of the residents were observed with their canned supplements or milk (in plastic bottles/cartons) poured into cups. These beverages were opened with straws placed in the containers. Specific observations during lunch included:</p> <ul style="list-style-type: none"> * Resident #15 was served Glucerna supplement in a can, with a straw. Resident #15 was not offered the option of having the supplement poured into a cup. * Resident #9 was served Nepro supplement in a can. A straw was placed into the can; Resident #9 was not offered the option of having the supplement poured into a cup. <p>The Dietitian was interviewed on 6/15/16 at 9:40 am, and stated beverages served in cans, cartons and bottles should be poured into cups in accordance with residents' preferences.</p> <p>The Director of Nutrition services was interviewed on 6/16/16 at 11:15 am, and stated that beverages served in bottles, cans and cartons should be poured into cups.</p> <p>5. On 6/15/16 at 10:20 am, during a group interview, the group stated there was not enough staff available during meals and during the night shifts. The group stated that after 10 pm, there were only 2 CNAs. The group stated they often had to wait up to 45 minutes for their call lights to</p>	F 240			

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F 240	<p>Continued From page 22</p> <p>be answered. The group stated the 400 and 500 halls were really short of staff. The group stated meal times took too long and did not understand why staff stood around the tray line waiting for trays. They stated that although they liked being able to go to the tray line to pick their meal, the process took too long.</p> <p>The group further stated they usually had to ask or wait for their meals to get something to drink. The group stated water was not served unless asked for, as well, as condiments. The group stated that not all the residents were able to eat what they wanted. If a resident was on a special diet, they could not get anything not on the diet especially if they were not able to voice their wishes. The group further stated fluids were not always offered in a glass or cups. They usually got drinks from a can.</p> <p>Resident Council Grievance meeting minutes from the last three months documented the following:</p> <ul style="list-style-type: none"> * Review of February Concerns - Meal service changed to improve flow and timing of meals and hall trays delivered before dining rooms and staff are unable to address residents' special needs or provide extra assistance due to "being so busy." * March - Residents need assistance in the rehab dining rooms during meals and in completing menus; too much Mexican food on menus; potatoes and fruit too hard. * April - Salt and pepper over used in vegetables and gravies; potatoes under cooked; and meat overcooked and tough; meals cold in dining 	F 240			

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F 240	Continued From page 23 room; requests for smaller portions not provided; and drinks are not served timely at dinner meals. * May - "Staff continue to turn off call lights without providing care. They say they will return but often forget. Staff also need to be quicker in answering the red bathroom call lights. Staff are not helping as efficiently in the dining room during tray line as they could be." A Mini Inservice for staff, dated 5/10/16, documented that residents' continue to "report drinks are not served timely at the dinner meal in the dining room. Residents are stating there are times they receive their meal and have yet to be served anything to drink. This concern has been expressed during several resident council meetings." The inservice directed that all residents should receive water, as well as, beverages of choice. The inservice stated CNAs are responsible to serve beverages at dinner meals and for staff to be aware of who is in the dining room to ensure drinks are passed prior to meal service.	F 240			
F 241 SS=G	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, family and staff interview, the facility failed to ensure 4 of 19 sampled residents (#1,	F 241	Dignity and Respect of Individuality *CORRECTIVE ACTIONS FOR	7/22/16	

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F 241	<p>Continued From page 24</p> <p>#7, #12 and #13) were provided care and services in a manner enhancing their dignity and respect. This resulted in harm to Resident #1 when she experienced resentment and demoralization when a tab alarm was attached to her clothing and the loud alarm that sounded when she moved or stood. It also placed Resident #7 at risk of psychosocial harm when she was not provided with toileting assistance necessary to avoid incontinence and incontinence briefs were put on her when she had been continent previously. Residents #12 and #13 were administered insulin injections during meals in the main dining room, creating the potential of embarrassment and humiliation. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 7/6/15; current diagnoses included Parkinson's disease, respiratory failure, pain, and anxiety. Resident #1 received hospice care for end stage Parkinson's disease. Review of the 4/20/16 quarterly MDS indicated Resident #1 was usually understood by others, had no behavioral symptoms, and had a history of falls. Her Admission MDS assessment documented she required the extensive assistance of one staff member with walking, transfers, and bed mobility.</p> <p>Resident #1's Care Plan, reviewed and revised on 6/10/16, stated a tabs alarm was initiated to address the problem of potential for falls on 3/21/16. Documentation included, "I may hide or disable it because the sound bothers me, remind me it alerts the staff that I may need help."</p> <p>Resident #1 was observed with large writhing movements, primarily of her arms and upper</p>	F 241	<p>RESIDENT SPECIFIC:</p> <p>-Resident #1 IDT met with Hospice team on July 12, 2016 to discuss plan of care for resident .The tabs alarm was discontinued for use .Resident and son is aware of plan of care. The care plan was updated to reflect changes made .The behavior monitoring, care plan and meds for the resident was reviewed and updates were made according to resident's wishes and preference. Hospice chaplain and LSW will increase frequency of monthly visits to address resident's spiritual and coping mechanisms to address her anxiety. Facility LSW will provide counseling weekly to ensure that resident's psychosocial needs are met. The schedule will be subject to change according to what the resident will be able to tolerate.</p> <p>-Resident #7 was discharged on June 21, 2016 to home as planned. Refer to F225 for additional plan of correction.</p> <p>-Resident #12 was discharged on June 23, 2016 to an ALF as planned.</p> <p>-Resident #13 IDT met with resident and was educated regarding the facility policy about administering medication in privacy. Resident stated that he has no preference regarding place of medication administration. IDT recommended medication administration in privacy to maintain his dignity. Resident will be visited routinely by IDT to ensure that his dignity is being honored. Medication administration audit was performed specific to the resident to ensure that the</p>		

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F 241	<p>Continued From page 25</p> <p>body, at various times during the survey (6/12/16 at 8:00 pm - 8:30 pm, 6/13/16 at 7:00 am and 9:30 am, and 6/14/16 at 6:10 pm).</p> <p>Resident #1 was interviewed on 6/13/16 at 9:30 am, and reported she had a history of falls due to her advanced Parkinson's disease and the tab alarm was to be attached to her clothing when she was in the wheelchair to prevent falls. She stated she resented the alarm due to the loud sound that emanated when it went off. She stated it was very important to remain independent as much as she could. Resident #1 was interviewed a second time on 6/14/16 at 9:50 am, and stated she was capable of disconnecting the alarm by unclipping it from her clothing. Resident #1 stated she had unclipped it at times because it bothered her, but was encouraged by staff to keep it connected. Resident #1 reported she had not disconnected it recently. Resident #1 concluded, stating the tab alarm use was upsetting and made her feel, "Like a dog on a leash."</p> <p>Resident #1 was observed during the survey, between 6/12/16 and 6/17/16, a number of times without the alarm connected. She was also observed during the survey with the alarm connected. On 6/14/16 at 6:10 pm, Resident #1 was observed eating dinner in the dining room. Within a period of 5 minutes (6:10 pm - 6:15 pm), the alarm sounded with a loud, piercing beep, 4 times. Within 5 seconds of each incident, a staff member turned the sound off and reconnected the alarm to Resident #1's clothing. Resident #1 reached down once to pick something up off the floor; however, in the other 3 instances the alarm was set off by Resident #1's writhing movements of her upper body in the wheelchair. She was not</p>	F 241	<p>deficient practice will not continue.</p> <p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE :</p> <ul style="list-style-type: none"> -The deficient practice of alarm use in the facility will no longer be continued .There are no current resident in the facility that utilize an alarm as part of their plan of care. -All residents who receive injections has the potential of being affected by this deficient practice. IDT has reviewed the residents and were informed of the facility policy to administer medications in privacy to ensure that their dignity is preserved. The resident's preference for medication administration were obtained and care planned according to their wishes. -LN #7 was educated and counseled. -LN mentioned for the incident in resident #7 was educated and counseled. -Resident Council meeting was held July 15, 2016 to address any immediate concerns that might affect resident's dignity. <p>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</p> <ul style="list-style-type: none"> - The facility will be alarm free to ensure that the deficient practice will not continue. -Staff education was performed on July 		

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F 241	<p>Continued From page 26</p> <p>attempting to stand, get out of the chair, or do something unsafe in 3 of the 4 instances the alarm sounded.</p> <p>CNA #1 was interviewed on 6/13/16 at 9:30 am, and stated Resident #1 was to have the tab alarm on when she was in the wheelchair and verified Resident #1 removed it at times. She stated Resident #1 had a history of getting up independently and was on 15 minute checks for falls prevention.</p> <p>The DNS was interviewed on 6/16/16 at 5:30 pm, and verified Resident #1 had a history of falls and that multiple interventions had been attempted to prevent falls. She verified Resident #1 was capable of removing the tab alarm and it was not an effective measure to prevent falls. She stated Resident #1 was stubborn, knew what she wanted, and desired independence.</p> <p>2. Resident #7 was admitted to the facility on 6/3/16, for rehabilitation following a total knee replacement. She had an admission diagnosis of chronic obstructive pulmonary disease and required oxygen continuously. Resident #7 required staff assistance for toileting and transfers when admitted.</p> <p>During an interview on 6/13/16 at 2:10 pm, Resident #7 stated that she had problems with her bladder when she was initially admitted after knee replacement surgery. She stated it was hard for her to get to the bathroom on time. Resident #7 stated it took 2 to 3 staff to assist her with toileting initially, because of her limited weight bearing status following surgery. She stated she was prescribed Lasix and was</p>	F 241	<p>15, 2016 regarding F tag 241.</p> <p>-The following audits will be performed: 1. Ensure alarms are no longer used by the facility 2. Medication administration by the LN, with focus on providing privacy during med pass to ensure that resident's dignity is preserved 3. Call light response time by direct staff, with focus on ensuring that resident's call lights are answered in a timely manner. Any issue observed will be acted on immediately to ensure compliance. The monthly audits will be reviewed during the QA meetings.</p> <p>-IDT will met with the resident's during the monthly resident council meeting to address issues with call light response time.</p> <p>-Facility management will randomly select resident rooms on a weekly basis and inquire residents about call light response times. Any issues reported will be addressed immediately. The results of the management audits will be presented to the QA meeting for further remediation, if trends with negative call light response times are noted.</p> <p>-Refer to F tag 225 for resident #7. Resident was discharged to home as planned.</p> <p>- Any psychosocial needs or concerns shared with the IDT during a new admission/quarterly care conferences will be immediately brought to the NHA /LSW for remediation.</p> <p>-Refer to F tag 225 concerning IDT review of grievances will also include respecting resident dignity. Staff has been educated that any immediate issues observed</p>		

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F 241	<p>Continued From page 27</p> <p>incontinent the first couple days because staff did not help her. Resident #7 stated she waited an hour to an hour and a half to be toileted. Resident #7 reported staff came to her room and turned off her call light and said they would come back but did not come back. She stated she remained in wet incontinence briefs for extended timeframes. Resident #7 stated staff got angry when they had to come and assist her to the toilet. It took several staff to do so and reported one staff member stated, "Again?" when she needed assistance to toilet.</p> <p>Family Member #1 was interviewed on 6/14/16 at 3:00 pm. Family Member #1 stated Resident #7 was admitted to the facility for rehab about a week and a half ago. Family Member #1 stated Family Member #2 was with Resident #7 during the day she was admitted (6/3/16) to the facility following surgery. Family Member #1 stated he was with Resident #7 during the second day (6/4/16) following Resident #7's admission and that both he and Family Member #2 went and spoke with the Administrator due to their concerns. Family Member #1 stated Resident #7 had been completely continent prior to the surgery and was aware when she needed to use the toilet. Family Member #1 stated Resident #7 had a catheter in the hospital but it was removed prior to her coming to the facility. He stated Resident #7 was put into incontinent briefs when she was admitted to the facility even though she was continent. Family Member #1 stated both he and Family Member #2 observed Resident #7 waiting too long for assistance and Resident #7 was incontinent, urinating in her brief, as a result. He stated he had medical training and helped Resident #7 to the toilet twice when he was</p>	F 241	<p>during the audits will be reported to the NHA /DNS.</p> <p>*MONITORING A.WHO: - DNS/NHA/Designee B.FREQUENCY: - will audit 3x a week for 1month, then 2x/week for 1 month, weekly x 1 month for a period of 12 weeks. Any issue noted will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits.</p> <p>C.START DATE: - July 18,2016</p> <p>*DATES WHEN CORRECTIVE ACTION IS COMPLETED: - July 22,2016</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2016
NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
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F 241	<p>Continued From page 28</p> <p>visiting because staff did not come timely and Resident #7 had already been incontinent. Family Member #1 stated he was concerned because Resident #7 had what looked like skin breakdown to her bottom.</p> <p>A Bowel and Bladder Continence Evaluation, dated 6/8/16, documented Resident #7 was incontinent of urine a total of 4 times on 6/3/16 and on 6/4/16. On 6/5/16 and 6/6/16, there were no recorded incidents of incontinence; however, there was one incident of Resident #7 being wet. A SNRC Admission Assessment, dated 6/3/16, noted Resident #7's buttocks area was red and excoriated.</p> <p>The Administrator was interviewed on 6/16/16 at 2:00 p.m. He stated Family Member #1 and Family Member #2 came into his office on 6/6/16 and expressed their concerns regarding Resident #7's lack of care, including toileting. He stated he grabbed a complaint form and documented their concerns at that time. He stated he went to the charge nurse after the discussion and began investigating the concerns immediately. He stated that he found out Resident #7 was admitted with an incontinence brief on and had since been progressed to an incontinence pull up. He stated he directed staff to respond timely to call lights and toileting assistance after talking with Family Member #1 and Family Member #2.</p> <p>3. On 6/13/16 at 7:00 am, Resident #12 was observed in the small dining room eating breakfast. LN #7 had administered Resident #12's oral medications. LN #7 then assisted Resident #12 in lifting the left corner of her shirt and administered Resident #12's insulin. On</p>	F 241			

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F 241	Continued From page 29 6/16/16 at 9:30 am, Resident #12 stated she was not asked about getting her injection in the dining room, that it was "just how it was done." 4. On 6/13/16 at 7:20 am, Resident #13 was observed in the small dining room eating breakfast. LN #7 had administered Resident #13's oral medications. LN #7 then assisted Resident #13 in lifting the right corner of his shirt and administered Resident #13's insulin. On 6/16/16 at 10:00 am, Resident #13 stated he was not asked about getting his medications in the dining room and he had always got his insulin in the dining room. Resident #13 stated he had not been asked.	F 241			
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of Resident Council meeting minutes, review of an inservice record, and resident and staff interview, it was determined the facility failed to ensure 1 of 20 sampled residents (Resident #8), and 2 of 7 residents in the group meeting, were allowed to make choices regarding foods and condiments. This resulted in Resident #8, who was on a therapeutic diet, not being served foods she	F 242	Self Determination –Right to Make Choices *CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC: Resident #8- RD met with the resident on 07/11/16, to discuss her concerns regarding her physician prescribed	7/22/16	

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F 242	<p>Continued From page 30</p> <p>selected and wanted to eat, creating dissatisfaction. It also resulted in frustration of members of the resident group due to lack of response from the facility to their concerns. Findings include:</p> <p>1. Resident #8 was admitted to the facility on 4/29/16, for rehabilitation following a fall at home. Diagnoses included muscle and right lower extremity weakness, diabetes mellitus, hyperlipidemia, hypertension, congestive heart failure, atrial fibrillation, and coronary artery disease. Review of the admission MDS assessment, dated 5/6/16, indicated Resident #8 was understood by others and could understand others, had no behavioral indicators; however, was depressed, tired and having a poor appetite. The MDS assessment documented Resident #8 as being on a therapeutic diet with an initial weight of 216 pounds (lbs).</p> <p>Review of Resident #8's care plan, dated 5/6/16, identified the problem of "I have potential altered nutrition related to my vitamin deficiency, chronic pain, and reflux." The goal was defined as "I will maintain nutritional status through my next review date." One of the care plan approaches documented, "I need a therapeutic cardiac, regular texture, thin liquid diet for meals." Review of the Resident #8's initial admission orders, dated 4/29/16, indicated she was prescribed a cardiac diet. The plan of care notes, dated 5/6/16, stated, "Meal intakes of cardiac, regular texture diet are fair at 50-75% due to the food being 'bland' per (Resident #8)."</p> <p>Therapeutic menu extensions were provided for the week of the survey. Review of the cardiac</p>	F 242	<p>therapeutic diet. She was offered her to be on a regular diet per her request, but then denied wanting to discontinue her therapeutic diet. Resident is aware of the changes with the dining room with emphasis on the availability of condiments on the table for use. Staff has been educated regarding resident's current diet with emphasis on resident being able to request a regular diet if and when she chooses to.</p> <p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE : All other residents have potential to be affected. Upon admission, the admitting nurse will notify the resident of their physician prescribed diet(s) and any texture modifications as well as their right to request a diet change and/or to speak with the Registered Dietitian regarding any dietary concerns they may have. -Group Concerns: Facility meal service times will be adjusted and reposted. Director of Nutrition Services will purchase condiment holder for all tables for the large and small dining room and nursing staff will fill condiment holders. Care plans will be updated for residents who desire their beverage be served in a bottle or carton. DNS will provide assigned responsibilities to dining room staff to ensure that meals are served in a timely manner. Dining staff was educated to offer all residents a beverage of choice</p>		

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F 242	<p>Continued From page 31</p> <p>diet menus showed: omission of high sodium meats such as bacon, ham, and sausage for breakfast, 1% milk was served versus 2%, substitution of whole wheat bread for bread, low salt gravies and sauces, low salt soups, low salt grains (rice pilaf, whipped potatoes, risotto, Mexican rice), low salt meats (low salt chicken taco without cheese, low salt spaghetti with meatballs, low salt baked fish) for regular items, and half portions of some desserts were served (pudding, shortcake).</p> <p>Resident #8 was interviewed on 6/13/16 at 12:46 pm. She stated she was admitted to the facility for rehabilitation and was working to improve strength so she could return home. She stated she was prescribed a cardiac diet when she was admitted to the facility and she did not want to be on this diet. She stated she had not been on a therapeutic diet prior to admission to the facility. Resident #8 stated the food was bland, had no flavor and tasted, "Like hell." Resident #8 stated she was provided with a written menu ahead of time that she could select from. She stated she frequently selected foods that she did not receive and was told by staff that she could not have them due to her diet restriction. She stated she recently selected pizza from the menu but was not allowed to have it; selected Mexican rice on 6/12/16 but was served plain rice instead, and was recently served plain noodles. Resident #8 stated she did not understand why there were foods listed on the menu for her to select from that she was not allowed to have.</p> <p>Observations during the survey noted salt, pepper, Mrs. Dash, and/or other seasonings or condiments were not available on the tables in</p>	F 242	<p>and water when entering the dining room and that residents have the right to request a diet despite their physician prescribed therapeutic diet order.</p> <p>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: Secondary review of resident's admitting diet and texture modifications will be discussed during the resident's care conference. Discussion of food concerns, complaints, and right to sign Risk/Benefit form will be reviewed. A copy of all signed Risk/Benefit forms will be provided to the primary care physician. The Director of Nutrition Services will provide department in-service and training on protocol for serving therapeutic diets. -The facility will audit the following: 1. Condiments are available for resident use. 2. Fluids are offered and poured in a glass if resident desires. 3. Residents are served in a timely manner 4. Resident wishes are honored when requesting foods that go against their therapeutic diets. Any issues will be addressed immediately during the audits. The results of the audits will be reviewed during the QA meetings.</p> <p>*MONITORING A.WHO: RD/Designee</p>		

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F 242	<p>Continued From page 32 the dining room, including on Resident #8's table.</p> <p>On 6/14/16, Resident #8 was observed eating lunch at 12:48 pm. She stated she was not served the tomato juice she ordered on her menu, but was served grape juice instead. Resident #8's menu was on the table and tomato juice was circled indicating her selection. Grape juice was not selected on the menu.</p> <p>The DNS was interviewed on 6/16/16 at 5:50 pm, and stated staff served foods to Resident #8 according to her therapeutic diet parameters. She stated staff met with Resident #8 on 5/4/16 and encouraged the use of Mrs. Dash (herb based seasoning without salt) for added flavor.</p> <p>The Dietitian was interviewed on 6/15/16 at 9:40 am, and verified salt and pepper were not put on the tables customarily at meals. She stated residents could ask for salt if they wanted it. She stated Resident #8 should be served the foods she selected from the menu that included allowable cardiac diet choices. The Dietitian stated Resident #8 had informed her of the diet being bland and that she did not want to be on the diet. The Dietitian was informed of Resident #8's selection of tomato juice, circled on her menu at lunch, and the resident being served grape juice instead. The dietitian stated Resident #8 should have been served low sodium tomato juice.</p> <p>The Director of Nutrition services was interviewed on 6/16/16 at 11:15 am, and stated the facility used to provide salt and pepper shakers on the tables. She stated the previous administrator instructed staff to remove the salt</p>	F 242	<p>-</p> <p>B.FREQUENCY: - will audit 3x a week for 1 month, then 2x/week for 1 month, weekly x 1 month for a period of 12 weeks. Any issue noted will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits.</p> <p>C.START DATE: - July 18,2016</p> <p>*DATES WHEN CORRECTIVE ACTION IS COMPLETED: - July 22,2016</p>		

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F 242	<p>Continued From page 33</p> <p>and pepper shakers to prevent residents that should not have sodium from accessing it. his practice had continued since that time. She further stated therapeutic diets were identified in the dietary software and tray cards with this information were printed prior to the meal. She stated dietary staff referred to the tray cards when serving and nursing served the beverages.</p> <p>The Practice Paper: Individualize Nutrition Approaches for Older Adults in Health Care Communities Volume 110, Issue 10, Pages 1554-1563, October 2010, include, "It is the position of the Academy of Nutrition and Dietetics (formerly the American Dietetic Association) that the quality of life and nutritional status of older adults residing in health care communities can be enhanced by individualization to less-restrictive diets."</p> <p>Resident #8's food choices were not honored and respected.</p> <p>2. On 6/15/16 at 10:20 am, the group of residents stated meal service took too long and they did not understand why staff stood around the tray line waiting for trays. They stated that although they liked being able to go to the tray line to pick their meal, the process took too long.</p> <p>The group further stated they usually had to ask or wait for their meals to get something to drink. The group stated water was not served unless asked for, as well as, condiments. The group stated that not all the residents were able to eat what they wanted. If a resident was on a special diet, they could not get anything not on the diet especially if they were not able to voice their</p>	F 242			

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

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F 242	<p>Continued From page 34</p> <p>wishes. The group further stated fluids were not always offered in a glass or cups. They usually got drinks from a can.</p> <p>Resident Council Grievance meeting minutes from the last three months documented the following:</p> <ul style="list-style-type: none"> * Review of February Concerns - Meal service changed to improve flow and timing of meals and hall trays delivered before dining rooms and staff are unable to address residents' special needs or provide extra assistance due to "being so busy." * March - Residents need assistance in the rehab dining rooms during meals and in completing menus; too much Mexican food on menus; potatoes and fruit too hard. *April - Salt and pepper over used in vegetables and gravies; potatoes under cooked; and meat overcooked and tough; meals cold in dining room; requests for smaller portions not provided; and drinks are not served timely at dinner meals. *May - "Staff continue to turn off call lights without providing care. They say they will return but often forget. Staff also need to be quicker in answering the red bathroom call lights. Staff are not helping as efficiently in the dining room during tray line as they could be." <p>A Mini Inservice for staff, dated 5/10/16, documented that residents' continue to "report drinks are not served timely at the dinner meal in the dining room. Residents are stating there are times they receive their meal and have yet to be served anything to drink. This concern has been</p>	F 242			

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F 242	Continued From page 35 expressed during several resident council meetings." The inservice directed that all residents should receive water, as well as, beverages of choice. The inservice stated CNA are responsible to serve beverages at dinner meals and for staff to be aware of who is in the dining room to ensure drinks are passed prior to meal service.	F 242			
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of Resident Council meeting minutes, review of an inservice record, and staff, family, and resident interviews, it was determined the facility failed to ensure sufficient numbers of staff were available to meet the needs of residents. This was true for 5 of 19 sampled residents (#4, #5, #6, #7, and #8) and 6 of 7 residents in group interviews. This deficient practice resulted in residents experiencing incontinence due to lack of timely assistance with toileting placed residents at risk of psychosocial and physical harm due to unmet needs. Finding include: 1. On 6/12/16 at 6:00 pm, Resident #4 stated staff took over 30 minutes to answer call lights. Resident #4 stated staff would often just come in	F 244	Listen on group grievance/Recommendation *CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC: -Resident #4 IDT met with resident to discuss his staffing issues. IDT will meet with resident weekly for 1 month and prn to discuss timeliness of call light response. Staff has been educated during the all staff meeting not to turn off call lights unless resident's needs are addressed. CNA hall assignment will be made to designate staff duties every shift to ensure that staff is available in the hallway to answer call lights. Any	7/22/16	

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F 244	<p>Continued From page 36</p> <p>a turn off the call light without providing cares. Resident #4 stated there was not enough staff at night and during meals. Resident #4 stated, the facility pulled all the staff to the dining room to help with the meals so there was no one on the halls to answer the call lights.</p> <p>2. On 6/13/16 at 12:30 pm, a family member stated she came to the facility several times a day because she felt she needed to be there because there was not enough staff. The family member stated the staff the facility had did a good job, but there was not enough of them.</p> <p>3. On 6/14/16 at 10:10 am, Resident #6 stated the facility needed more help. Resident #6 stated she could push her call light and sometimes had to wait over 30 minutes for staff to respond or staff just ignored the call light.</p> <p>4. On 6/15/16 at 10:20 am, during a group interview, the group stated there was not enough staff available during meals and during the night shifts. The group stated that after 10:00 pm, there were only 2 CNA's. The group stated they often had to wait up to 45 minutes for their call lights to be answered. The group stated the 400 and 500 halls were really short of staff. The group stated meal times took too long and did not understand why staff stood around the tray line waiting for trays. They stated that although they liked being able to go to the tray line to pick their meal, the process took too long.</p> <p>The group further stated they usually had to ask or wait for their meals to get something to drink. The group stated water was not served unless asked for as well as condiments. The group</p>	F 244	<p>concerns verbalized by the resident will be immediately addressed.</p> <p>-Resident #5 Staff has been educated during the all staff meeting not to turn off call lights unless resident's needs are addressed. CNA hall assignment will be made to designate staff duties every shift to ensure that staff is available in the hallway to answer call lights. IDT met with nursing staff to educate them on family's concern (turning resident q 2 hours). IDT met with restorative nursing assistant to ensure that ROM is being performed on the resident. IDT will meet with resident's family weekly for 1 month and prn to ensure that their concerns are being addressed.</p> <p>-Resident #6 Staff has been educated during all staff meeting to promptly answer call lights and to not ignore them ensuring that resident needs are met in a timely manner. IDT will meet with the resident weekly x 1 month and prn to ensure that her concerns are addressed. Any issues will be addressed in a timely manner.</p> <p>-Resident #7 was discharged on June 21, 2016 to home as planned.</p> <p>-Resident #8 was visited by IDT regarding her staffing and call light concerns. Resident stated that she has better understanding now of how the facility is staffed and "felt reassured." IDT will continue to follow up with resident weekly for 1 month and prn. Any concerns verbalized by the resident will be addressed in a timely manner.</p>		

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F 244	<p>Continued From page 37</p> <p>stated that not all the resident were able to eat what they wanted. If a resident was on a special diet, they could not get anything not on the diet especially if they were not able to voice their wishes. The group further stated fluids were not always offered in a glass or cups. They usually got drinks from a can.</p> <p>Resident Council Grievance meeting minutes from the last three months documented the following:</p> <p>*Review of February Concerns- Meal service changed to improve flow and timing of meals and hall trays delivered before dining rooms and staff are unable to address residents' special needs or provide extra assistance due to "being so busy."</p> <p>*March-Residents need assistance in the rehab dining rooms during meals and in completing menus; too much Mexican food on menus; potatoes and fruit too hard.</p> <p>*April-Salt and pepper over used in vegetables and gravies; potatoes under cooked; and meat overcooked and tough; meals cold in dining room; requests for smaller portions not provided; and drinks are not served timely at dinner meals.</p> <p>*May- "Staff continue to turn off call lights without providing care. They say they will return but often forget. Staff also need to be quicker in answering the red bathroom call lights. Staff are not helping as efficiently in the dining room during tray line as they could be."</p> <p>A Mini Inservice for staff, dated 5/10/16, documented that residents' continue to "report</p>	F 244	<p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE :</p> <p>- All residents has the potential to be affected by the deficient practice. Staff education for prompt call light response and prioritizing resident needs i.e. toileting was in serviced to all staff on July 15, 2016.</p> <p>-IDT met in the monthly resident council meeting, to discuss resolution regarding call light concerns and staffing response.</p> <p>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</p> <p>-Manager on duty will be assigned in the dining room to provide staff oversight and assistance.</p> <p>-The following audits will be performed: 1. Timeliness of call light response 2. Direct care staff addressing the needs of the resident without turning the call light off before addressing resident's needs. Any issues reported during the audits will be immediately addressed and be brought to the daily standup meetings for further resolution. Results of the audits will be will be reviewed during the QA meetings.</p> <p>-CNA hall assignments will be made to designate staff duties every shift.</p> <p>-Refer to F240 tag for further plan of care.</p> <p>-In-service regarding customer service was performed on July 15, 2016.</p> <p>*MONITORING</p>		

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F 244	<p>Continued From page 38</p> <p>drinks are not served timely at the dinner meal in the dining room. Residents are stating there are times they receive their meal and have yet to be served anything to drink. This concern has been expressed during several resident council meetings." The inservice directed that all residents should receive water, as well as, beverages of choice. CNAs were identified as responsible to serve beverages at dinner meals and for staff to be aware of who is in the dining room to ensure drinks are passed prior to meal service.</p> <p>5. Resident #7 reported insufficient staffing following her recent admission to the facility for rehabilitation due to total knee replacement surgery. During an interview on 6/13/16 at 2:10 pm, Resident #7 stated that it was hard for her to get to the bathroom on time and it took 2 to 3 staff to toilet her initially because of her non-weight bearing status. Resident #7 stated she waited an hour to an hour and a half to be toileted. Resident #7 reported staff came to her room and turned off her call light and said they would come back but did not. She stated she was incontinent the first couple days following her admission to the facility because she did not receive timely toileting assistance. Resident #7 reported nights were the worst for call light response time and that it still took 30-45 minutes when she turned on her call light. Resident #7 also stated, "Forget it at meal time. Don't even put it (call light) on."</p> <p>Resident #7's family member was interviewed on 6/14/16 at 3:00 p.m. Family Member #1 stated Resident #7 was admitted to the facility for rehab about a week and a half ago following a total</p>	F 244	<p>A.WHO: -DNS/Designee</p> <p>B.FREQUENCY: - will audit 3x a week for 1 month, then 2x/week for 1 month, weekly x 1 month for a period of 12 weeks. Any issue noted will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits.</p> <p>C.START DATE: - July 18,2016</p> <p>*DATES WHEN CORRECTIVE ACTION IS COMPLETED: - July 22,2016</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 244	Continued From page 39 knee replacement. Family Member #1 stated Resident #7 had been completely continent prior to the surgery and was aware when she needed to use the toilet. Family Member #1 stated the resident had a catheter in the hospital but it was removed prior to her coming to the facility. He stated Resident #7 was put in incontinent briefs when she was admitted to the facility, although she was continent. Family Member #1 stated both he and Family Member #2 observed Resident #7 waiting too long for assistance and Resident #7 was incontinent and urinated in her briefs, as a result. He stated he had medical training and helped Resident #7 to the toilet twice when he was visiting because staff did not come timely and she had already been incontinent. 6. Resident #8 stated on 6/13/16 at 12:40 pm, that the facility was short staffed. Resident# 8 reported waiting up to 45 minutes at night for toileting. She reported "Nights were the worst." She stated there was only one nurse aide routinely assigned to cover 2 halls (400 and 500). Resident #8 stated she was incontinent if she had to wait too long. 7. An Interview with Resident #5's family member [Family Member #3] was conducted on 6/15/16 at 5:30 pm. Family Member #3 stated Resident #5 was dependent on staff for all cares. Family Member #3 stated the facility was understaffed at times. She stated when the facility was understaffed, Resident #5 had to wait more than 2 hours to be repositioned and range of motion was not provided. She said she noticed longer wait times for assistance during meals.	F 244			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		7/22/16	

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F 278	<p>Continued From page 40</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, it was determined the facility failed to ensure assessment documentation accurately reflected residents' abilities. This was true for 4 of 10 sampled residents reviewed for side rails (#2, #3, #6 and #10). This resulted in MDS</p>	F 278	<p>Assessment /Accuracy/Coordination/Certified</p> <p>*CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC: -Resident #2 side rail was discontinued. A</p>		

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F 278	<p>Continued From page 41</p> <p>assessment which did not accurately reflect the residents' ability to easily remove their side rails. Findings include:</p> <p>1. Resident #10's MDS assessment, dated 4/11/16, documented he was moderately cognitively impaired and required total assistance with mobility and cares. The MDS assessment documented Resident #10 did not have any physical or mechanical device or equipment that could easily be removed.</p> <p>On 6/16/16 at 4:00 pm, Resident #10 was observed lying in bed. The bed was against the wall to his right side with 4 full side rails up. Resident #10's left side was affected by a previous cerebral vascular accident. Resident #10 stated he felt "trapped."</p> <p>2. Resident #6's MDS assessment, dated 6/13/16, documented she was cognitively intact, and required total assistance for mobility. The MDS assessment documented Resident #6 did not have any physical or mechanical device or equipment that could easily be removed.</p> <p>On 6/16/16 at 4:00 pm, Resident #6 was observed in bed with 4 full side rails up. Resident #6 stated she thought the side rails could be put down, but did not know if she could do it. Resident #6 stated, "they [facility] just put them up, they [facility] did not ask."</p> <p>3. Resident #3's MDS assessment, dated 6/13/16, documented Resident #3 was severely cognitively impaired, and required total assistance for mobility and cares. The MDS assessment documented Resident #3 did not</p>	F 278	<p>correction MDS was completed.</p> <p>-Resident #3 side rail was discontinued. A correction MDS was completed.</p> <p>-Resident #6 side rail was discontinued. A correction MDS was completed.</p> <p>-Resident #10 A correction MDS was completed. Resident is no longer utilizing a side rail. IDT will follow up with the resident weekly for 1 month and prn to ensure that his psychosocial needs are met.</p> <p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE :</p> <p>-The MDS for residents on side rails were reviewed and verified with their MDS assessment. Any immediate issue that was noted during the audit was corrected.</p> <p>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</p> <p>-The MDS nurse was educated by the DNS regarding the coding of side rail according to the RAI manual.</p> <p>-MDS audit will be performed concerning coding of side rail use.</p> <p>*MONITORING</p> <p>A.WHO: - DNS/Designee -</p> <p>B.FREQUENCY: - will audit 3x a week for 1 month, then</p>		

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F 278	Continued From page 42 have any physical or mechanical device, or equipment, that could easily be removed. On 6/16/16 at 4:00 pm, Resident #3 was observed in bed with bilateral lower side rails. Resident #3 was observed not to be able to lower her side rails. 4. Resident #2's MDS assessment, dated 4/22/16, documented Resident #2 was severely cognitively impaired, and required total assistance with mobility and all cares. The MDS assessment documented Resident #2 did not have any physical or mechanical device, or equipment, that could easily be removed. On 6/16/16 at 4:00 pm, Resident #2 was observed in bed with bilateral, full upper and lower side rails. Resident #2 was observed not to be able to lower her side rails.	F 278	2x/week for 1 month, weekly x 1 month for a period of 12 weeks. Any issue noted will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. C.START DATE: - July 18,2016 *DATES WHEN CORRECTIVE ACTION IS COMPLETED: - July 22,2016		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure professional standards of practice during medication administration were observed for 1 of 4 nurses reviewed for medication administration (LN #7). This directly impacted 2 of 4 residents (#12 and #13) sampled for medication administration. This resulted in residents' medications being pre-signed as given prior to	F 281	Services Provided meet Professional Standards *CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC -Resident #12 was discharged as planned. -Resident #13 was interviewed and he is aware of his current medications and	7/22/16	

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F 281	<p>Continued From page 43</p> <p>actual administration. The practice placed residents at increased risk of adverse outcomes due to medication errors. Findings include:</p> <p>On 6/13/16 at 7:00 am, LN #7 was observed during medication administration to Resident #12 and Resident #13. LN #7 was observed to take the medication out of the cart, check the medication with the MAR, and then sign off the medication as given on the MAR. LN #7 then removed the medications from the cards and/or containers and administered the medications to the residents. Resident #12 was administered 16 different medications and Resident #13 was administered 12 different medications. During the observation, LN #7 was asked if those were her initials on the MAR for the medication she was about to administer. LN #7 confirmed her initials.</p> <p>The facility's Medication Administration Policy, dated 6/13/16, documented "Medications are not signed off until the resident has received and/or swallowed the medication."</p> <p>Nursing: Scope and Standards of Practice (American Nurses Association, 2010), require documentation after the medication has been administered to avoid medication errors.</p>	F 281	<p>resident states, that "he has been administered medications prescribed by his MD."</p> <p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE :</p> <ul style="list-style-type: none"> - All residents has the potential of being affected by the deficient practice. License nurses will be audited during medication administration to ensure that the deficient practice will not occur. Any concerns observed in the audits will be addressed in a timely manner. <p>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</p> <ul style="list-style-type: none"> -LN #7 was educated regarding the best practice with Med administration. LN was also counseled. -A license staff meeting was rendered on July 15, 2016 and nurses were in serviced regarding the facility medication administration policy and best practice during medication administration. -License nurses will be audited during med pass to ensure that they are not pre-signing before the actual medication administration. Any immediate issues observed will be addressed. Results of the audits will be reviewed during the monthly QA meetings. 		

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F 281	Continued From page 44	F 281	<p>*MONITORING A.WHO: -DNS/Designee B.FREQUENCY: - will audit 3x a week for 1 month, then 2x/week for 1 month, weekly x 1 month for a period of 12 weeks. Any issue noted will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits.</p> <p>C.START DATE: - July 18,2016</p> <p>*DATE S WHEN CORRECTIVE ACTION IS COMPLETED: - July 22,2016</p>		
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 observations, record review, and resident, family and staff interviews, the facility failed to provide the necessary nursing care and</p>	F 309	<p>Provide care/Services for Highest Well being</p>	7/22/16	

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F 309	<p>Continued From page 45</p> <p>services for 3 of 19 sampled residents (#5, #7 and #9). The facility's protocol to address hypoglycemia, and physician orders for checking blood sugars and administering insulin, were not followed for Resident #5 and Resident #9, creating the potential for adverse health consequences. Resident #7's compression stockings were not applied in accordance with physician orders for prevention of deep vein thrombosis (DVT). Findings include:</p> <p>1. Resident #7 was admitted to the facility on 6/3/16 for rehabilitation following a total knee replacement surgery. She had admission diagnoses including chronic embolism, depression, anxiety, chronic pain, and chronic obstructive pulmonary disease.</p> <p>Resident #7's TKA (total knee arthroplasty) Rehab Hospital Transfer Orders and Instructions, dated 6/3/16, documented thigh high compression stockings were to be worn throughout the day for DVT prophylaxis, a stocking could be applied directly over the bandage, and the compression stockings should be removed at night and for showering. No documentation was found indicating compression stockings had been applied during Resident #7's admission to the facility.</p> <p>The Resident #7's Interim ADL (activities of daily living) Care Plan stated she had a self-care deficit related to the diagnosis of TKA. The care plan directed CNAs to assist Resident #7 with ADLs, as needed, and to encourage her to complete ADLs as independently as possible. Compression stockings were not specifically addressed on the interim care plan.</p>	F 309	<p>*CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC:</p> <p>-Resident #5 blood sugars were reviewed by IDT and there were no hypoglycemia episodes noted. -Resident #9 blood sugars were reviewed by IDT and there were no hypoglycemia episodes noted. -Resident #7 discharged to home as planned. Staff has been educated regarding the need for TED hose use for residents who have orders.</p> <p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE :</p> <p>-All diabetics who are receiving insulin has the potential of being affected by this deficient practice. IDT reviewed current MAR flow sheet for residents receiving insulin to review blood sugars. There were no observed hypoglycemic trends. -IDT reviewed residents with TED hose orders, and provided staff with a roster to ensure application of TED hose is being followed. -Staff has been educated regarding the importance of TED hose application with residents with orders.</p> <p>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</p> <p>-License nurse education was provided on July 15, 2016 regarding the facility</p>		

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F 309	<p>Continued From page 46</p> <p>Resident #7 was observed in her room during the survey a total of 4 times. She was not wearing compression stockings during the following observations:</p> <ul style="list-style-type: none"> * 6/12/16 at 6:50 pm * 6/13/16 at 11:25 am * 6:14;16 at 2:10 pm * 6/16/16 at 3:50 pm <p>LN #1 was interviewed on 6/16/16 at 4:15 pm and stated Resident #7 was to wear compression stockings per physician's orders.</p> <p>Resident #7 was interviewed on 6/16/16 at 3:50 pm. She stated her physician ordered compression stockings to be worn daily. She stated she was unable to put them on herself and needed staff assistance. She pointed to a towel rack on the wall and stated the compression stockings had been hanging there since the second or third day after admission. Compression stockings were observed hanging on the towel rack at this time. Resident #7 stated the compression stockings had not been applied since staff provided her initial shower, a couple days after she was admitted.</p> <p>Family Member #1 was interviewed on 6/14/16 at 3:00 pm. Family Member #1 stated Resident #7 was admitted to the facility for rehab about a week and a half ago following total knee replacement surgery. Family Member #1 stated he was employed in the medical profession and was concerned that Resident #7 was not wearing the compression stockings. Family Member #1 stated Resident #7 had a small sore under her</p>	F 309	<p>hypoglycemic protocol and facility documentation procedure.</p> <p>-The following audits will be performed on diabetic residents receiving insulin 1. Audit of LN to ensure that the hypoglycemic protocol and facility documentation procedure are being followed. 2. Audit of direct care staff to ensure that TED hose application for residents who have orders are followed. Any issues observed will be immediately addressed. Results of the audits will be reviewed during the QA meetings.</p> <p>*MONITORING A.WHO: - DNS/Designee</p> <p>B.FREQUENCY: - will audit 3x a week for 1month, then 2x/week for 1 month, weekly x 1 month for a period of 12 weeks. Any issue noted will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits.</p> <p>C.START DATE: - July 18,2016</p> <p>*DATES WHEN CORRECTIVE ACTION IS COMPLETED: - July 22,2016</p>		

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F 309	<p>Continued From page 47</p> <p>knee cap on the back of her leg and that may have been why she was not wearing the stockings. He stated, "It makes me nervous. I fear more for a blood clot than I do for skin breakdown."</p> <p>2. Resident #9 was admitted to the facility on 4/19/14. Diagnoses included dementia, anxiety, bipolar disease, heart failure, diabetes mellitus, and end stage renal disease (ESRD). Resident #9 received hemodialysis 3 days a week. She was prescribed a pureed diet. Resident #9's 5/3/16 annual MDS assessment noted Resident #9 required extensive assistance of one staff for most ADLs, including eating. The MDS assessment also identified Resident #9 as having long and short term memory problems, disorganized thinking, and receiving insulin injections during each of the 7 days in the assessment period.</p> <p>Resident #9's 2/3/16 quarterly MDS assessment documented her weight as 142 lbs. Resident #9's weight was 134.4 lbs on 6/14/16, which was a 5.3% weight loss since 2/3/16.</p> <p>A Physician Order Report, signed by the MD on 5/5/16, included a prescription initiated on 12/19/14, for Lantus insulin 100 unit/ml, 5 units subcutaneous once a day, to be administered at 7:00 am. The physician also prescribed Humalog insulin 100 unit/ml per sliding scale with blood sugars to be checked twice a day at 6:00 am and 5:00 pm. The sliding scale parameters stated:</p> <p>* If Resident #9's BG was less than 70, the MD was to be called. * If her BG level was 150-199, give 1 unit.</p>	F 309			

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F 309	<p>Continued From page 48</p> <ul style="list-style-type: none"> * If her BG level was 200-249, give 3 units. * If her BG level was 250-299, give 5 units. * If her BG level was 300-349, give 7 units. * If her BG level was 350-399, give 9 units. * For a BG level greater than 399, call MD. <p>The hypoglycemia protocol, documented in the Physician Order Report, instructed staff to:</p> <ul style="list-style-type: none"> * Call MD if BG is less or equal to 70. * Give 4-6 oz of orange juice if resident is able to swallow. * If resident is not able to swallow start IV and give 50 ml D50W. * Recheck blood sugar after 15 minutes of treatment. * If resident is unconscious, cannot swallow, does not have IV access give 1 mg of Glucagon IM or subcutaneous x 1 dose only. * Recheck blood sugar in 15 minutes and notify MD if blood sugar is still less than 70." <p>Resident #9's Medications Flowsheet for March 2016, indicated she had 8 instances of BG levels of 70 or below recorded at 6:00 am, as follows:</p> <ul style="list-style-type: none"> * 3/2/16 - 64 * 3/11/16 - 64 * 3/12/16 - 70 * 3/13/16 - 65 * 3/14/16 - 69 * 3/23/16 - 67 * 3/25/16 - 70 * 3/26/16 - 68 <p>There was no documentation on the Medications Flowsheet or in nurses' notes that the physician was notified of the low BGs, whether orange juice</p>	F 309			

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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
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F 309	<p>Continued From page 49</p> <p>or a different carbohydrate source was administered, that BG levels were rechecked, or that potential signs and symptoms of hypoglycemia were monitored. Lantus, 5 units scheduled at 7:00 am, was administered on all dates noted above except on 3/13/16. It was not signed off as being administered on that date.</p> <p>Resident #9's Medications Flowsheet for March 2016, did not include documentation that her BG level was assessed at 5:00 pm on the following 6 dates: 3/10/16, 3/20/16, 3/21/16, 3/24/16, 3/27/16, and 3/31/16. In March, for the dates that Resident #9's BG level was assessed at 5:00 pm, she required administration of sliding scale insulin on 6 occasions.</p> <p>The Medications Flowsheet for April 2016, documented Resident #9 had 3 instances of a BG level of 70 or below at 6:00 am, that lacked documentation of follow up:</p> <ul style="list-style-type: none"> * 4/11/16 - 61 * 4/18/16 - 70 * 4/25/16 - 70 <p>There was no documentation on the Medications Flowsheet or in nurses' notes to demonstrate the physician was notified of the low BG levels, whether orange juice or a different carbohydrate source was administered, that BG levels were rechecked, or that potential signs and symptoms of hypoglycemia were monitored. Lantus, 5 units scheduled at 7:00 am, was administered on all dates noted above.</p> <p>The Medications Flowsheet for April 2016, showed Resident #9's BG level was not</p>	F 309			

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F 309	<p>Continued From page 50</p> <p>assessed at 5:00 pm, on the following 10 dates: 4/1/16, 4/3/16, 4/12/16, 4/17/16, 4/19/16, 4/24/16, 4/25/16, 4/26/16, 4/28/16, and 4/29/16. In April, for the dates her BG level was assessed at 5:00 pm, Resident #9 required administration of sliding scale insulin a third of the time (7 occasions). Resident #9's BG on 4/22/16 at 5:00 pm was 179. There was no documentation to indicate 1 unit of insulin was administered in accordance with the sliding scale parameters on that date.</p> <p>The Medications Flowsheet for May 2016, documented Resident #9 had 1 instance of a BG level of 70 or below when assessed at 6:00 am (BG of 64 on 5/5/16). There was no documentation on the Medications Flowsheet or in nurses' notes to demonstrate the physician was notified of the low BG level, whether orange juice or a different carbohydrate source was administered, that her BG levels were rechecked, or that potential signs and symptoms of hypoglycemia were monitored. Lantus, 5 units scheduled at 7:00 am, was administered on 5/5/16.</p> <p>Review of the Medications Flowsheet for May 2016, indicated Resident #9's BG level was not assessed at 5:00 pm, on the following 4 dates: 4/9/16, 4/12/16, 4/29/16, and 4/31/16. In May, for the dates in which her BG level was assessed at 5:00 pm, Resident #9 required administration of sliding scale insulin 11 times. Resident #9's BG level on 5/26/16 at 5:00 pm, was 239. There was no documentation to indicate 3 units of insulin was administered in accordance with the sliding scale parameters. Resident #9's BG level on 5/27/16 at 5:00 pm, was 164. There was no</p>	F 309			

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F 309	<p>Continued From page 51</p> <p>documentation that 1 unit of insulin was administered in accordance with the sliding scale parameters.</p> <p>LN #1 was interviewed on 6/16/16 at 4:15 pm, and stated Resident #9's food and fluid intake was often poor. Resident #9 was observed in the dining room during breakfast on 6/13/16 from 7:05 am - 8:15 am. She required staff assistance to eat and was not observed to initiate eating independently.</p> <p>The DNS was interviewed on 6/16/16 at 5:00 pm, and referred to the Diabetes Management Protocol noted above in the event of hypoglycemia. The DNS stated if blood sugar was less than 70, the physician should be notified. The DNS indicated documentation of physician notification, administration of carbohydrate, and rechecking blood sugar should be found in the Medication Administration Record and/or in nurses' notes. The DNS was asked to provide any additional documentation to show the low blood sugars were followed up on. None was provided beyond the nurses' notes which were reviewed above.</p> <p>3. Resident #5 was admitted to the facility on 7/5/12, with diagnoses which included aphasia, cerebrovascular disease, and diabetes mellitus. Resident #5 received all food and fluids via a gastrostomy (G) tube, had a tracheostomy, and received 9 liters of oxygen continuously via trach collar. Resident #5 was prescribed a total of 4 cans/day of Vital tube feeding formula administered via bolus feedings. Resident #5's 2/21/16 annual MDS documented Resident #5 was in a persistent vegetative state.</p>	F 309			

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F 309	Continued From page 52 Resident #5 observed during the survey from 6/12/16 - 6/17/16, to be non-responsive and totally dependent on staff for all cares. When the surveyor introduced herself to Resident #5 on 6/13/16 at 11:30 am, she did not respond in any manner. A Physician Order Report signed by the MD on 5/5/16, documented a diagnosis of diabetes mellitus, prescription of Metformin 1000 mg (diabetic medication) via G tube twice a day at 10:00 am and 10:00 pm, Lantus insulin 100 unit/ml 20 units administered subcutaneously twice a day at 10:00 am and 10:00 pm, and Humalog insulin 100 unit/ml administered subcutaneously per sliding scale to be administered 15 minutes prior to or after meals. The physician's orders also included a finger stick blood glucose check twice a day and as needed. The hypoglycemia protocol documented in the Physician Order Report instructed staff to: * Call MD if BG is less or equal to 70. * Give 4-6 oz of orange juice if resident is able to swallow. * If resident is not able to swallow start IV and give 50 ml D50W. * Recheck blood sugar after 15 minutes of treatment. * If resident is unconscious, cannot swallow, does not have IV access give 1 mg of Glucagon IM or subcutaneous x 1 dose only. * Recheck blood sugar in 15 minutes and notify MD if blood sugar is still less than 70. The Medications Flowsheet for May 2016, documented Resident #5 had a BG level of 61 on	F 309			

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F 309	<p>Continued From page 53</p> <p>5/27/16 at 9:00 pm. Documentation on the MAR indicated the BG was rechecked and was 145. A nurses' note the next day, on 5/28/16 at 4:14 am, stated Resident #5's tube feeding was given in response to the BG of 61, with an improvement to 145 within an hour after the feeding was administered. There was no documentation that the physician was notified of the low BG level. No changes in Resident #5's diabetic medications were made in response to the low BG. Resident #5's Lantus, 20 units, was administered at 10:00 pm on 5/27/16, per the Medications Flowsheet. Blood glucose levels were not consistently taken in accordance with physician's orders. The Medications Flowsheet for May 2016, indicated Resident #5's BG level was not assessed at 10:00 am on the following 6 dates: 5/5/16, 5/15/16, 5/23/16, 5/24/16, 5/30/16 and on 5/31/16.</p> <p>The Medications Flowsheet for June 2016, documented Resident #5 had subsequent hypoglycemia incidents on 6/2/16 and 6/3/16, with a BG of 69 recorded at 9:00 pm. The Medications Flowsheet documented Resident #5's insulin scheduled to be given at 10:00 pm, was administered. According to the Medications Flowsheet, Resident #5's BG level was rechecked and was 120. A nurses' note the next day, on 6/3/16 at 6:30 am, documented Resident #5's tube feeding was given in response to the BG of 69 with prompt improvement to 120 noted after the feeding was administered. The nurses' note further documented Resident #5's BG was rechecked prior to the 4:00 am tube feeding and was 59, with an improvement to 124 after feeding. Documentation stated the physician was notified; however, it was not clear if the physician</p>	F 309			

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F 309	Continued From page 54 was notified twice for two separate incidents or notified once. It was unclear when the physician was notified. The physician reduced Resident #5's Lantus insulin to 15 units twice daily on 6/3/16 and again to 10 units twice daily on 6/9/16. Interview with Resident #5's family member (Family Member #3) was conducted on 6/15/16 at 5:30 pm. Family Member #3 stated Resident #5 was dependent on staff for care. She verified Resident #5 was in a persistent vegetative state, all nutrition was provided via a G tube, Resident #5 was a diabetic, and Resident #5 had been experiencing new onset of low blood sugar incidents. The DNS was interviewed on 6/16/16 at 5:00 pm and stated nursing staff should follow the diabetic protocol in the event of hypoglycemia incidents. The DNS stated if blood sugar was less than 70, the physician should be notified right away.	F 309			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		7/22/16	

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F 325	<p>Continued From page 55</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and family interview, it was determined the facility failed to ensure 1 of 19 sampled residents (Resident #5) was provided with care and services to ensure maintenance of adequate nutritional parameters. Resident #5 was not assessed for nutritional requirements to ensure her tube feeding regimen met her nutritional needs, and her tube feeding regimen was not reassessed in light of a significant weight loss, risk for skin breakdown, constipation, and onset of hypoglycemia. Findings include:</p> <p>Resident #5 was admitted to the facility on 7/5/12, with diagnoses including diabetes mellitus, iron deficiency anemia, gastro-esophageal reflux disease, vitamin D deficiency, gastroparesis, and constipation. Resident #5 received all food and fluids via a gastrostomy (G) tube, had a tracheostomy, and received oxygen continuously via trach collar. Resident #5's 2/21/16 annual MDS assessment documented she was in a persistent vegetative state. Resident #5 was prescribed insulin and 2 medications daily for constipation.</p> <p>Resident #5 was observed during the survey from 6/12/16 - 6/17/16 to be non-responsive and totally dependent on staff for all cares. When the surveyor introduced herself to Resident #5 on 6/13/16 at 11:30 am, she did not respond in any manner.</p> <p>A Physician Order Report, signed on 5/5/16, noted Resident #5 was prescribed (on 12/10/14): Vital 1.0, 1 can, bolus feeding, twice a day at</p>	F 325	<p>Maintain Nutritional Status Unless Unavoidable *CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC:</p> <p>-The RD has reviewed and assessed Resident #5 nutritional status and estimated energy needs on 6/23/16. The new orders are as follows: 1. Vital 1.0 supplement has been decreased to 1 can /day per peg tube. 2. Increased vital high protein to 1 can 3x/day via g tube 3.Increased propass protein supplement to 1 pack via peg tube TID 4.Maintain 100 ccs of H2O before and after feeding. 5. Maintain additional 780 cc. H2O /day for med pass. New orders to provide 948 CC of formula per day, 1067 kcal/day, 78 grams of protein per day and total hydration of 2355 CC per day. New propass orders provide additional 120 kcal per day and 24 grams of protein per day.</p> <p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE :</p> <p>-Other residents has the potential to be affected by this deficient practice. The RD has reviewed residents who are at risk for significant weight loss, planned weight loss, hospice residents, tube feedings and residents</p>		

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F 325	<p>Continued From page 56</p> <p>4:00 am and 10:00 pm. This provided 20 grams (gm) of protein, 474 ml formula, and 474 calories a day. The amount of water the tube feeding formula provided was not documented. Resident #5 was also prescribed Vital High Protein, 1 can, bolus feeding, twice a day at 10:00 am and 4:00 pm. The Vital High Protein provided 42 gm protein, 474 ml formula, 474 calories. The amount of water the tube feeding formula provided was not documented. Resident #5 was also prescribed ProPass, one packet per day. Review of the nutritional analysis from Hormel Health Labs manufacturer, ProPass instant whey protein supplement provided 8 gm protein and 30 calories. In regards to fluids, Resident #5 was prescribed (on 6/17/15): 100 cc water flush before and after the tube feed bolus to equal 800 cc/day four times a day at 10:00 am, 4:00 pm, 10:00 pm, and 4:00 am. Additional free water with medications equaled 780 ml per day. Calculations of the above nutrition plan (including water provided in the tube feeding formula per manufacturer's nutrition analysis) were completed. The calculations showed Resident #5 received a total of 978 calories, 70 gm protein, and 1977 ml of water per day.</p> <p>The Dietitian was interviewed on 6/15/16 at 9:30 am, and stated Resident #5 weighed 247 lbs in January 2015 and the goal was for her to lose weight. Based on 247 lbs, Resident #5 lost 68.5 lbs over the past year and 5 months. Resident #5's most recent weight was 178.5 lbs on 6/2/16, recorded in the Matrix software, and her weight was 185.3 lbs on 3/10/16. Resident #5 lost 6.8 lbs, a 3.6% weight loss, in approximately 90 days, prior to the survey.</p>	F 325	<p>with dietary concerns to ensure that their nutritional needs are met. Any weight loss issues were forwarded to the M.D</p> <p>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</p> <ul style="list-style-type: none"> - The RD will continue to provide the facility administration, DNS and Medical Director monthly significant weight change report. Any immediate issues will be informed to the primary medical provider for resolution. The Nutrition at Risk weekly meeting with the IDT will review residents with significant weight loss changes, planned weight losses, newly admitted residents, residents on hospice, tube feeds and resident with dietary concerns. Concerns will be addressed by the primary medical provider for resolution. Results of the audit will be reviewed in the QA meetings. -RD will in-service staff for signs and symptoms of dehydration and malnutrition. -The following will be audited: 1. MAR audits to ensure that tube feed formula and water flushes are administered per MD orders. 2. MAR will be audited for correct listing of daily tube feed formula, calories, and protein. 3. Significant weight loss audits for residents at risk. <p>*MONITORING</p> <p>A.WHO: The DNS/ designee</p> <p>B.FREQUENCY:</p>		

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F 325	<p>Continued From page 57</p> <p>The Medications Flowsheet for May 2016, documented Resident #5 had a BG level of 61 on 5/27/16 at 9:00 pm. A nurse's note the next day, on 5/28/16 at 4:14 am, documented Resident #5's tube feeding was given in response to the BG of 61, with an improvement to 145 within an hour after the feeding was administered. There was no documentation demonstrating the physician or dietitian were notified of the low BG level on this date.</p> <p>The Medications Flowsheet for June 2016, documented Resident #5 had subsequent hypoglycemia incidents on 6/2/16 and 6/3/16, with a BG of 69 recorded at 9:00 pm on 6/2/16. According to the Medications Flowsheet, Resident #5's BG level was rechecked and was 120. A nurse's note the next day, on 6/3/16 at 6:30 am, documented Resident #5's tube feeding was given in response to the BG of 69 with prompt improvement to 120 noted after the feeding was administered. The nurse's note further stated Resident #5's BG level was rechecked prior to the 4:00 am tube feeding and was 59, with an improvement to 124 noted after the feeding. Documentation showed the physician and dietitian were notified.</p> <p>Interview with Resident #5's family member (Family Member #3) was conducted on 6/15/16 at 5:30 pm. Family Member #3 stated Resident #5 was dependent on staff for care. She verified Resident #5 was in a persistent vegetative state, all nutrition was provided via a G tube, she was a diabetic and had been experiencing new onset of low blood sugar incidents, and had lost a lot of weight. She stated it had been the goal for Resident #5 to lose weight, but now (as of this</p>	F 325	<p>- will audit weekly for 2 months, then biweekly for 1 month for a period of 12 weeks. Any issue noted will be immediately addressed. The QA committee will review any issues uncovered by the weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits.</p> <p>C.START DATE: - July 18,2016</p> <p>*DATES WHEN CORRECTIVE ACTION IS COMPLETED: - July 22,2016</p>		

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F 325	<p>Continued From page 58</p> <p>week) the goal was for her weight to stabilize. When asked if there was anything else important to note at the conclusion of the interview, she stated she was concerned about the skin breakdown to Resident #5's buttocks.</p> <p>Resident #5's most recent protein level, albumin, was obtained on 1/1/15. According to the Laboratory Detail report, Resident #5's albumin was 3.2, low, with a normal range of 3.4-5, according to the report. Her protein status had not been re-evaluated since 1/1/15, a year and 5 months prior, however, she had sustained a weight loss of 68 lbs since that time.</p> <p>On 6/15/16 at 9:00 am, Resident #5 was observed during a skin assessment to have an approximately 0.5 diameter open area surrounded by scar tissue on her left buttocks. Resident #5 had multiple areas on her buttock of resolved skin breakdown.</p> <p>Resident #5's care plan, with a start date of 5/26/16, identified the nutritional problem of, "I have potential for altered nutritional needs secondary to not being able to feed myself and need a feeding tube for all foods and fluids to meet my nutritional needs." The goal was, "I will maintain adequate nutritional status through next review and will continue to tolerate my feedings until the next review date." Resident #5's weight loss was not identified on the care plan and the goal did not identify weight loss as currently being a goal. Resident #5's risk of skin breakdown, most recent low protein level, and presence of constipation, were not identified on the nutrition care plan. The care plan included the approach of Vital 1.0 and Vital High Protein</p>	F 325			

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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 325	<p>Continued From page 59 bolus feeding administration as noted above.</p> <p>Resident #5 had been on the same tube feeding regimen of Vital and Vital High Protein since 12/10/14, however, she had experienced a weight loss of 68.5 lbs in the past year and 5 months, experienced recent low blood sugar incidents, her protein level (prior to 68.5 lb weight loss) was low, had impaired skin integrity to her buttocks, and had a diagnosis of, and was treated for, constipation.</p> <p>A nutritional assessment comparing Resident #5's nutritional needs for calories, protein, and fluid, to what the tube feeding regimen provided, was not found in Resident #5's record. The Observation Report for nutrition, dated 2/23/16, was identified by the Dietitian as being the most recent full nutritional assessment. The report did not identify what Resident #5's nutritional needs were or include a comparison and analysis in regards to what her tube feeding regimen provided. The Observation Report for nutrition, dated 2/23/16, documented 948 calories, 74 gm of protein, 906 ml of free water, and 800 ml of other water were provided daily by the tube feeding regimen. A calculation of the water provided from the tube feeding formula was not made on this assessment or anywhere else in Resident #5's record. The section for total water intake was not filled out and was blank; however, the box was checked indicating total water intake was sufficient. Per the surveyor's calculations, Resident #5 received a total of 1977 ml of water per day (water in the tube feeding formula 397 ml, free water 800 ml per physician's orders, and water with medications 780 ml per physician's orders). Resident #5's nutritional requirements</p>	F 325			

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F 325	Continued From page 60 for calories and protein were not documented. The Dietitian was interviewed on 6/15/16 at 9:30 am, and stated the Matrix nutrition assessment form (Observation Report) did not include a section for nutrition requirements and that was why it was not documented. Per surveyor's request, the Dietitian hand wrote on the Observation Report for nutrition, dated 2/23/16, Resident #5's daily nutritional requirements as: 1000-1200 calories, 70-84 gm protein, and 2100 ml water. Resident #5's tube feeding regimen provided 1977 ml of water which was less than her requirements of 2100 ml per the Dietitian's calculations. Resident #5's tube feeding regimen provided 948 calories which was less than her requirements of 1000-1200 calories per the Dietitian's calculations. Resident #5 was receiving less calories and fluid than her requirements, which had not been identified in the facility's nutrition assessment process. Per the Dietetics in Health Care Communities, Dietetic Practice Group of the Academy of Nutrition and Dietetics, Pocket Resource for Nutrition Assessment 2013 Edition, page 13, "The first step in the Nutrition Care Process is the completion of a nutritional assessment and determination of nutrition needs."	F 325			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		7/22/16	

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F 329	<p>Continued From page 61</p> <p>adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to ensure residents were not administered antibiotic medications without clinical rationale for continued use. This was true for 2 of 2 resident sampled for prophylactic antibiotic use (#1 and #4). This created the potential for residents to experience adverse outcomes resulting from unnecessary medications. Findings include:</p> <p>1. Resident #4 was admitted on 1/30/14, with diagnoses which included diabetes, chronic pain, history of urinary tract infections, and currently had a supra-pubic catheter.</p> <p>Recapitulated Physician Orders, dated 5/1/16,</p>	F 329	<p>Drug regimen is Free from Unnecessary Drugs</p> <p>*CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC: ¿ Resident #1 and # 4 were affected by the deficient practice. -Resident #1 antibiotic was discontinued. -Resident #4 antibiotic was discontinued.</p> <p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE : -All resident taking oral antibiotic for</p>		

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F 329	<p>Continued From page 62</p> <p>documented Resident #4 received Amoxicillin 500 mg every day for prophylactic treatment of chronic UTI. The start date of the medication was 11/9/14.</p> <p>A History and Physical, dated 11/9/14, documented Resident #4 had an indwelling suprapubic catheter and had experienced multiple urinary tract infections over the past several months. The History and Physical noted Resident #4 was likely colonized. Being colonized means you carry the infectious agent but are not actively sick with infection.</p> <p>Resident #4's Monthly Pharmacist Chart Review, dated 5/25/14-5/26/16, did not contain documentation regarding medication of any kind.</p> <p>2. Resident #1 was admitted on 7/5/15, with end stage Parkinson's disease. A History and Physical dated 6/30/15, documented Resident #1 was on Keflex 250 mg every day for prophylactic treatment of UTI.</p> <p>A subsequent History and Physical, dated 5/1/16, documented the continuation of Keflex due to a history of chronic UTI for patient comfort.</p> <p>Resident #1's Monthly Pharmacist Chart Review, dated 7/10/15-5/26/16, did not contain documentation regarding medication of any kind.</p> <p>Resident #1 and Resident #4's medical records did not contain documentation regarding reassessments, rationale for the antibiotic's continued use, and determination of the need for the continued use of the antibiotics.</p>	F 329	<p>prophylactic use will be affected by this deficient practice. The residents who were on oral prophylactic medications were evaluated for justification of the antibiotic use. The use of prophylactic antibiotic on current residents with no clinical indication has been discontinued.</p> <p>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</p> <p>-License nurse education regarding F 329 regulation was conducted on July 15, 2016.</p> <p>-Monthly review by Pharmacist will include evaluation of the need for prophylactic antibiotic use and will include recommendation from the resident's MD.</p> <p>-Audits will be performed on new orders to ensure that no prophylactic antibiotic will be prescribed unless it is clinically warranted and with appropriate documentation justifying the need for the resident use.</p> <p>*MONITORING A.WHO: -DNS/Designee - B.FREQUENCY: - will audit 3x a week for 1month , then 2x/week for 1 month ,weekly x 1 month for a period of 12 weeks .Any issue noted will be immediately addressed. The QA committee will review any issues</p>		

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F 329	Continued From page 63 On 6/16/16 at 7:30 am, the DNS stated Resident #1 and Resident #4 were receiving antibiotic therapy for chronic UTIs, and the facility did not have other paperwork other than what had been provided. On 6/20/16, the facility faxed documentation for Resident #1 and Resident #4, however the fax did not provide new or additional information on prophylactic antibiotic treatments for Resident #1 or Resident #4.	F 329	uncovered by the weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. C.START DATE: - July 15,2016 *DATES WHEN CORRECTIVE ACTION IS COMPLETED: - July 22,2016		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		7/22/16	

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F 520	Continued From page 64 This REQUIREMENT is not met as evidenced by: Based on staff interview, it was determined the facility failed to ensure a physician was a member of the facility's Quality Assurance Committee. The lack of physician involvement on the committee had the potential to compromise the efficacy of the Quality Assurance program, thereby, placing residents at risk of adverse outcomes. Findings include: On 6/9/16 at 5:45 pm, the Administrator stated the QAPI committee members consisted of: the Administrator, DNS, LSW, MDS Coordinator, Activity Director, and Pharmacist. The Administrator confirmed that a physician was not a member of the committee. The Administrator stated the facility's medical director was sent an update, but does not actually attend the quarterly meetings.	F 520	QAA Committee Members Meet Quarterly/Plans -SEE MARK POC *CORRECTIVE ACTIONS FOR RESIDENT SPECIFIC: - Our Quality Assurance and Performance Improvement Program (QAPI) represent our facility's commitment to continuous quality improvement. The program ensures a systematic performance evaluation, problem analysis and implementation of improvement strategies to achieve our performance goals. The facility shall establish an inter-disciplinary QAPI Committee. The committee shall consist of, at a minimum, a chairperson (NHA), Director of nursing services, physician, and three other facility staff members. Additional staff members may be included when their expertise is needed. It is our policy to have the QAPI team to meet on a quarterly basis with all necessary team members and additional professional consultants present. The NHA met with our Medical Director about the need to attend our quarterly QAPI meetings. Our Medical Director is in support and will now attend our quarterly QAPI meetings with our other attendees as noted in our policy. QAPI meeting was rendered on June 29th.		

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F 520	Continued From page 65	F 520	<p>*CORRECTIVE ACTION FOR POTENTIAL RESIDENTS THAT MAY BE AFFECTED BY THIS DEFICIENT PRACTICE :</p> <ul style="list-style-type: none"> - All residents have the potential to be affected by the Medical Director not being present in our quarterly QAPI meetings <p>*MEASURES(FACILITY SYSTEMS) THAT WILL BE PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:</p> <ul style="list-style-type: none"> - Systematic changes that will occur will be the invitation and attendance of our medical director and/or physician at our quarterly QAPI meetings. <p>*MONITORING A.WHO: NHA/DNS/Designee - B.FREQUENCY: - Quarterly QAPI attendance will be presented to and monitored by our QAPI team. C.START DATE: - July 15,2016</p> <p>*DATES WHEN CORRECTIVE ACTION IS COMPLETED: -July 22,2016</p>		