IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
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3232 Elder Street
P.O. Box 83720
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August 12, 2016

Darrin Radeke, Administrator
Mini-Cassia Care Center
Po Box 1224
Burley, ID 83318

Provider #: 135081

Dear Mr. Radeke:

On **July 29, 2016**, a survey was conducted at Mini-Cassia Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 22, 2016**. Failure to submit an acceptable PoC by **August 22, 2016**, may result in the imposition of penalties by **September 16, 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 **September 2, 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 **October 27, 2016**. A change in the seriousness of the deficiencies on **September 12, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 27, 2016** includes the following:

Denial of payment for new admissions effective **October 27, 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 **January 25, 2017**, 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 **October 27, 2016** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx

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

- BFS Letters (06/30/11)

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

This request must be received by **August 22, 2016**. If your request for informal dispute resolution is received after **August 22, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135081	A. BUILDING _____ B. WING _____	07/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINI-CASSIA CARE CENTER	1729 MILLER AVENUE BURLEY, ID 83318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from July 25, 2016 to July 29, 2016. The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator Jenny Walker, RN Rachel Moorhead Lopez, MSW Abbreviations: AD = Activity Director Angulated = Bone fractures wherein the fragmented shards of the bones are positioned in angles from one another ASAP = As soon as possible BLE = Bilateral lower Extremeties CCD = Consistent Carbohydrate Diet (Used for people with diabetes, requires a person to keep a level intake of carbohydrates throughout each day, and from one day to the next.) CHF = Congestive Heart Failure CNA= Certified Nursing Assistant DD = Developmental delay DNR = Do Not Resuscitate DNS = Director of Nursing Services Dystonia = a neurological, sometimes painful, movement disorder syndrome in which sustained or repetitive muscle contractions result in twisting and repetitive movements or abnormal fixed postures. Hemiplegia = paralysis of one side of the body H&P = History and Physical Humerus = long bone in the arm of humans extending from the shoulder to the elbow	F 000		

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

Electronically Signed | 08/22/2016

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F 000	Continued From page 1 Hx = History Kussmaul breathing = a deep and labored breathing pattern often associated with severe metabolic acidosis, particularly diabetic ketoacidosis LE = Lower Extremeties LPN = License Practical Nurse MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Assessment NAR = Nutrition at Risk NRR = Nutritional Risk Review O2 = Oxygen PASRR = Pre-Admission Screening and Resident Review POA = Power of Attorney RN = Registered Nurse RSC = Resident Services Coordinator s/sx = signs and symptoms TAR = Treatment Administration Record TV = Television w/c = Wheelchair	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 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. 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	F 155		8/22/16

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F 155	Continued From page 2 option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure a discrepancy regarding code status was resolved for 1 of 8 sample residents (#7) reviewed for code status. The failure created the potential for confusion among staff responding to a life-threatening event involving Resident #7 due to inconsistent information about her code status and advance directives. Findings include: Resident #7 was admitted to the facility on 5/13/16 with multiple diagnoses, including dementia with behavioral changes. Resident #7's 5/25/16 admission MDS assessment documented intellectual disability with no organic condition, no condition or chronic disease that may result in life expectancy of less than 6 months, and severe cognitive impairment. An Idaho Physician Orders For Scope of Treatment (POST) documented, "Do Not Resuscitate (No Code): Allow Natural Death; Patient does not want any heroic or life-saving measures..." The POST was signed, but not dated, by Resident #7's POA for healthcare, and signed by a physician on 6/18/14.	F 155	The facility will ensure that all residents have a clear advanced directive or it is clear that the resident or legal representative do not desire to have one in place. Resident #7 is considered a Full Code based on her mental retardation and inability to make life decisions independently. Her status is now clearly marked on her care plan and in her medical record. The family and her physicians are aware of her current code status and are aware that they may make changes as legally appropriate on her behalf. All advanced directives will be clarified each quarter and as needed by legal representatives. The interdisciplinary team has been educated on 8/17/16 on immediate clarification of advanced directives and code status upon admission and quarterly resident care meetings. An audit list of residents admitted or reviewed during the quarter will be completed by the administrator or designee each month to review the clarity	

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F 155	Continued From page 3 Resident #7's 5/16/16 MD Admit Progress Note documented a past medical history of developmental delay and a plan for full code. Resident #7's Social History and Discharge Plan assessment, dated 5/23/16, documented a history of intellectual disability, mental illness, or developmental disability; and, "PASRR states old information does state low IQ and mental retardation [intellectual disability]." Resident #7's care plan documented, "I am a full code due to my dx [diagnosis] of MR [intellectual disability]. However, I have a living will that I signed to follow my desires of DNR." This focus area and one intervention, "Arrange a consultation with my doctor, me, and my [relative] ASAP to discuss and hopefully resolve this discrepancy" was initiated on 6/1/16 with a goal for resolution of the discrepancy within one week. Resident #7's Progress Notes, dated 5/13/16 to 5/28/16 at 7:53 pm, documented only one Resident Services note. That progress note, dated 5/27/16, documented, "...PASRR information is marked as MR due to a previous H&P that was done on her saying she had low IQ and MR..." No documentation of efforts to resolve the advance directives discrepancy was found in Resident #7's clinical record. On 7/29/16 at 1:10 pm, the DNS said the facility followed Idaho Code regarding advance directives for residents with DD [intellectual disability]. The DNS said the discrepancy about	F 155	of the code status and advanced directives. The audits will be brought to the Quality Assurance Meeting for review monthly X 3, then q 2 months X 6. The Administrator will be responsible for ensuring the plan of correction is completed.	

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F 155	Continued From page 4 Resident #7's advance directives had not been resolved and that the MDS nurse and RSC were working on the issue.	F 155		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		8/22/16

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F 157	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on closed record review, policy review, and staff interviews, it was determined the facility failed to immediately notify the family member/legal representative of fall-related injuries experienced by 1 of 9 residents reviewed for falls (#13). Resident #13's family/legal representative was not immediately notified of a 11/17/15 fall in which Resident #13 experienced pain, or of a 1/8/16 fall in which he experienced an angulated displaced fracture of the humerus. This failure created the potential for harm if residents experienced complications or compromised medical status without family involvement. Findings included: Resident #13 was admitted to the facility with diagnoses that included dementia with behavioral disturbance. "Brief Interview for Mental Status (BIMS)," dated 10/7/15 and 1/5/16, documented Resident #13 had severe cognitive impairment. Nursing Progress Notes, dated 11/17/15, documented, "Res (resident) was in bed sleeping and roomates (sic) 1:1 [one-to-one aide] heard res fall out of bed and checked and found res on floor. Dr. [Physician] was notified and family will be notified by next shift." Nursing Progress Notes, dated 11/17/15, documented, "Res had head to toe assessment done without any c/o (complaints of) pain noted after fall but later he had some soreness to right shoulder." The Nursing Progress Notes contained no further documentation that the	F 157	The facility will ensure that residents, physicians, and legal representatives or an interested family member are immediately notified when there is an accident involving resident injury and has the potential for requiring physician intervention. Resident #13'□s POA was aware of the continual decline which brought the resident from the previous care setting. The POA was updated frequently on the resident's condition and she was pleased with resident□s care. The facility will include with the incident and accident reports a copy of the note or the verification that the physician and responsible party was notified of all falls or injury or potential injury. The interdisciplinary team will not release the incident and accident for filing until notification is documented and verified. There was an inservice in general staff meeting on 8/10/16 on informing responsible parties of incidents and accidents. The training will be reviewed in the general staff meeting and will continue to be a reminder each month X3, then quarterly X3. The DNS will audit the completion of the documentation of notification on the Incident Tracking form. The audits and the staff training will be brought to the Quality Assurance Meeting for review monthly X 3, then quarterly X 3. The Director of Nursing will be	

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F 157	Continued From page 6 family of Resident #13 was notified of the fall, or notified that Resident #13 had experienced soreness to the right shoulder. An Incident/Accident Review, dated 11/17/15, documented Resident #13 fell in his room. The Fall Incident Accident Report and "Follow Up Check Off Sheet for Incident Reports," both dated 11/17/15, documented Resident #13's family/responsible party was not notified of the fall. Nursing Progress Notes, dated 1/8/16, documented, "X-rays taken...gross positive fracture to right humerus," and that Resident #13 was experiencing pain. The 1/8/16 Fall Incident and Accident Report documented, "No," in the area asking whether Resident #13's family/responsible party had been notified of the fall. A physician's note, dated 1/8/16, documented, "Chief Complaint: right arm pain .. .Last night patient had a reported fall he was held (sic) back into bed ... This morning he was experiencing more pain and discomfort. He had x-rays of the right arm ... showing an angulated displaced fracture..." The facility's Assessing Falls and Their Causes Policy, dated 2/ 2015, documented, "After a fall: The licensed nurse will notify the resident's ... family in an appropriate time frame. When a resident falls, the following information should be recorded in the resident's medical record: Notify the following individuals when a resident falls: a. the resident's family."	F 157	responsible to ensure the plan of correction is complete.	

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F 157	Continued From page 7 On 7/28/16 at 1:40 pm, the DNS, when asked if Resident #13's family was notified of the 11/17/15 and 1/8/16 falls, stated, "From our computer charting (regarding the fall on 11/17/15), it states the family would be notified by the next shift, but I can't prove the family was notified. Regarding the fall on 1/8/16, the nurses should have followed up with calling the family. My expectation would be that the day shift staff follow through and call the family and then chart it, but I don't see it charted anywhere." On 7/28/16 at 4:30 pm, the Administrator stated that anytime there was a fall, even if there is no injury, the expectation was that the resident's family was notified. The Administrator also stated if there was a fall or any type of bruising, staff were required to complete an Incident/Accident report. On 7/28/16 at 5:30 pm, the DNS stated she was unable to locate documentation that Resident #13's family was notified of his 11/17/15 and 1/8/16 falls.	F 157		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and	F 226	The facility will ensure that all allegations	8/22/16

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F 226	Continued From page 8 family and staff interviews, it was determined the facility failed to ensure all injuries of unknown origin and allegations of neglect were immediately reported to the State Agency and thoroughly investigated for 2 of 15 residents (#7 and #13) reviewed for abuse and neglect. Findngs include: The facility's Abuse Policy and Procedure, dated 10/2014, documented, "The facility has developed a system for identifying, investigating, preventing, and reporting any incident, or suspected incident of abuse ... it is the responsibility of employees to promptly report to facility management any incident or injuries of unknown origin ... All reports of resident verbal, physical, mental abuse ... neglect ... are promptly and thoroughly investigated by facility management." The Abuse Policy and Procedure further documented, "Some essential components of a thorough investigation include ... all visible injuries must be measured and described in detail. In case of injury of unknown source, all staff having possible contact with the resident over the 24 hours prior to injury discovery must be interviewed. In cases of injury of unknown source, all staff having possible contact with the resident over the 24 hours prior to injury discovery must be interviewed. Injuries of unknown source occur when both of the following conditions are met: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury of the location of the injury." This policy was not followed. Examples include:	F 226	of neglect and injuries of unknown origin are reported to the State Agency and thoroughly investigated. For resident #13, the resident□s chin bruise was found by the physician to be atraumatic. The bruise on the left rib was not reported to the interdisciplinary team on an incident and accident form that is required for all bruising. On 8/10/16 the nurses were inserviced on the importance of reporting all bruising on an incident and accident form. Recurring education will happen monthly X 3 months then quarterly x3. For resident #7, the family was satisfied with the results of our investigation and the outcome. The interdisciplinary team will review all allegations of neglect and determine if they can be substantiated. All allegations of abuse as described in Idaho Department of Health Informational Letter #2014-04 are to be called into the State Agency. On 8/10/16 the IDT was inserviced on the importance of reporting all neglect and abuse. Recurring education will happen monthly X 3 months then quarterly x3.An audit was implemented to ensure all possible abuse is reported and investigated. On 8/10/16 the general staff was inserviced on the importance of reporting all bruising, neglect and abuse on appropriate forms and how that information gets communicated to the State Agency. Recurring education will happen monthly X 3 months then quarterly x3. The inservice documentation will be	

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F 226	Continued From page 9 1. Resident #13 was admitted to the facility with diagnoses including dementia with behavioral disturbance. A Brief Interview for Mental Status (BIMS), dated 10/7/15 and 1/5/16, documented Resident #13 had severe cognitive impairment. An 11/12/15 Nursing Progress Note documented, "Resident has a 3x6 cm (centimeter) blue discoloration to his left chin and a 3x7 to his left flank." An Incident/Accident Review, dated 11/13/15, documented Resident #13 had been bruised in the shower/tub room. A physician's note, dated 11/13/15, documented, "Patient is seen per request of staff to evaluate for left jaw bruising. It was found a day or so ago." A Nursing Progress Note, dated 12/3/15, documented, "Patient states his RLQ (right lower quadrant) is hurting ... Found a bruise to right lateral rib area during shower." A 12/11/15 physician's note documented, "Patient is seen per request of staff to evaluate for skin discoloration to the right aspect of torso. Staff not aware of any trauma to the area. And the resident does not contribute to the history." The facility's Incident/Accident Log Books from December 2015 to January 2016 did not include a report of the bruise to Resident #13's right lateral rib area.	F 226	brought to the quality assurance meetings for review of completed training. The administrator is responsible to ensure compliance with the plan of correction.	

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F 226	Continued From page 10 On 7/28/16 at 1:40 pm, when asked whether the bruising that was identified on 11/12/15 to the left jaw had been reported to the State Agency as an injury of unknown origin, the DNS indicated it was not reported. When asked what happened to Resident #13 to cause the bruising to the rib area, the DNS stated an Incident/Accident Report was not completed and there was no documentation of what occurred. On 7/28/16 at 1:45 pm, the Administrator stated, the nurse did not report the 12/3/15 bruising to Resident #13's rib area to anyone and Resident #13 was unable to tell what happened. The Administrator stated that the facility's protocol was to write up an incident report for any bruising. He said if the resident could not say what happened the bruising was to be reported and investigated as abuse. 2. Resident #7 was admitted to the facility on 5/13/16 with multiple diagnoses, including dementia with behavioral changes. Resident #7's 5/25/16 admission MDS assessment, documented severe cognitive impairment, extensive 2-staff assistance with bed mobility/transfers, total 2-staff assistance with dressing/toileting/personal hygiene, frequent bowel incontinence, and presence of an indwelling urinary catheter. On 7/27/16 at 10:35 am, a family member said s/he and a friend visited on 5/24/16 around 8:30 pm, they found Resident #7 "hanging out" of bed, the call light on the other side of the room, caked food in her neck, dried feces in her pants, and	F 226		

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clothes with urine on them in a bag in the closet. The family member said s/he reported the concerns to RN #3 who was "rude" and who said Resident #7 did not need the call light because she "yells out." The family member said it took "about 30 minutes" for staff to answer the call light and when they did, they said they would be back in 15 minutes. The family member said when the staff did not return, s/he and the friend cleaned up Resident #7 and changed her wet bed linens. The family member said s/he wrote a complaint and slid it under the RSC's door that night and talked to the DNS the next day.

On 7/28/16 at 3:30 pm, the RSC said she received a call at home on the night of 5/24/16 about Resident #7's family member's concerns and referred the caller to the Administrator. The RSC did not recall the specific concerns.

On 7/28/16 at 4:25 pm, the Administrator said he received a call at home on the night of 5/24/16 about Resident #7's family member's concerns and immediately called the facility. The Administrator said he spoke briefly with a Door Monitor staff member then at length with RN #3. The Administrator said he was able to rule out neglect that night after talking to RN #3. The Administrator said he did not interview Resident #7's family member, Resident #7, other residents, or any other staff that night or at any time. The Administrator said he reviewed video film the next day, which showed staff frequently in and out of Resident #7's room during the time in question. The Administrator said he did not document his conversations with RN #3 or the Door Monitor staff and that the allegation of neglect was not reported to the State Agency.

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F 226	Continued From page 12 The DNS, who accompanied the Administrator on 7/28/16 at 4:25 pm, said she found Communication Forms written by Resident #7's family member, RN #3, CNA #6, and CNA #7, on 5/25/16 when she arrived at work that morning. The DNS said she spoke with Resident #7's family member and thought the issue was resolved. The DNS said she did not document her part of the investigation.	F 226		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure notice was given prior to a room change for 1 of 12 sample residents (#2). The failed practice created the potential for psychosocial harm if the resident experienced confusion, anxiety, agitation, or fear related to the change. Findings include: Resident #2 was admitted to the facility in 2014 with multiple diagnoses, including dementia with behavioral changes. The clinical record documented Resident #2's room was changed on 9/28/15 and his representative was given a Notification of Room Change on 10/28/15, 30 days after the room change.	F 247	The facility will ensure that all responsible parties are notified of room changes prior to the change. For resident #2 the responsible party was notified of the room change that actually happened on 10/28/15. Social Service note and census indicate the change happened on 10/28/15. On investigation the 9/28/15 room change form was inaccurate. Other residents will be protected from the deficient practice by having all room change forms brought to the morning Standup Meeting and reviewed to ensure responsible parties and roommates are properly informed. An audit of the room changes made and the notification of the responsible party will be implemented by	8/22/16

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F 247	Continued From page 13 On 7/27/16 at 11:45 am, the DNS said Resident #2's representative was notified after the room change.	F 247	the administrator. Copies of room change forms and the audit will be brought to the quality assurance meeting and reviewed monthly X3, and quarterly X3. The administrator will be responsible to ensure the plan of correction is implemented and followed.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff, resident, and resident family interview, it was determined the facility failed to ensure 2 of 8 residents (#4 and #7) sampled for activities, were offered and provided with activities of their choice. This created the potential for harm if residents experienced mood changes and/or behaviors resulting from boredom. Findings include: 1. Resident #4 was admitted to the facility with diagnoses that included dementia, dystonia, muscle wasting, and atrophy. An Activity Assessment, dated 1/12/12, documented Resident #4 enjoyed card games, board games, bingo, checkers, painting, throwing a ball, balloon games, outdoor walks, and having	F 248	The facility will ensure that an ongoing program of activities is designed to meet the interests, physical, and mental, and psychosocial well being of each resident. For resident #4 the care plan has been updated to reflect that she will be offered music or TV if she does not desire to attend activities. The interactions will be documented in the resident's activity charting record and an activity audit will be completed to ensure that the resident's planned activities have been implemented. A copy of the charting will be reviewed in the quality assurance meeting monthly X3, and quarterly X3. For resident #7 the care plan has been	9/26/16

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F 248	Continued From page 14 poems, letters, and newspapers read to her. An Activity Assessment, dated 1/4/13, documented Resident #4 liked crafts, coloring, water paints, exercises such as ball playing, Native American festivals, music, most TV and movies, being involved in activities and being around residents and staff. Resident #4's Care Plan, dated 8/24/15, documented communication deficits due to dementia and directed staff to "provide a program of activities that accommodated her communication abilities." An Activity Assessment, dated 11/30/15, documented Resident #4 preferred activities in her own room, in the day/activity room, inside the facility, and group activities. It further documented Resident #4 liked the staff to wake her up for activities, and might participate in an activity program as tolerated. Resident #4's Care Plan, dated 8/24/15 and revised 2/18/16, documented she was dependent on staff for activities, cognitive stimulation, and social interaction due to physical limitations, immobility, cognitive deficits, and dementia. Interventions included: * Engage in simple, structured activities such as looking at books, going to enjoy music, going outside when weather permits, coming to other activities to observe what others are doing, arts and craft with bright colors. * Encourage Resident #4 to participate in	F 248	updated to reflect that she will have other sensory stimulation if not attending activities only if she desires it. The interactions will be documented in the resident's activity charting record and an activity audit will be completed to ensure that the resident's planned activities have been implemented. A copy of the charting will be reviewed in the quality assurance meeting monthly X3, and quarterly X3. Other residents will be protected from the deficient practice by reviewing all other residents during the interdisciplinary team meetings to ensure that activity care plans accurately reflect the needs and desires of the residents. All activity participation and refusals will be documented in the new activity charting binder. The documentation will become part of the residents' permanent record. The resident chart review and activity participation will be documented on the 'Activities Care Planned and Check Audit' by the administrator or designee. There was an inservice on 8/10/16 for the general staff on encouraging resident participation in activities. The training will be reviewed in the general staff meeting and will continue to be reviewed each month X3 and quarterly X3. The training and the activity charting will be reviewed by the quality assurance committee monthly X 3, and quarterly X 3. The administrator will be responsible to ensure the plan of correction is implemented and followed.	

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F 248	Continued From page 15 activities which are of interest to her, her preferred activities were identified as visits from staff, group activities, crafts, music and entertainment, ball toss, exercise, outdoor wheelchair rides, simple crafts, and read to me * Invite Resident #4 to scheduled activities, outings and programs of her desire; stating she liked the following independent activities: Music, TV, listening to the newspaper reading in the morning. A Brief Interview for Mental Status (BIMS), dated 6/21/16, documented Resident #4 was severely cognitively impaired. An Activity Progress Note, dated 7/22/16, documented, "When I attend activities, it is usually to watch; listen to music that is playing in the main south lobby." On 7/25/16 at 4:30 pm, Resident #4 was observed in her room lying in bed asleep. The Activity Calendar for July 2016 documented the activity for 7/25/16 at 4:30 p.m. was Garden Club. On 7/26/16 at 11:45 am, Resident #4 was observed seated in a bolster wheelchair in the 100 hallway. She was not able to communicate at that time. The July 2016 Activity Calendar documented the activity for 7/26/16 at 3:00 pm was bean bag toss. On 7/26/16 at 1:20 pm, Resident #4's roommate,	F 248		

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Resident #10, stated, "With the activities here, my roommate (Resident #4) is not able to read or change the TV channel. She can't do anything. They (staff) just come in our room and give her a newspaper as if she could pick it up and read it. I don't know why they do that. They don't sit and offer to read it to her."

On 7/26/16 at 3:40 pm, Resident #4 was observed lying in bed asleep. Staff were not observed offering to take her to the bean bag toss activity that took place at 3:00 pm.

On 7/28/16 at 8:20 am, Resident #4 was observed lying in bed asleep. There was a TV on in the room located on her roommate's side of the room with a privacy curtain drawn between the two beds that blocked Resident #4's view of the TV if she were to want to watch it.

The Activity Calendar, dated July 2016, showed the activity posted for 7/28/16 at 8:30 a.m. was current events. At that time, staff were not observed to offered Resident #4 the opportunity to attend the current events activity.

On 7/28/16 at 9:00 am, the Activity Director stated, "We get the newspaper, read it to her, and she likes to hear people. We do it almost every day. We read the newspaper to her. She is more of a watcher. As far as going outside, it depends if she is up or not. It depends on the nurses to get her up. She has a TV in her room and that is for stimulation." When asked if Resident #4 was offered any activities that day, the Activities Director stated, "I have not been able to sit with her today." When taken to Resident #4's room and asked if she thought

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F 248	Continued From page 17 Resident #4 could see the TV, the Activity Director stated, "Well no, because she is propped up by the pillow and she can't see it." The July 2016 Activity Calendar documented the activity for 7/28/16 at 10:15 am was exercise. On 7/28/16 at 10:15 a.m., Resident #4 was observed in bed asleep. Staff did not offer her the opportunity to participate in the exercise activity. On 7/29/16 at 8:30 am, Resident #4 was observed lying in bed asleep with the TV on behind the privacy curtain blocking Resident #4's view if she were awake and interested in watching. The July 2016 Activity Calendar documented the activity for 7/29/16 at 8:30 am was current events. On 7/29/16 at 8:30 am, Resident #10 (Resident #4's roommate) was asked if staff had come to offer Resident #4 an opportunity to participate in the current events activity. Resident #10 stated, "No, nobody has come by this morning. Nobody has come by and I haven't seen anyone read to [Resident #4] like current events. They really don't come by." On 7/29/16 at 9:00 am, the DNS stated she did not know if Resident #4 was being read to and if not, it may due to staffing. She further stated residents were to be offered activities. 2. Resident #7 was admitted to the facility on 5/13/16 with multiple diagnoses, including dementia with behavioral changes.	F 248		

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Resident #7's 5/25/16 admission MDS assessment documented she had severe cognitive impairment, adequate hearing and vision, was understood by others and able to understand others, and had minimal depression.

The care plan for activities, dated 5/23/16, documented Resident #7 enjoyed eating chocolate, watching love stories, action, and some comedy, and would try to attend Relief Society meetings. The care plan also documented Resident #7 needed assistance/escort to activity functions.

A handwritten sign on the wall by Resident #7's TV noted Resident #7 liked Animal Planet, National Geographic, and the Discovery Channel, 1950's and 1960's type music - Elvis Presley in particular - and dogs.

The July 2016 Activity Calendar documented Current Events was scheduled for 8:30 am and Relief Society was scheduled for 10:00 am on 7/26/16.

On 7/26/16 from 8:15 am to 10:15 am, Resident #7 was observed in her w/c in the South Unit common area near her room while staff moved about in the unit's common area. During that time frame, the Current Events activity did not occur on the South Unit and Resident #7 was not offered the opportunity to attend the Relief Society activity.

On 7/26/16 at 10:35 am, 1:30 pm, 2:00 pm, 5:30 pm, and 6:15 pm, Resident #7 was observed in bed. The TV was turned off and no music/songs

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were playing.

On 7/27/16 at 10:35 am, Resident #7's family member said there was "not much" activity available or offered. The family member said Resident #7 "seems bored" and had said she was bored.

On 7/28/16 at 8:45 am, Resident #7 was observed in her w/c, parked in the South Unit common area near her room. Fifteen to twenty feet away from her, a small radio in a wall pocket near the front entrance was playing music at a very low volume. The music could not be heard more than a few feet from the radio.

On 7/28/16 at 9:05 am, the AD said the activities calendar applied to all residents. The AD said staff took South Unit residents to the North Unit lobby for activities because the North Unit lobby was larger than the South Unit common area.

On 7/28/16 at 9:15 am, Resident #7 was observed in bed. The TV was off and no music/songs were playing.

On 7/28/16 at 9:20 am, the AD said Resident #7's TV was "always on." The AD accompanied the surveyor to Resident #7's room, noted the TV was off, and stated Resident #7's family had posted the handwritten sign by her television. The AD said Resident #7 did not have a radio but listened to music channels on the TV.

Immediately after that, the AD accompanied the surveyor to the South Unit common area. The AD said she could "barely" hear the music playing on the radio on the wall. The AD leaned in to within

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F 248	Continued From page 20 a foot of the radio and said country music was playing. The AD said the South Unit was "more quiet" and smaller than the North Unit and that there was not a set time for the Current Events activity on the South Unit.	F 248		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, review of the shower schedule, and staff interview, it was determined the facility failed to maintain a homelike environment in 1 of 2 shower rooms (South shower room). The failure created the potential for a negative psychosocial effect for 4 of 12 sample residents (#3, #4, #7, and #10) and 13 random residents (#16, and #18 - #29) who used the shower room. Findings include: a. A musty odor was noted in the South shower room during the initial tour of the facility on 7/25/16 and on 7/27/16 at 11:00 am. The odor was also noted 4 times on 7/28/16 as follows: On 7/28/16 at 9:05 am, CNA #5 accompanied the surveyor to the South shower room and said she noticed an odor in the room. On 7/28/16 at 6:05 pm, RN #1 accompanied the surveyor to the South shower room and said the	F 252	The facility will ensure that mold and mildew does not develop in shower rooms. No residents were adversely affected by the deficient practice. Ventilation fans were hard wired to stay on to prevent humidity from lingering and growing mold. The floor was cleaned and resurfaced on 7/29/16 to make the room more comfortable. The facility will audit the Cleanliness and odor in the shower rooms on the nightly cleaning form. The audit form will be completed 2X weekly and will be brought to the quality assurance meeting and reviewed monthly X3, and quarterly X3. The Director of Nursing Services will be responsible to ensure the plan of correction is implemented and followed.	9/23/16

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F 252	Continued From page 21 room smelled "moldy." On 7/28/16 at 6:15 pm, the Maintenance Supervisor accompanied the surveyor to the South shower room and said the room smelled "a little musty" because the vent fan had been turned off. The Maintenance Supervisor left the vent fan on when he left the room. On 7/28/16 at 6:20 pm, the Medical Records Supervisor accompanied the surveyor to the South shower room and said she smelled a "strange" odor. The Medical Records Supervisor provided a copy of the shower schedule for the South hall residents. The shower schedule documented Residents #3, #4, #7, #10, and #25 - #29 were scheduled for a shower on Tuesdays and Fridays, Resident #16, #18, #21, #23, and #24 were scheduled for a shower on Mondays and Thursdays, and Residents #20 and #22 were scheduled for a shower on Mondays and Wednesdays. b. On 7/28/16 at 6:15 pm, six 2-to-4 inch wide by 12-to-24 inch long light brown and rust colored streaks were observed on the shower stall floor in the South shower room. The streaks smeared when a shoe sole was rubbed across them. The Maintenance Supervisor, who was in the shower room at the time of the observation, said the floor needed to be scrubbed and that he would notify housekeeping.	F 252		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		9/28/16

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F 280	Continued From page 22 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident, resident family member, and staff interview, it was determined the facility failed to ensure the comprehensive care plans for 2 of 24 sampled residents (#3 and #4) were followed and implemented by staff. This had the potential to result in harm to a) Resident #3, who was not provided a working/functioning call light or offered snacks as care planned; and b) Resident #4 who was not offered activities of his/her choice or snacks as care planned. Findings Include: Resident #3 was admitted to the facility with diagnoses that included dementia with behavioral disturbance and hemiplegia, related to	F 280	The facility will ensure that comprehensive care plans are followed. Resident #3'□s call system was repaired within 15 minutes of maintenance being notified that it was not functioning properly. The functionality of the call buttons and lights has been added to our weekly maintenance rounds. Maintenance Round Audit will be reviewed monthly by the Quality Assurance Committee. For resident #3 there were no noted adverse effects of not being offered snacks. There was put in place a snack tracking form that will be signed off by the	

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F 280	Continued From page 23 cerebrovascular disease. On 7/25/16 at 4:15 pm, Resident #3 was observed sitting in a wheelchair with her left hand and left arm severely contracted. Resident #3's Care Plan, dated 10/22/15 and revised on 7/13/16, documented she was at risk for falls as she was unaware of safety needs, was incontinent, and experienced immobility from left sided weakness. Interventions included, "I need prompt responses to all requests for assistance ... therefore check on me frequently ... I need a safe environment with a working ...call light." Resident #3's Care Plan initiated on 10/22/15 and revised on 10/27/15, documented ADL/Self Care deficits related to dementia, limited left-sided ROM, and left-sided hemiplegia. Interventions included, "I am able to inform staff that I need to use the toilet. Please assist me to the toilet or bedside commode as I request." An additional Care Plan initiated on 10/27/15 documented Resident #3's Altered Nutritional Status interventions included snacks between meals. On 7/25/16 at 4:30 pm, CNA #4 stated Resident #3 used the call light with her right hand and was able to push it when she needed assistance. CNA #4 stated Resident #3 was incontinent and required total assistance with ADLs. On 7/26/16 at 11:30 am, Resident #3's call light was activated, however, when activated the call light produced no sound at the nurses' station,	F 280	floor nurse as an audit to ensure snacks are being offered and documented on the CNA flow sheet. The CNA flow sheet is part of the resident's permanent file. The tracking forms will be a permanent part of the functions of the facility and will be reviewed by the quality assurance committee monthly X 3, and quarterly X 3. For resident #4 the care plan has been updated to reflect that she will be offered music or TV if she does not desire to attend activities. The interactions will be documented in resident's activity charting record and an activity audit will be completed to ensure that resident's planned activities have been implemented. A copy of the charting will be reviewed in the quality assurance meeting monthly X3, and quarterly X3. For resident #4, there were no noted adverse effects of not being offered snacks. There was put in place a snack tracking form that will be signed off by the floor nurse as an audit to ensure snacks are being offered and documented on the CNA flow sheet. The CNA flow sheet is part of the resident's permanent file. The tracking forms will be a permanent part of the functions of the facility and will be reviewed by the quality assurance committee monthly X 3, and quarterly X 3. There was an inservice in general staff meeting on 8/10/16 on immediately reporting non-functioning call systems, offering snacks and use of the snack	

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F 280	Continued From page 24 nor did it activate the hallway light outside her room to alert staff she required assistance. On 7/26/16 at 3:00 pm, the 100 hall snacks were observed to include a nectar thick fluid for Resident #3. Observations of the snack container continued until 8:45 p.m. during which Resident #3 was not offered snacks. On 7/26/16 at 3:40 pm, Resident #3's call light again failed to produce an audible alert to staff or activate the hallway light above her door when tested. On 7/26/16 at 4:05 pm, CNA #2 stated, "[Resident #3] can use her call light, with her right hand. I'm not aware of any problems with the call light." On 7/26/16 at 4:10 pm, when asked if the 3:00 pm snacks had been distributed, CNA #3 stated, "No, not all of them. Usually the residents will ask for snacks, and if not, then we will see if they are here at the nurse's station. We should be asking if they want it. Then if not, I tell the nurse they don't want it, or put it back in the bucket, or throw it away." When asked whether Resident #3 was offered her 3:00 pm snacks, CNA #3 stated, "No. We have been busy with other residents and we haven't gotten to it. It [Resident #3's nectar thick fluids in the snack cart] is still here. When asked whether Resident #3 could use her call light to call for assistance, CNA #3 stated, "Yes, she is able to use the call light with her right hand. I'm not aware of it not working." On 7/26/16 at 6:20 pm, Resident #3 was observed sitting in her wheelchair in her room.	F 280	tracking form, and assisting residents to participate in offered activities. The training will be reviewed in the general staff meeting and will continue to be reviewed each month X3 and quarterly X3. Snack audits, maintenance audits, and activity audits will ensure that all residents who are care planned to receive certain services will get them. The training and tracking audit sheets will be reviewed by the quality assurance committee monthly X 3, and quarterly X 3. The Director of Nursing Services will be responsible to ensure the plan of correction is implemented and followed.	

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She pushed the call light with her right hand, but the call light did not sound at the nurses' station or activate the hallway light above her door. Resident #3 repeatedly pushed the call light before wheeling herself to her roommate's bed, where she attempted to push the roommate's call light; Resident #10's call light also failed to sound at the nurses' station or activate the hallway light above the residents' door. During this time, 2 unidentified CNAs were observed walking past Resident #3's room.

On 7/26/16 at 6:45 pm, as Resident #3 attempted to activate her own, as well as her roommate's call light, the DNS was observed at the nurses' station. The DNS began walking towards Resident #3's room. When asked if she was aware Resident #3's call light was not working, the DNS stated, "I was not aware of the call lights not working." The DNS then entered Resident #3's room, pushed the call light herself, and stated, "They are not turning on. They are not working. I don't know why. If I pull it out of the wall socket it works, but when I push the button it doesn't work." At this time, Resident #3 was yelling out to the DNS, "I need to pee. I need to pee."

On 7/26/16 at 6:50 pm, the DNS walked out of Resident #3's room and said, "It must be something in the wall." When she arrived at the 100 hall nurses' station, the DNS stated, "They are not lit up at the board at the nurses' station for either [resident's bed call light]." Resident #3 was again observed pushing the inoperable call light on her, and her roommate's bed, as the DNS entered the next, vacant, room, removed the call light, attached the call light to Resident

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#3's call light port and unsuccessfully attempted to activate the audible alarm at the nurses' station or the hallway light above Resident #3's door. During this time, from 6:20 pm to 6:50 pm, Resident #3 continued pushing her call light and yelling out, "I need to pee."

On 7/27/16 at 9:45 am, Resident #3's family member stated the call light had not been working for a couple of months and that she had told an unidentified nurse. When asked whether snacks were offered to Resident #3, the family member stated, "I'm not sure if they are offering her any snacks. I've never seen them offer her a snack."

On 7/27/16 at 11:10 am, the DNS stated, "The snacks need to be handed out definitely." When the DNS was shown Resident #3's care plan directing staff to offer snacks and ensure the call light was operable, the DNS stated, staff should have offered Resident #3 snacks and made sure her call light was working.

2. Resident #4 was admitted to the facility with diagnoses that included dementia, dystonia, muscle wasting, and atrophy.

Resident #4's Care Plan, dated 8/24/15, documented a communication problem due to dementia. Interventions included directions to staff to "provide a program of activities that accommodated her communication abilities."

Resident #4's Care Plan initiated 8/24/15 and revised on 2/18/16, documented she was dependent on staff for activities, cognitive stimulation, and social interaction due to her

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F 280	Continued From page 27 physical limitations, immobility, cognitive deficits, and dementia. Interventions included: Interventions included: * Engage in simple, structured activities such as looking at books, going to enjoy music, going outside when weather permits, coming to other activities to observe what others are doing, arts and craft with bright colors * Encourage Resident #4 to participate in activities which are of interest to her, her preferred activities were identified as visits from staff, group activities, crafts, music and entertainment, ball toss, exercise, outdoor wheelchair rides, simple crafts, and read to me * Invite Resident #4 to scheduled activities, outings and programs of her desire; stating she liked the following independent activities: Music, TV, listening to the newspaper reading in the morning. A Brief Interview for Mental Status (BIMS), dated 6/21/16, documented Resident #4 was severely cognitively impaired The Altered Nutritional Status Care Plan revised on 6/29/16 documented staff were to offer Resident #4 between-meal snacks. An Activity Progress Note, dated 7/22/16, documented Resident #4 enjoyed watching others engaged in activities and listening to music playing in the main south lobby. On 7/25/16 at 4:30 pm, Resident #4 was	F 280		

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F 280	Continued From page 28 observed in his room lying in bed asleep. The July 2016 Activity Calendar documented the activity for 7/25/16 at 4:30 p.m. was Garden Club. On 7/26/16 at 11:45 am, Resident #4 was observed seated in a bolster wheelchair in the 100 hallway. She was not able to communicate at that time. On 7/26/16 at 3:00 pm, staff were observed bringing snacks to the 100 hall. The snack container included pudding for Resident #4. The observation ended at 8:45 pm without staff offering a snack to Resident #4 during the 5-hour and 45-minute time frame. The July 2016 Activity Calendar documented the activity for 7/26/16 at 3:00 pm was bean bag toss. At 3:40 pm, Resident #4 was observed lying in bed asleep. Staff did not offer to assist her to the bean bag toss between 3:00 pm and 3:40 pm. On 7/28/16 at 8:20 a.m., Resident #4 was observed lying in bed asleep. There was a TV on in the room, however, it was located on the roommate's side of the room, and the privacy curtain which separated bed A and bed B was pulled, blocking Resident #4's view of the TV if she were to want to watch it. Review of the Activity Calendar, dated July 2016, showed the activity posted for 7/28/16 at 8:30 a.m. was current events. At that time, staff were not observed to offered Resident #4 the opportunity to attend the current events activity.	F 280		

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F 280	Continued From page 29 On 7/28/16 at 9:00 am, the Activity Director stated, "We get the newspaper, read it to her, she likes to hear people. We do it almost every day. As far as going outside, it depends if she is up or not. It depends on the nurses to get her up. She has a TV in her room and that is for stimulation." When asked if Resident #4 had been offered any activities that day, the Activity Director stated, "I have not been able to sit with her today." When taken to Resident #4's room, where the television was on her roommate's side of the room behind a privacy curtain that obscured Resident #4's view of it, the Activity Director stated, "Well no, [Resident #4 cannot see the TV] because she is propped up by the pillow and she can't see it. I haven't gotten to the 8:30 am current events on the South side [100 unit] yet." The July 2016 Activity Calendar documented the activity for 7/28/16 at 10:15 am was exercise. On 7/28/16 at 10:15 am, Resident #4 was observed in bed asleep. Staff did not offer her the opportunity to participate in the exercise activity. On 7/29/16 at 8:30 am, Resident #4 was observed lying in bed asleep with the TV on, but out of sight behind the drawn privacy curtain. The July 2016 Activity Calendar documented the activity for 7/29/16 at 8:30 am was current events. On 7/29/16 at 8:30 am, Resident #10 [Resident #4's roommate], when asked if any staff had come to offer Resident #4 the activity of current	F 280		

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F 280	Continued From page 30 events stated, "No, nobody has come by this morning. Nobody has come by and I haven't seen anyone read to [Resident #4] like current events. They really don't come by." On 7/29/16 at 9:00 am, the DNS stated, she did not know if Resident #4 was being read to and if not, it may due to staffing. She further stated residents were to be offered snacks and the expectation was that care plans be followed.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, it was determined the facility failed to ensure blood glucose levels greater than 250 mg/dl and edema were monitored for 1 of 4 residents (#8) reviewed for diabetes management and edema. The failure created the potential for harm if Resident #8 experienced complications or compromised medical status related to diabetes or edema. Findings include: Resident #8 was re-admitted to the facility on 1/25/16 with multiple diagnoses including Type II diabetes mellitus and chronic obstructive pulmonary disease.	F 309	The facility will ensure that residents are provided necessary care and services to attain and maintain the high practicable physical, mental and psychosocial well-being. Resident #8□'s physician has adjusted the appropriate blood glucose range to fall between 80 and 400 which is a normal range for that resident. Results outside of that range should be reported to the physician. An audit tool to monitor blood glucose ranges, report out of range values to MD and ensure facility is	9/28/16

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F 309	Continued From page 31 a. Resident #8's May, June, and July 2016 MARs documented that staff was to check blood glucose levels daily and notify the physician if blood glucose was less than 80 mg/dl or greater than 250 mg/dl. Resident #8's May 2016 MAR documented blood glucose levels greater than 250 mg/dl occurred 7 of 31 days. Resident #8's June 2016 MAR documented blood glucose levels greater than 250 mg/dl occurred 9 of 30 days. Resident #8's July 2016 MAR documented blood glucose levels greater than 250 mg/dl occurred 5 of 26 days. Resident #8's record did not include documentation that the blood glucose levels above 250 mg/dl were reported to the physician. Resident #8's current care plan documented staff were to monitor, document, and report to the physician any signs and/or symptoms of hyperglycemia, including increased thirst and/or appetite; frequent urination; weight loss; fatigue; dry skin; poor wound healing; muscle cramps; abdominal pain, Kussmaul breathing, acetone breath, stupor, and coma. There was no documentation in Resident #8's clinical record that signs and symptoms of hyperglycemia were monitored as directed in Resident #8's care plan. On 7/28/16 at 10:45 am, when asked if the doctor	F 309	monitoring signs and symptoms of hyperglycemia and hypoglycemia will be implemented and will continue weekly X 4 weeks, every other week X 2 months, and monthly X 3. The facility has obtained from the physician and documented baseline edema for resident #8 and will for all other residents with edema. Resident has refused the use of diuretics. An audit tool to monitor edema and report out of range values to MD will be implemented and will continue weekly X 4 weeks, every other week X 2 months, and monthly X 3. Nurses were inserviced on 7/28/16 on resident specific blood glucose parameters and the reporting, treatment and documentation thereof. They were also inserviced on monitoring signs and symptoms of hyperglycemia and hypoglycemia, and reporting significant weight changes and edema. The nurses will be trained on the exact medical definitions of the levels of edema. The training for blood sugars, and edema will be reviewed in the nurses meeting and will continue to be reviewed each month X3, and quarterly X3. The training will be reviewed by the quality assurance committee monthly X 3, and quarterly X 3. Other residents will be protected from the deficient practice by reviewing all diabetic residents and those with edema, ensuring each has an intervention on the Medication Administration Record reminding to monitor for blood glucose parameters, weights and edema, and the reporting out of range values to MD.	

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F 309	Continued From page 32 was notified of blood glucose levels over 250 mg/dl in July 2016, LPN #2 stated, "No, I thought it was greater than 400 [mg/dl]." b. Resident #8's TARs for May, June, and July 2016 instructed staff to monitor for left lower extremity 3+ pitting edema. In addition staff were to assess for edema weekly and as needed. Staff documented the existence of 3+ pitting edema using a check mark. The weekly and as needed edema checks were documented as a numeric value. Resident #8's current care plan documented: * Elevate legs in w/c and encourage her to lie down between meals to reduce bilateral lower extremity edema. * Encourage her to wear knee high TED hose on in the morning and off at bedtime. * Monitor for and document any edema. Notify the physician if her edema is more than baseline. Neither the care plan nor the physician orders identified Resident #8's baseline level of edema, such as trace, 1+, etc. Resident # 8's medication orders did not include diuretic medication. A 6/10/16 Nurse's Note documented Resident #8 complained of swollen legs; staff encouraged her to wear TED hose daily. Resident #8's weight records and edema monitoring, and physician's progress notes, documented different levels of edema on the	F 309	The Diabetic Resident Audit and the Resident Edema Audit will be used to ensure compliance with the regulation. Audits will be implemented and will continue weekly X 4 weeks, every other week X 2 months, and monthly X 3. There was an inservice in general staff meeting on 8/10/16 on immediately reporting blood glucose levels and edema. The training will be reviewed in the general staff meeting and will continue to be a reviewed each month X3 and quarterly X3. The training and the audits will be reviewed by the quality assurance committee monthly X 3, and quarterly X 3. The Director of Nursing Services will be responsible to ensure the plan of correction is implemented and followed.	

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F 309	Continued From page 33 same day, examples included: * 5/2/16: Edema was identified as both 2+ and 3+, there was no note to indicate the extremity assessed, the time or a recheck to determine the accuracy of the assessment. * 5/7/16: A physician's progress note documented "trace edema," nursing documented "3+ pitting edema." * 5/16/16: Edema was identified as both 2+ and 3+ there was no note to indicate the extremity assessed the time or a recheck to determine the accuracy of the assessment. * 5/23/16: Edema was identified as both 2+ and 3+ there was no note to indicate the extremity assessed the time or a recheck to determine the accuracy of the assessment. * 5/30/16: Edema was identified as both 2+ and 3+ there was no note to indicate the extremity assessed, the time, or a recheck to determine the accuracy of the assessment. Licensed nursing staff failed to accurately assess and document the lower extremity edema for Resident #8. On 7/27/16 at 12:00 pm, the DNS said the resident's physician was not notified of the increased edema.	F 309		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care;	F 328		8/22/16

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F 328	Continued From page 34 Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure oxygen was administered at the flow rate and frequency ordered by the physician for 1 of 2 sample residents (#7) reviewed for oxygen therapy. The failure placed Resident #7 at risk for subtherapeutic effect from the oxygen and increased risks for side effects or complications. Findings include: Resident #7 was admitted to the facility on 5/13/16 with multiple diagnoses, including dementia with behavioral changes and CHF. Resident #7's 5/25/16 admission MDS assessment documented severe cognitive impairment, extensive assistance of 2 staff for bed mobility/transfers, total assistance of 2 staff for dressing, and oxygen use. Resident #7's CHF care plan, initiated 5/25/16, documented oxygen therapy at 3 liters by nasal cannula continuously as one of the interventions. Resident #7's physician orders for 7/1/16 to 7/31/16 documented a 5/20/16 order for oxygen at 3 liters via nasal cannula continuously to keep oxygen saturation levels equal to or greater than 90% and to call the physician if it was less than 90%.	F 328	The facility will ensure that residents receive ordered treatment for respiratory care and oxygen administration. For resident #7 the nurse recognized the disconnection and corrected the inappropriate flow of the oxygen. There was no adverse reaction to the resident because of the deficient practice. The aid who placed the oxygen on the resident was educated on the importance of paying attention to oxygen flow. For this resident and others who may be affected by the deficient practice, the oxygen concentrators and other oxygen dispensing equipment will be labeled with the resident name, appropriate liter flow and nurse initials. The labeling and checking of liter flow will be audited each week by the director of nursing and documented x 2 months. This documentation will be brought to the quality assurance committee for review. There was a review of the importance of ensuring that oxygen is appropriately placed at the right liter flow on 8/10/16. Training on the importance of correct connection of oxygen and correct liter flow will be reviewed in the general staff meeting and will continue to be a reviewed each month X3 and quarterly	

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F 328	Continued From page 35 On 7/26/16 at 2:00 pm, LPN #1 was observed as she prepared Resident #7 for a DuoNeb respiratory treatment via nebulizer. The LPN checked the Resident #7's oxygen saturation at 75%. An oxygen nasal cannula was in her nostrils, however the LPN found the oxygen tubing was disconnected from the oxygen concentrator by the bed. The LPN immediately reconnected the tubing to the concentrator and used the call light to summon help to move Resident #7 up in bed. At 2:13 pm, CNA #2 responded and assisted the LPN to reposition Resident #7. By this time, Resident #7's oxygen saturation was 90-91%. At 2:18 pm, the LPN removed Resident #7's oxygen nasal cannula, applied a face mask, and started the DuoNeb nebulizer treatment. Two minutes later, Resident #7's oxygen saturation was 87%. The LPN stopped the nebulizer treatment and reapplied the nasal cannula. LPN #1 said she was trained in nursing school not to "leave oxygen on when giving a nebulizer treatment." A minute later, Resident #7's oxygen saturation returned to between 90% and 92%. After that, the LPN left the oxygen nasal cannula in place while she administered the DuoNeb treatment and Resident #7's oxygen satuation levels stayed in the low 90s. On 7/27/16 at 11:20 am, Resident #7 was observed seated in a w/c next to the bed with the oxygen nasal cannula in both nostrils. The oxygen tubing was connected to the oxygen concentrator on the other side of the bed, however, the flow rate on the concentrator was at 2.5 liters per minute.	F 328	X3. The training will be reviewed by the quality assurance committee monthly X 3, and quarterly X 3. The Director of Nursing Services will be responsible to ensure the plan of correction is implemented and followed.	

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F 328	Continued From page 36 On 7/27/16 at 11:35 am, LPN #1 accompanied the surveyor to Resident #7's room. When asked what the flow rate was on the concentrator, the LPN said it was 2.5. The LPN changed the concentrator to 3 liters per minute.	F 328		
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 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to	F 329	The facility will ensure that residents do not receive unnecessary drugs and that	9/28/16

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F 329	Continued From page 37 ensure eye drops were administered accurately. This was true for 1 random resident (#16) and created the potential for harm when the resident received excessive doses of the medication. Findings include: The facility's Medication Administration policy and procedures, dated September 2014, documented: * Medications must be administered in accordance with orders, including any required time frames. * Medications must be administered within one hour before or after their prescribed time, unless otherwise specified (for example, before and after meals). * If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's attending physician or the facility's Medical Director to discuss the concerns. Resident #16 was admitted to the facility on 5/30/12 with multiple diagnoses, including dementia with behavioral disturbance and glaucoma. Resident #16's July 2016 MAR documented orders for Brimonidine Tartrate Solution 0.2% one drop to right eye three times daily related to glaucoma. The scheduled administration times	F 329	medications will be given as ordered. Resident #16 was reviewed for adverse side effects related to the extra eye drop and found to have no adverse reaction. The nurse was educated on the importance of not giving more medication than is ordered even when there is pressure from the resident to do so. All nurses will be audited for medication administration to ensure compliance with MD orders. These audits will be completed by the compliance date and continue each quarter for all nurses. Correct medication administration was reviewed in the general staff meeting on 8/10/16 and will continue to be reviewed each month X3 and quarterly X3. Correct medication administration was reviewed in the nursing meeting on 7/28/16 and will continue to be taught each month X3 and quarterly X3. The training and a copy of the medication pass audit will be reviewed by the quality assurance committee monthly X 3, and quarterly X 3. The DNS or trained designee will perform the audits and the Administrator will be responsible to ensure the plan of correction is implemented and followed.	

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F 329	Continued From page 38 were 7:00 am, 2:00 pm, and 9:00 pm. On 7/26/16 at 7:00 pm, the Administrator answered Resident #16's call light and notified the DNS that Resident #16 requested his eye drops. The DNS stated Resident #16 had already received the drops an hour prior, and the DNS was observed coming out of Resident #16's room with a bottle of eye drops in her hand. On 7/26/16 at 7:30 pm, the DNS said two medication errors had occurred for the same medication as the 9:00 pm dose was given at 6:00 pm and again at 7:00 pm. The DNS said Resident #16 requested eye drops at 6:00 pm, which were administered, and then he requested the drops again at 7:00 pm. The DNA stated she tried to explain to Resident #16 that he already received the medication, but he became upset so the DNS administered the drops again to avoid behavioral issues.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356		8/22/16

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F 356	Continued From page 39 The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to post current nurse staffing information. The failure had the potential to affect all other residents living in the facility and visitors to the facility. Findings included: On 7/25/16 at 11:25 am, a white board on the wall in the hallway by Room 13 was observed with the resident census and current date noted, but spaces for the number of RNs, LPNs, CNAs, and NAs, and the total hours for each of the disciplines were blank for all 3 shifts (days, evenings, and nights). On 7/26/16 at 9:30 am, the white board on the wall in the hallway by Room 13 was observed with a blank in the space for the number of CNAs and their total hours on the day shift.	F 356	The facility will ensure that the facility name, resident census, current date, and total number of hours worked by category or RN, LPN, CNA, and NA is posted in a clear and readable format, in a prominent place. There were no residents adversely affected by the deficient practice. Ensuring that the board is updated at the beginning of each shift was reviewed general staff meeting on 8/10/16 and will continue to be reviewed each month X3 and quarterly X3. There was a daily audit tool implemented on 8/17/16 to ensure that the board is complete. The audit tool and the training will be reviewed by the quality assurance committee monthly X 3, and quarterly X 3. The South nurse is responsible to update	

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F 356	Continued From page 40 On 7/27/16 at 10:30 am, the white board on the wall in the hallway by Room 13 was observed with a blank in the space for the number of CNAs and NAs and the total hours for each of the disciplines on the day shift. On 7/28/16 at 5:45 pm, the white board on the wall in the hallway by Room 13 was observed with blanks in the spaces for the number of RNs, LPNs, CNAs, and NAs and the total hours for each of the disciplines on the evening shift. The Administrator was in the area and said the door monitor staff had not updated the posted information. The facility failed to ensure residents living in the facility, and visitors to the facility, had information related to the number of RNs, LPNs CNAs, and NAs on duty and the total hours of each discipline per shift.	F 356	the board and the administrator will implement the audit tool. The Administrator will be responsible to ensure the plan of correction is implemented and followed.	
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a	F 368		9/28/16

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F 368	Continued From page 41 nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observation, policy and record review, and resident, resident family member, and staff interviews, it was determined the facility failed to ensure nourishing snacks were being provided to 2 of 8 (#3 and #4) sampled residents and 2 of 8 residents (#10 and #16) attending a resident group meeting for the 3:00 pm snack time and the evening 8:00 pm snack time. This deficient practice had the potential to compromise the nutritional health of residents, as well as, lead to psychosocial harm if residents dependent on staff to offer and assist them with snacks, felt helpless when staff did not do so. Findings include: The Snacks Policy Statement, dated May 2014, documented, "It is the center policy to provide: 1) bulk snacks and beverages to each resident/patient care area for availability upon request, 2) snacks as identified in the individual plans of care, and 3) bedtime ... snacks to all residents." Action Steps: 1. The Food Services Department will collaborate with the nursing and management team to identify a par stock of beverage and snack items that will be provided to each resident/patient care area. 6. Nursing Services is responsible for delivering the individual snacks to the identified resident and for offering a snack to all other residents. 7. All snacks will be appropriately stored for time and temperature control as appropriate." This policy was not followed.	F 368	The facility will ensure that evening snacks are offered to all residents. For resident #3 there were no noted adverse effects of not being offered snacks. There was put in place a snack tracking form which the on-duty nurse will use to ensure snacks are being passed and the percentage eaten is documented in the residents' permanent chart. The tracking forms will be signed off by the nurse and will be reviewed by the quality assurance committee for completeness and accuracy monthly X 3, and quarterly X 3. For resident #4 there were no adverse effects of not being offered snacks. There was put in place a snack tracking form which the on duty nurse will use to ensure snacks are being passed and the percentage eaten is documented in the residents' permanent chart. The tracking forms will be signed off by the nurse and will be reviewed by the quality assurance committee for completeness and accuracy monthly X 3, and quarterly X 3. This snack tracking form will be used to ensure accurate documentation of all snacks (for residents care planned for snacks and those that are not care planned to have snacks). The nurse will use a combination of comparing the	

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F 368	Continued From page 42 a. During a Resident Council Meeting on 7/26/16 at 1:20 pm regarding snacks, Resident #10 stated, "You have to ask for it. I'm not getting my string cheese and I think [staff] are eating my string cheese." Resident #16 stated, "I'm not offered any snacks." b. Resident #3's care plan, dated 10/27/15, documented staff were to offer between-meal snacks for altered nutritional status. Resident #4's care plan, revised 6/29/16, documented staff were to offer between-meal snacks for altered nutritional status. On 7/26/16 at 3:00 pm, the 100 hall snack cart was observed arriving to the 100 unit. The cart held a container of snacks that included pudding, string cheese, bananas, nectar-thickened fluids, chocolate mighty shakes, and Ritz crackers. The nectar-thickened fluid was labled for Resident #3 and the pudding was labled for Resident #4. The container of snacks was observed until 8:45 pm (for a total of five hours and forty five minutes) during which staff did not offer Resident #3 or Resident #4 a snack. During this time, the container of snacks was observed in the eye wash/hand wash room next to the nurses' station. Staff were not observed to place the snacks that came out at 3:00 pm or at 8:00 pm into the refrigerator located at the nurses' station. On 7/26/16 at 4:10 p.m., when asked if the 3:00 pm snacks were distributed, CNA #3 stated, "No, not all of them. Usually the residents will ask for snacks, and if not, then we will see if they are here at the nurses' station. We should be asking	F 368	tracking to the snack tray, making observations, and questioning CNAs to complete the tracking form. The information will be compared to the CNA flow sheets and the form will be signed off by the nurse and will be reviewed by the quality assurance committee for completeness and accuracy monthly X 3, and quarterly X 3. On 8/10/16 the form was reviewed in the general staff meeting and will continue to be reviewed each month X3 and quarterly X3. The forms will come out with the snacks and the original is found on the facility shared drive for access of all nursing staff. The Director of Nursing Services will be responsible to ensure the plan of correction is implemented and followed.	

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if they want it. Then if not, I tell the nurse they don't want it, or put it back in the bucket, or throw it away." When CNA #3 was specifically asked if Resident #3 and Resident #4 were offered their 3:00 pm snacks, the CNA stated, "No. We have been busy with other residents and we haven't gotten to it. It is still here (referring to Resident #3's snack of Nectar Fluids and Resident #4's pudding sitting in the container)." At that time, CNA #3 did not remove the snacks from the container or offer it to Resident #3 or Resident #4.

On 7/26/16 at 5:00 pm, LPN #1 stated, "The kitchen delivers snacks at 10:00 am, and 3:00 pm" When asked if kitchen staff notified nursing staff snacks had been delivered, LPN #1 stated, "No, not really. We just know the time when to expect them. They usually sit them [snacks] at the corner of the cabinet at the nurses' station and the door monitor or a CNA will pass them out." When asked how soon snacks should be distributed after arriving on the unit, LPN #1 stated, "Within ten minutes. Whoever is out here will pass them out." When asked if residents received their 3:00 pm snacks that day, LPN #1 stated, "Yes, they got them today." When asked when the residents received their snacks, LPN #1 stated, "I don't know. It's been wild today so, I don't know."

On 7/26/16 at 5:05 pm, when asked about snacks, the Dietary Manager stated, "I've told [nursing staff] to distribute the snacks within 30 minutes. I understand sometimes it gets busy and hectic, but that would be my expectation ... within 30 minutes."

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On 7/26/16 at 5:10 pm, LPN #1 was shown the snacks that had been in the eye wash/hand wash room since 3:00 pm and which had not been passed out to residents. LPN #1 stated, "I don't know why they were back here [eye wash room]. Usually, whatever is left over is supposed to go back in the refrigerator." When asked if any residents received their 3:00 pm snacks, LPN #1 stated, she did not know for sure, but did not think so.

On 7/26/16 at 8:00 pm, Cook #1 was observed bringing out the 8:00 pm snacks to the 100 hall nurses' station. Cook #1 did not alert a staff member that the snacks had arrived at the nursing station. The container of snacks included pudding, nectar fluids, jello, applesauce, ice chips, ½ peanut butter and jelly sandwiches, bananas, animal crackers, and meat/cheese sandwiches.

On 7/26/16 at 8:05 pm, CNA #1 stated, "We have a set time the snacks should come out. Regarding the 3:00 pm snacks, it would be up to the floor staff to get the snacks passed out because I can't leave my 1:1 resident. The floor staff are responsible for putting the snacks in the refrigerator once they come out. Then they are supposed to pass them out right then and there once they get to the floor."

On 7/26/16 at 8:10 p.m., Cook #1 was taken into the eye wash/hand wash room and shown the snacks that had been sitting out since 3:00 pm and not distributed to residents. Cook #1 stated, "These will all have to go in the garbage. The floor staff should have passed them out. I was not aware they were even in here. They should

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have already been passed out. I bring them out and staff know what time they come out. Regarding the 8:00 pm snacks, they should have already been passed out as well to the residents."

On 7/26/16 at 8:15 pm, the Dietary Manager was shown the container of snacks that had been sitting in the eye wash/hand wash room since 3:00 pm and not passed out to residents. The Dietary Manager stated, "They [staff] know when they [snacks] come out and are supposed to put them in the refrigerator. I would have to say no one got their snacks at 3:00 pm and now I will have to throw all these out."

On 7/27/16 at 8:30 pm, CNA #2 stated, "We have certain times the snacks come out and we just know the times. We are supposed to help each other when it comes to the snacks." When CNA #2 was asked if the 8:00 pm snacks had passed to residents yet, CNA #2 stated, "No. We are just putting our Hoyer people down. We have up to one-half hour. We wait for half an hour to see if the residents will want them or not. After that we will put them in the refrigerator or take them back to the kitchen and tell them [dietary staff] residents refused." When CNA #2 was asked if Resident #3 and Resident #4 received their 8:00 pm snacks yet, the CNA stated, "No, they are sleeping. I'm not sure if anyone else had offered them."

During an interview with a family member of Resident #3 on 7/27/16 at 9:45 am, when asked whether snacks were offered to Resident #3, the family member stated, "I'm not sure if they [staff] are offering her any snacks. I've never seen them

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F 368	Continued From page 46 offer her a snack." On 7/27/16 at 11:10 am, the DON expressed concern that snacks were not getting to residents who stayed in bed and the need to develop a better system to ensure they did. She also stated Resident #3 and Resident #4 should have been offered snacks as noted in their care plans.	F 368		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, policy review, and staff interviews, it was determined the facility failed to ensure kitchen staff stored, prepared, served, and distributed food under sanitary conditions. This resulted in staff not washing their hands after exiting the kitchen area, re-entering the kitchen and preparing food; lack of clean caddy carts containing salt/pepper shakers; rusty canned goods and dented canned goods were stored with food that was being used; and inaccurate documentation on the three compartment sink sanitizer solution log. These failed practices created the potential for residents to experience infections or other adverse health	F 371	The facility will ensure that food is stored prepared, distributed and served under sanitary conditions. a. Unservable foods were immediately separated from other food. There is now an area set aside for the storage of food not meant for consumption. The kitchen staff was inserviced on this procedure on 7/26/16. Audits of the food not meant for consumption will be completed weekly X 2 then monthly X 3. The education will continue and be reported to the quality assurance	8/22/16

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F 371	Continued From page 47 outcomes. Findings include: a. The facility's Food Storage-Dry Goods Policy, dated May 2014, documented, "It is the center policy to insure all dry goods will be appropriately stored in accordance with guidelines of the USDA Food Code. Action Steps: Dry Storage- 3. The Food Services Director or designee ensures that all canned food items shall be kept clean, dry, and properly sealed." During observation of the facility kitchen dry storage room on 7/25/16 at 10:40 am, one large bag of yellow onions was observed opened and sitting in a black milk crate. There was also one 6-pound 8-ounce can of sliced apples sitting next to a full box of fresh red potatoes. The top of the can had red rust; handwritten on the can was a date of "3/30" and "Do not use." On 7/25/16 at 11:00 am, the Dietary Manager stated, "Whenever we get cans dented up, we call [food company]. We usually wait until we have four to five cans then we call. [The outdated can of apple slices] has been here about four weeks, since I've been here that I know of." On 7/26/16 at 8:30 am, the still-opened bag of onions sitting on a milk crate and the same rusty 6-pound 8-ounce can of sliced apples sitting next to a large opened box of fresh red potatoes were observed in the dry storage room. A 6-pound dented can of pineapple sitting next to the rusty can, which were next to the opened box of red potatoes, was also observed at this time. b. On 7/25/16 at 11:32 am, the Dietary Manager was observed exiting the kitchen area. With a	F 371	committee each month X 3 and quarterly X 3. There were no residents adversely affected by the deficient practice. b. There was an inservice on 8/10/16 on proper hand washing. Audits of the proper hand washing will be completed weekly X 2 then monthly X 3.The training will be reviewed in the general staff meeting and will continue to be a reminder each month X3 and quarterly X3. The training audit sheets will be reviewed by the quality assurance committee monthly X 3, and quarterly X 3. c. The kitchen staff was educated on documenting the PPM and the date immediately after making the sanitizer on 7/29/16. The sanitizer log will be audited weekly X 2 then monthly X 3 to ensure compliance.The education will continue and be reported to the quality assurance committee each month X 3 and quarterly X 3. d. The serving carts were put on a cleaning schedule to be cleaned each shift and as needed throughout the day to maintain sanitation. The sanitation will be documented on the schedule. The salt and pepper shakers were replaced with individualized packets on 8/1/16. The kitchen staff was inserviced on the new cleaning schedule on 8/1/16. Audits of the sanitation of the cart, and the cleanliness of the salt and pepper will be completed weekly X 2 then monthly X 3.The education will continue and be reported to the quality assurance committee each month X 3 and quarterly X 3. The Administrator will be responsible to	

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F 371	Continued From page 48 bare hand, the Dietary Manager grasped the handle on the exit door which led to the outside garbage area, exited outside to the garbage area, re-entered the kitchen, and then touched the entrance door handle. The Dietary Manager did not wash his hands when he re-entered the kitchen. He then used a pot holder to grasp the handle to a pot of creamed corn on the stove, poured the creamed corn into a blender, and put the pot back on the stove. The Dietary Manager then grabbed one scoop of white thickener in a large scooper and poured the thickener into a blender. At no point in the process, or when these actions had been taken, did the Dietary Manager wash his hands. c. The three-compartment sink "Sanitizer Bucket Log" for July 2016 did not include documentation of the required parts per million (PPM) of the sanitizing solution for the 7/25/16 day shift. On 7/25/16 at 11:45 am, Dietary Aide #1 stated, "I have not recorded it today." The Dietary Aide was then observed writing "5:30 am" on the Sanitizer Bucket Log, and documented the sanitizing solution was 200 parts per million (ppm) at 5:30 am. On 7/25/16 at 12:35 pm, the Dietary Manager stated, "The opening cook usually is the one who checks the Sanitizer Solution for the three-compartment sink." When the Dietary Manager was shown the Sanitizer Bucket Log and informed Dietary Aide #1 documented the 5:30 am time and 200 ppm at 11:45 am, he stated, "I was not aware she signed the log as checking it at 5:30 am."	F 371	ensure the plan of correction is implemented and followed.	

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F 371	Continued From page 49 d. A black caddy cart that was dirty and sticky was observed on 7/25/16 at 12:37 pm in the South hallway next to the kitchen area and a large room tray cart. The caddy cart contained two containers of red juice, and a dirty salt shaker on which the top half was covered with a brownish, dirty white tape. On 7/25/16 at 12:45 p.m., the Dietary Manager stated, "We use the cart all the time and they are for any residents or staff to use." When the Dietary Manager was shown the salt shaker with the brownish dirty white tape on top, he stated, "I know, there was too much salt coming out at one time." When he was asked how long it had been covered with tape, he stated, "I'm not sure." On 7/29/16 at 9:45 am, when asked about hand hygiene practices in the kitchen, the Dietary Manager stated, "I would expect my staff to immediately wash their hands. They are supposed to go to the sink and do a rigorous scrub and be able to sing happy birthday in their head at least twice is what I tell them. Then use the hand towels to dry off their hands and grab a clean paper towel to shut the water off." Regarding the rusty and dented cans in the dry storage, the Dietary Manager stated, "That is where [previous kitchen staff] were keeping them before I got here four weeks ago. I guess we could possibly put the rusty cans on a milk crate and sit them outside so they can be disposed of."	F 371		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	F 456		8/22/16

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F 456	Continued From page 50 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to maintain 1 of 1 sit-to-stand type mechanical lifts in safe operating condition for use by 1 random resident (#17). The failure created the potential for injury if the resident's skin rubbed exposed jagged hard foam on the knee support. Findings include: On 7/28/16 at 6:40 pm, a sit-to-stand mechanical lift was observed in the North Unit shower room. Strips of black Duct Tape-like tape, 7-to-9 inches long, were taped unevenly over the middle section and bilateral edges of the knee rest areas on the lift. The tape on the left knee rest edge was split down the middle with an exposed 4-5 inch long area of jagged hard foam under the tape. Also, a 2-inch crack in the hard plastic trim surrounding the foot platform was observed near the base of the control center and a synthetic sheepskin type material covering the sling for the lift was worn and tattered. LPN #2, who was present, said the lift was old and the "fake sheepskin" was "tattered." LPN #2 said Resident #17 was the only resident who used the sit-to-stand lift on the North Unit and she did not know if any South Unit residents used it. Resident #17 was admitted to the facility in April 2015 with multiple diagnoses, including generalized muscle weakness and history of traumatic brain injury and falling.	F 456	The facility will ensure that the Sara Lift and other equipment used in the nursing department is clean and in good repair. The facility has repaired the old Sara Lift and has acquired a new Sara Lift. Resident #17 had no adversely affects by the deficient practice. The facility has repaired the old Sara Lift and has acquired a new Sara Lift. There was an inservice on 8/10/16 on ensuring that equipment is in good functional condition and is safe and clean. The training will be reviewed in the general staff meeting and will continue to be a reminder each month X3 and quarterly X3. The training will be reviewed by the quality assurance committee monthly X 3, and quarterly X 3. On 8/10/16 the form was reviewed The facility will audit the cleanliness and proper repair of all lifts and other nursing equipment on the nightly cleaning form. If there is anything that is in disrepair that will be communicated in the maintenance binder to the maintenance manager who will make those repairs and document in the binder that they are completed. The cleaning will be documented on the cleaning audit form. The audit form will be completed 2X weekly and will be brought to the quality assurance meeting and reviewed monthly X3, and quarterly X3. The Director of Nursing Services will be responsible to ensure the plan of	

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F 456	Continued From page 51 Resident #17's fall risk care plan, revised 7/11/16, documented an intervention for 2-staff transfers with the sit-to-stand lift. On 7/28/16 at 7:00 pm, the Administrator said there was 1 sit-to-stand mechanical lift in the facility and only 1 resident used it. The Administrator said he was aware of the exposed jagged hard foam and crack in the plastic trim around the foot platform on the mechanical lift.	F 456	correction is implemented and followed.	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review and staff and resident family member interviews, it was determined the facility failed to ensure 2 of 31 sampled residents (#3 and #18) had a functioning call lights. This created the potential for harm when residents were unable to summon staff assistance when needed. Findings include: The facility call light policy and procedure, revised 7/9/14, documented, "It is the policy of this facility to provide the resident a means of communication with nursing staff. If the call light is defective, immediately report this information to the unit supervisor."	F 463	The facility will ensure that nurse station is equipped to receive resident calls through a communication system from resident rooms and toileting and bathing areas. Residents #18 and #3□s shared call system was repaired with 15 minutes of being notified that it was not functioning properly. The functionality of the call buttons and lights has been added to our weekly maintenance rounds. There was an inservice in general staff meeting on 8/10/16 on immediately reporting non functioning call systems. The training will be reviewed in the	8/22/16

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F 463	Continued From page 52 Resident #3 was admitted to the facility with diagnoses including dementia with behavioral disturbance, hemiplegia, and hemiparesis related to cerebrovascular disease. On 7/25/16 at 4:15 pm, Resident #3 was observed sitting in a wheelchair with her left hand and left arm severely contracted. Resident #3's care plan, initiated on 10/22/15 and revised on 7/13/16, documented the resident was at risk for falls, unaware of safety needs, and experienced incontinence and immobility from left-sided weakness. Interventions included, "I need prompt responses to all requests for assistance ... therefore check on me frequently ... I need a safe environment with a working ... call light.'" On 7/25/16 at 4:30 pm, CNA #4 stated Resident #3 used the call light with her right hand and was able to push it when she needed assistance. LPN #1 stated, "[Resident #3] is able to use the call light with her right hand." On 7/26/16 at 11:30 am, the call light located on Resident #3's bed was activated, however the staff alert audible did not sound at the nurse's station and the hallway light over Resident #3's door did not turn on. The South Maintenance Request Log Book for April 2016 to July 2016 contained no requests for maintenance to repair or fix the call light in Resident #3's room. On 7/26/16 at 3:40 pm, the call light did not sound the audible alert at the nurses' station or	F 463	general staff meeting and will continue to be a reminder each month X3 and quarterly X3. The training and the maintenance round sheets will be reviewed by the quality assurance committee monthly X 3, and quarterly X 3. The Administrator will be responsible to ensure the plan of correction is implemented and followed.	

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turn on the hallway light above Resident #3's door.

On 7/26/16 at 4:05 pm, CNA #2 stated, [Resident #3] can use her call light with her right hand. I'm not aware of any problems with the call light."

On 7/26/16 at 4:10 pm, CNA #3, when asked if Resident #3 could use the call light for assistance, stated, "Yes, she is able to use the call light with her right hand. I'm not aware of it not working."

On 7/26/16 at 6:20 pm, Resident #3 was observed sitting in her wheelchair in her room. She activated the call light with her right hand, but the call light again did not sound the audible alert at the nurses' station or turn on the hallway light over Resident #3's door. Resident #3 repeatedly continued to activate the call light before wheeling herself to her roommate's bed [Resident #18], where she repeatedly attempted to activate Resident #18's call light, which also was not working. Two unidentified CNAs were observed walking by Resident #3's room apparently unaware she was attempting to summon staff assistance..

On 7/26/16 at 6:45 pm, Resident #3 attempted to activate the call light on both her own, as well as, her roommate's bed. At this time, the DON was observed at the nurses' station. The DON was seen walking towards Resident #3's room. When asked if she was aware Resident #3's call light not working, the DON stated, "I was not aware of the call lights not working." The DON entered Resident #3's room, pushed the call light button herself and stated, "They are not turning on.

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They are not working. I don't know why. If I pull it out of the wall socket it works, but when I push the button it doesn't work." At this time, Resident #3 was heard yelling, "I need to pee. I need to pee."

On 7/26/16 at 6:50 pm, the DON walked out of Resident #3's room and said, "It must be something in the wall." The DON walked to the nurses station and stated, "They are not lit up at the board at the nurses station for either [bed in the resident's room]. At this time, Resident #3 was again observed attempting to activate the call light on her- and her roommate's [Resident #18's] bed. The DON went into the next, vacant room, took that call light out, and tried unsuccessfully to test it in Resident #3's room. From 6:20 pm to 6:50 pm, Resident #3 continued her attempts to activate her call light while yelling out, "I need to pee."

On 7/26/16 at 6:50 pm, the Administrator walked into Resident #3's room, attempted to activate the call light, and stated, "Oh my, that is a problem. It looks like it's broken." The Administrator was observed pushing the call lights for both residents in the room, neither of which was operable. When asked if he was aware of the non-functioning call lights, the Administrator stated, he was not.

On 7/26/16 at 7:05 pm, the Administrator stated, "If the aides are aware of a call light not working, then they are supposed to be writing that in a communication book. We do have rounding sheets we use, and I guess we will have to add call lights to those sheets." The Administrator then stated, "A call light is important and

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F 463	Continued From page 55 maintenance would take care of those first." When he unsuccessfully attempted a different call light obtained from elsewhere for either bed in the room, the Administrator stated, "This one is not working either. I will have to get another one." At 7:15 pm, the Administrator attempted a third set of call lights, which also failed to activate the audible alert at the nurses' station or the hallway light above the residents' door. On 7/26/16 at 8:30 pm, the Administrator stated, "I now added call buttons to be actually tested to the maintenance room rounds form. I think [staff] were probably just doing a visual look at the call light without actually checking it to see if it is working." On 7/27/16 at 9:30 am, the Maintenance Director stated, "The last time I did my rounds was on 7/19/16. At that time, the call lights were working. We have a maintenance book that I expect staff to write things down in, and I expect to know things immediately if they are not working. Nothing was reported to me about call lights not working." During an interview with Resident #3's family member on 7/27/16 at 9:45 am, the family member stated the call light had not been working for a "couple" of months and that she told an unidentified nurse and the response from the nurse was, 'We'll get someone to work on it.' Whenever I came in to visit, I never saw anyone working on the call lights or checking them. I thought by now they would have had someone check it."	F 463		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS	F 468		8/22/16

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F 468	Continued From page 56 The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure handrails were securely attached to walls. This had the potential to affect 5 of 12 sample residents (#5, #6, #8, #11, #12), 1 random resident (#30), and other residents who moved about the North Unit hallways. The failure had the potential for more than minimal harm if residents sustained injury related to unsecured handrails. Findings included: On 7/25/16 from 10:50 am to 1:15 pm and 2:40 pm to 4:00 pm, Resident #5, #6, #8, #11, #12, and #30 were observed moving about the North Unit hallways. On 7/25/16 at 4:15 pm, the handrail between Room 22 and the window by the exit door was observed unsecured. The end of the handrail nearest Room 22 pulled off the wall bracket completely when the surveyor tugged on it. On 7/25/16 at 4:20 pm, the middle bracket on the handrail between Room 30 and the shower room was observed loose and it rattled when the handrail was tugged. On 7/25/16 at 4:40 pm, RN #2, who was in the area, said the middle bracket was loose on the handrail between Room 30 and the shower room.	F 468	The facility will ensure that corridors have firmly secured handrails on both sides. There were no residents adversely affected by the deficient practice. The handrails were immediately secured upon knowledge that they were loose. The stability of handrails have been added to our weekly maintenance rounds. There was an inservice on 8/10/16 on reporting loose handrails. The training will be reviewed in the general staff meeting and will continue to be a reminder each month X3 and quarterly X3. The training and the maintenance round sheets will be reviewed by the quality assurance committee monthly X 3, and quarterly X 3. The Administrator will be responsible to ensure the plan of correction is implemented and followed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135081	A. BUILDING _____ B. WING _____	07/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINI-CASSIA CARE CENTER	1729 MILLER AVENUE BURLEY, ID 83318

(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 468	Continued From page 57 On 7/25/16 at 4:45 pm, RN #2 accompanied the surveyor to the handrail between Room 22 and the window by the exit door. The RN pulled on the end of the handrail nearest to Room 22 and it came off the wall bracket. RN #2 said she would notify the Administrator. On 7/25/16 at 4:50 pm, the end of handrail nearest to Room 22 was observed to come off the wall bracket when the Administrator tugged on it. The Administrator said the unsecured handrails would be repaired right away.	F 468		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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January 10, 2017

Darrin Radeke, Administrator
Mini-Cassia Care Center
PO Box 1224
Burley, ID 83318

Provider #: 135081

Dear Mr. Radeke:

On **July 29, 2016**, an unannounced on-site complaint survey was conducted at Mini-Cassia Care Center. The complaint was investigated during the federal recertification survey conducted at the facility July 25, 2016 through July 29, 2016.

An initial tour of the facility was conducted when the survey team entered the facility on July 25, 2016. Resident rooms and common areas as well as staff interactions with residents in general were observed throughout the survey. Six licensed nurses and seven Certified Nursing Assistants were observed as they provided care to eight individual residents.

The clinical records of fifteen residents, including the identified residents, were reviewed for quality of life and quality of care issues. The facility's Incident and Accident Reports, grievance files and investigations of allegations of abuse, all for October 2015 through July 2016, were also reviewed.

Interviews were conducted with four individual residents, nine residents in a Resident Group Interview and an interested party for two residents. Interviews were also conducted with several licensed nurses and Certified Nursing Assistants, as well as the Director of Nursing, regarding quality of life and quality of care issues. In addition, the Administrator, Resident Services Coordinator, an Occupational Therapist, a housekeeper, three CNAs, two licensed nurses, and the Activity Director were interviewed about abuse prevention.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007221

ALLEGATION #1:

An identified resident was ambulatory and active at baseline and known to be verbally disruptive. In the month since admission to the facility, s/he has been medicated and is now in a wheelchair and has had several falls.

FINDINGS:

The clinical record documented the identified resident had a history of falls prior to admission to the facility, was admitted with psychotropic medications for behavioral disturbance, including delusions, and pain medication in place. The record documented decline in the resident's cognitive and physical condition related to advanced dementia and that psychotropic and pain medications were adjusted according to the resident's needs. The record documented five falls while the resident was ambulating or in a wheelchair. The facility developed and implemented care plans for behavior monitoring and the use of psychotropic medications, pain monitoring and pain medication use, and for falls on admission and modified and implemented care planned interventions as needed.

Deficient practice was not identified and the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

An identified resident filed a grievance against a nurse who was demeaning and treated him/her like a child. It should have been treated as abuse. The grievance was resolved to the resident's satisfaction.

FINDINGS:

The identified resident was interviewed and said s/he had a good relationship with the nurse in question. The allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

An identified resident intrusively wanders, urinates "all over the facility," and is not adequately supervised.

FINDINGS:

The clinical record documented the identified resident wandered into other resident rooms and urinated in various places when first admitted to the facility. The facility made an immediate room change two days later for "roommate comparability" and started one-to-one care on day four. The facility also moved the resident to the "quieter hall" for reduced stimulation but quickly resumed the one-to-one care when the move was not successful. Deficient practice was not identified and the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

David Scott, R.N., Supervisor
Long Term Care

DS/lj