



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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August 26, 2016

Rick Myers, Administrator
Life Care Center of Sandpoint
1125 North Division Street
Sandpoint, ID 83864-2148

Provider #: 135127

Dear Mr. Myers:

On **August 12, 2016**, a survey was conducted at Life Care Center of Sandpoint by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 6, 2016**. Failure to submit an acceptable PoC by **September 6, 2016**, may result in the imposition of penalties by **September 30, 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 16, 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 **November 10, 2016**. A change in the seriousness of the deficiencies on **September 26, 2016**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **November 10, 2016** includes the following:

Denial of payment for new admissions effective **November 10, 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 **February 8, 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 **November 10, 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>

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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 **September 5, 2016**. If your request for informal dispute resolution is received after **September 5, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The "D" is stylized with a vertical line through it, and "Scott" is written in a cursive-like font.

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

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

PRINTED: 09/19/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2016
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1125 NORTH DIVISION STREET SANDPOINT, ID 83864		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey and complaint investigation of your facility completed August 8, 2016 to August 12, 2016.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator Ina Tso, RN Marcia Mital, RN</p> <p>Abbreviations: ALF = Assisted Living Facility BFS = Bureau of Facility Standards BIMS = Brief Interview for Mental Status BP = Blood pressure BPSD = Behavioral or Psychological Symptoms of Dementia cc = cubic centimeter CNA = Certified Nursing Assistant CS = Central Supply COPD = Chronic obstructive pulmonary disease CVA = Cardiovascular Accident DC'd = Discontinued DFS = Director of Food Service DON = Director of Nursing DVT = Deep Vein Thrombosis MAR = Medication Administration Record MDS = Minimum Data Set ml = milliliter mg = Milligram(s) P&P = Policy and Procedure PRN = As Needed PT/INR = ProTime and International Normalized Ratio RCM = Resident Care Manager SOAP Note = Subjective, Objective, Assessment, & Plan</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

09/02/2016

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

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F 000	Continued From page 1 subQ = Subcutaneous	F 000			
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review, and policy review, it was determined the facility failed to ensure 1 of 14 sample residents (#3) were assessed to safely self-administer medications. The deficient practice created the potential for Resident #3 to receive less than optimal benefit from the medication. Findings include: The facility's Self-Administration of Medications P&P, revised June 2008, documented, "Each resident who desires to self-administer medication is permitted to do so if the facilities [sic] interdisciplinary team has determined the practice would be safe..." and "...an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability..." Resident #3 was readmitted to the facility on 3/25/16 with diagnoses that included COPD. Resident #3's quarterly MDS assessment, dated 6/16/16, documented she had moderately impaired cognition, her decisions were poor, and she required cues/supervision.	F 176	1) Resident #3 self-administration of medication assessment completed. 2) Residents with nebulizer treatments are at risk for this deficient practice. House-wide audit to identify residents who have the ability to self-administer nebulizer treatments. These residents will have self-administration of medication for nebulizers assessments completed. 3) In-service to nursing staff will be provided that residents with nebulizer orders that are able to self-administer must have a self-administration assessment completed. 4) DON, or designee, will audit to make sure that residents who are able to self-administer nebulizer have a completed assessment form. This will be done two times weekly for three weeks. Then weekly for four weeks. Then monthly for three months. 5) Audits will be taken to Quality	9/15/16	

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F 176	Continued From page 2 An 8/5/16 Telephone Order changed Resident #3's Albuterol/Ipratropium nebulizer treatments to 3 times daily PRN and documented, "LN to set-up, OK for resident to self administer." On 8/10/16 at 10:00 am, Resident #3 said that nurses set-up and start nebulizer treatments then leave and come back after it is finished. On 8/12/16 at 9:10 am, LPN #1 said Resident #3 self-administered the PRN Albuterol/Ipratropium nebulizer treatments, but she could not locate the assessment of his ability to do so. LPN #1 requested medical records assistance to locate an assessment and said she would provide the assessment if it was found. An assessment of Resident #3's ability to self-administer medications was not found in Resident #3's medical record or provided by the facility.	F 176	Assurance meetings for three months and reviewed to determine ongoing education needs, as needed.		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, policy review, and record review, it was determined the facility failed to ensure staff asked permission before going through, and removing, residents' personal belongings. This was true for 1 of 14 sample residents (#13) and 1 random resident (#20). This created the potential for psychosocial harm when the residents expressed concern that	F 241	1) Staff involved apologized to resident #13 and resident #20, during the survey. 2) Other residents will have rights protected by not having items removed from their room without residents' permission.	9/15/16	

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F 241	<p>Continued From page 3</p> <p>their privacy was violated. Findings include:</p> <p>The facility's Preservation of Residents' Rights P&P documented, "All associates are responsible for the preservation of residents' rights..." The Dignity P&P documented staff were to respect residents' "private space and property (i.e., changing the radio or television station only upon a resident's request, asking permission to access residents' drawers, cabinets, and closets)."</p> <p>On 8/10/16 at 11:45 am, Resident #13 and Resident #20 said their privacy had been "violated" an hour earlier by RCM #3. Resident #13 said Resident #20 was not in the room at the time when she, Resident #13, awakened and saw RCM #3 going through her drawers. Resident #13 said she asked the RCM what she was doing and the RCM said she was looking for "butt cream" then the RCM went through Resident #20's drawers. The residents said they were not missing items from their drawers. However, Resident #20 said she was missing a box of Salonpas containing 6 patches and a large bottle of Curel lotion and that both were in her bathroom that morning. Resident #20 said she had not used the Salonpas for a "long time." Both residents said they want to be asked, and present, if staff go through their things.</p> <p>The quarterly MDS assessment, dated 6/20/16, documented Resident #13's cognition was intact.</p> <p>The quarterly MDS assessment, dated 7/6/16, documented Resident #20's cognition was intact.</p> <p>On 8/11/16 at 6:20 pm, RCM #3 said she would not open residents' drawers or take their things</p>	F 241	<p>3) In-service will be provided to staff on resident rights and the need to inform resident, and obtain permission, prior to removing residents' personal items from resident rooms.</p> <p>4) Social Services, or designee, will interview five random residents, that are able to be interviewed, per week for four weeks. Then monthly for three months to ensure staff is asking permission to remove personal items, prior to removal. Resident council will be interviewed monthly for three months to ensure residents feel staff is asking for permission prior to removing personal items.</p> <p>5) Audits will be taken to Quality Assurance meetings and reviewed to determine ongoing education needs, as needed.</p>		

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F 241	<p>Continued From page 4</p> <p>without their permission. The RCM said the CS staff member found Salonpas patches in Residents #13 and #20's bathroom on 8/11/16 and brought them to her because over-the-counter medications cannot be left in a resident's room for safety reasons.</p> <p>On 8/11/16 at 7:25 pm, the CS staff member said that after Grand Rounds, 8-to-11 staff go on walking rounds throughout the facility to check on residents, tidy their rooms, and replace expired items, if needed. The CS staff member said 1 staff goes into her/his assigned rooms, and on 8/10/16, between 9:30 am and 10:00 am, she went into Resident #13 and Resident #20's room. She did not recall if either of the residents were present but said Resident #20 may have been at Bingo at the time. The CS staff member said she noticed Salonpas patches in the residents' bathroom which were going to expire in 2 weeks so she brought them to the RCM. The CS staff member said she did not see a bottle of Curel lotion and she was sorry she did not tell Resident #20 she took the Salonpas patches.</p> <p>On 8/11/16 at 7:45 pm, the DON said the facility is the residents' home environment and for their safety, unsecured medication(s) are removed from resident rooms. The DON said the facility did not follow through and inform the resident this time, but that this occurrence was an isolated incident.</p> <p>On 8/12/16 at 10:45 am, Resident #20 said she had not used Salonpas patches for "about a year," but she kept some in a basin to the right of the bathroom sink. She said the box of Salonpas patches was "down in the basin" behind a bottle</p>	F 241			

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F 241	Continued From page 5 of shampoo. Resident #20 said everything in the basin was spread out "like they [staff] were digging for something" and that she found the bottle of Curel lotion laying flat in the bottom of the basin. The resident said she kept the bottle of lotion standing upright to make it easier to reach. Resident #20 said she was "so upset that someone went through my stuff" that she did not initially see the bottle of lotion.	F 241			
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation and resident interview, it was determined the facility failed to ensure meals provided met the preferences for 5 of 14 residents in a Resident Group Interview and 1 random resident (#18). Failure to honor residents' meal choices created the potential for psychological distress and weight loss when residents were served foods they disliked. Findings include: 1. On 8/9/16 at 2:00 pm, 5 of 14 residents who attended a Resident Group Interview said they were frequently served foods they did not like. 2. On 8/9/16 at 5:05 pm, Resident #18 was	F 242	1) Meal cards were audited to verify accuracy with residents' likes and dislikes. Staff were in-serviced to honor resident #18's meal card and not serve him foods he disliked. 2) Residents who eat meals in the facility are affected by this practice. Quarterly follow-ups with residents will be conducted by the dietary department to ensure the accuracy of the residents' meal cards. 3) In-service training will be conducted with dietary cooks on preparing food that	9/15/16	

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F 242	Continued From page 6 served cooked spinach. Resident #18's meal card on the table documented he disliked spinach. At 5:08 pm, Resident #18 looked at the spinach and stated, "I never cared for it". Maintenance Director #2, who was in the vicinity at the time, told the resident he would order a new plate of food without spinach.	F 242	matches the meal cards, with dietary aides to double check that prepared meals match the meal cards (prior to being served), and with staff serving the meals on procedures for getting meal cards changed when requested by the residents.		
F 252 SS=D	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 and staff interview, it was determined the facility failed to provide a clean environment in 2 of 3 shower rooms used by residents. This had the potential to affect 23 residents on the 400 unit and 41 residents on the 100 unit. The deficient practice created the potential for residents to experience a decreased sense of self-worth due to the lack of environmental cleanliness. Findings include: During the environmental tour on 8/12/16 at 8:05 am with the Maintenance Director and the Assistant Maintenance Director, the following	F 252	4) Dietary Service Manager, or designee, will conduct random weekly audits of ten meal cards for four weeks, then monthly for three months to verify accuracy of meal cards. 1) Residents who take showers in the facility are affected by this practice. Maintenance personnel will repair identified damaged/missing grout. 2) Staff will be in-serviced on promptly reporting damaged/missing/dirty to maintenance and/or housekeeping staff. 3) The Housekeeping Director will monitor the cleanliness of the showers on a weekly basis.	9/15/16	

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F 252	Continued From page 7 was observed: 400-hall shower room: * The right shower stall had a black substance on the bottom of all three walls where the floor and wall met. The grout was missing between the tiles in the center of the floor from the right wall to the left wall. * The left shower stall had missing grout approximately one-foot-by-two-foot between the tiles on the floor. 100-hall shower room: * The shower stall had a black substance on the bottom of the left wall where the floor and wall met. The Maintenance Director and Assistant Maintenance Director acknowledged the above issues in the shower rooms during the environmental tour.	F 252	4) Administrator and maintenance department conducted an audit of the three resident showers for missing/damaged grout. Missing/damaged grout has been added to the maintenance department's monthly "The Equipment Lifecycle System" (TELS) report.		
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 record review, staff interview, it was determined the facility failed to ensure an anticoagulant medication was continued for 1 of	F 309	1) Resident #15 was discharged prior to survey.	9/15/16	

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F 309	<p>Continued From page 8</p> <p>5 sample residents (#15) reviewed for admission, transfer, or discharge. The failure increased the risk for the resident to develop blood clots, which could lead to DVT, stroke, and other adverse outcomes. Findings include:</p> <p>Resident #15 was admitted to the facility from home on 9/17/15, with diagnoses including dementia and chronic atrial fibrillation.</p> <p>Resident #15's list of home medications, dated 9/12/15, included Coumadin 7.5 mg every day except for Tuesdays and Saturdays when he received 5 mg.</p> <p>Resident #15's admission orders to the facility, dated 9/14/15, did not include Coumadin.</p> <p>A 10/6/15 physician SOAP Note documented the family asked about Resident #15's medications on 10/6/15 and wanted to know the results of a PT/INR [a blood test that measures how long it takes blood to clot]. The note documented, "He apparently has been on Coumadin for the last several years for his atrial fibrillation but it looks as though he has not been getting it since he got here ... family ... aware ... they're willing to allow us to use Lovenox to Bridge him until he can get his pro time [PT] back to a normal level ... we will try and reestablish his usual doses."</p> <p>On 10/6/15 at 10:00 am, the physician ordered Coumadin 10 mg by mouth "today only," then Coumadin 7.5 mg by mouth daily except 5 mg on Tuesday and Saturday, INR on 10/6/16, and Lovenox 40 mg by subcutaneous [under the skin] injection 1 time "now and until INR [greater than] 2.0."</p>	F 309	<p>2) Other residents who have been admitted from home within the last 30 days will be identified and have home medication list and current physician orders compared to ensure accuracy. Any discrepancies will be reported to the physician immediately.</p> <p>3) In-service will be provided to nursing staff to compare home medication list with physician admission orders for accuracy. Any discrepancies are to be immediately reported to the admitting physician.</p> <p>4) DON or designee will audit new admissions from the home setting for three months. Audit will be to compare home medication list with physician admission orders paying special attention to anticoagulants within 24 hours of admission. Any discrepancies will immediately be reported to the admitting physician for clarification.</p> <p>5) Audits will be taken to Quality Assurance meetings and reviewed to determine ongoing education needs, as needed.</p>		

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FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 9</p> <p>On 10/6/15, Resident #15's INR was 1.1.</p> <p>On 10/6/15 at 1:15 pm, the physician ordered PT/INR in the morning and every morning until further notice.</p> <p>On 10/7/15, Resident #15's INR was still 1.1 and Coumadin was changed to 10 mg daily.</p> <p>On 10/8/15, Resident #15's INR was 1.3 and Coumadin 10 mg daily was continued.</p> <p>A 10/8/15 physician SOAP Note documented, "...started back on his Coumadin which was inadvertently discontinued ... on Lovenox in addition to Coumadin ... not having any unusual bleeding or bruising ... has confusion but he has no other new neurologic symptoms."</p> <p>On 10/9/15, Resident #15's INR was 1.4, and Coumadin 12.5 mg times 1 dose was ordered.</p> <p>On 10/10/15, Resident #15's INR was 1.9, and Coumadin was decreased to 7.5 mg daily.</p> <p>On 10/11/15, Resident #15's INR was 2.1, Coumadin 7.5 mg daily was continued, and Lovenox was DC'd.</p> <p>On 10/12/15, Resident #15's remained 2.1, Coumadin was changed to 7.5 mg daily, except 5 mg only on Tuesday and Saturday, and an INR was ordered for 10/14/15.</p> <p>On 10/12/15, Resident #15 was discharged to an ALF. The discharge instructions, including the medications and a PT/INR for 10/14/15, were</p>	F 309			

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F 309	Continued From page 10 given to Resident #15's family. Resident #15 was at increased risk for CVA, DVT, and other adverse outcomes when Coumadin was not continued at the time of admission to the facility and he was subjected to repeated daily lab blood tests (7 total) and daily subcutaneous injections (6 total) to correct the issue. On 8/12/16 at 11:45 am, the DON said the facility missed the Coumadin when Resident #15 was admitted to the facility. On 8/15/16 at 4:58 pm, the BFS received an e-mail from the facility, which included a letter from the facility physician regarding Resident #15. The physician's letter documented, "...there was some concern about his falls risk. Coumadin was on his discharge list of medications ... I had anticipated a visit with the family to talk about the risk and benefit of this medicine during his stay. I thought that the risk of the medicine might be starting to outweigh its benefits so I initially kept it off his list. I did not get back to his family right away to discuss my concerns ... when I did discuss this medicine they were upset that he had been taken off this medicine ..."	F 309			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		9/15/16	

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F 323	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of I&As, policies, and residents' records, it was determined the facility failed to ensure risks to residents' safety were identified and interventions were implemented to reduce those risks. This deficient practice created the potential for: a) Residents to experience serious burns when coffee served to them ranged from 157.1 to 162.9 degrees Fahrenheit (F). This was true for 36 random residents who drank coffee. b) A resident to be entrapped or otherwise harm by the use of side rails, when Resident #9 was allowed to use side rails without completion of a side rail safety assessment to verify she could safely do so. This was true for 1 of 20 sampled residents (#9). Findings include: The facility's "Nutritional Services - Suggestions on Nutrition Services for General Orientation" policy documented hot beverages, soup, and cereal should not be served to the resident if in excess of 155 degrees F. This policy was not followed. Examples include: 1. On 8/10/16 at 10:55 am, with the DFS present, a coffee maker in the clean linen room on the 400 unit was observed. The DFS poured	F 323	a) 1) Coffee makers intended for resident service, outside of the dietary department, were removed. 2) Coffee intended for residents will come from the dietary department. Dietary staff will place coffee in appropriate dispensers, ensuring the coffee temperature is 155 degrees or lower, and distribute to the staff in the dining room and nursing stations to serve to the residents. The coffee temperatures will be recorded on a log. 3) Dietary staff will be in-serviced on appropriate serving temperatures. 4) Staff will be in-serviced on appropriate places to obtain coffee for residents. 5) Dietary Manager, or designee, will audit the temperature log for completion and accuracy twice a week for four weeks and then weekly for three months. b) 1) Resident #9 had assessment for grab bars completed. 2) House-wide audit of assessments for residents with grab bars in use completed.		

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F 323	<p>Continued From page 12</p> <p>coffee from the coffee maker into a plastic cup and measured the temperature of the coffee at 162.9 degrees F. The DFS stated the coffee was on the "hot side," staff put lids on cups to prevent spills, coffee temperatures were monitored, and the coffee maker's brewing/heating temperature could not be adjusted.</p> <p>On 8/10/16 at 4:35 pm the DFS poured coffee into a cup from the coffee maker in the 200-unit and measured the temperature at 157.1 degrees F. She stated the 200-unit coffee maker's brewing/heating temperature was preset and could not be adjusted.</p> <p>Hot fluids in excess of 157.1 degrees F result in third degree burns within 1 second of skin contact [American Society for Sanitary Engineering].</p> <p>On 8/9/16 at 2:00 pm, 1 of 14 residents attending a group interview stated he had spilled coffee on himself when he first arrived in the facility.</p> <p>On 8/10/16 at 4:55 pm, RCM #3 stated she served residents coffee with a lid on the cup from the coffee pot in the linen room.</p> <p>On 8/10/16 at 5:25 pm, RCM #1 stated coffee temperatures from the coffee makers in the sub-acute nutrition room were not monitored prior to serving it to residents.</p> <p>On 8/10/16 at 5:55 pm, CNA #4 stated she served residents coffee in lid-covered cups from the coffee pot in the nutrition room.</p> <p>On 8/10/16 at 5:57 pm, CNA #7 stated coffee</p>	F 323	<p>3) Staff in-serviced to ensure residents with grab bars on their beds have assessments completed, prior to grab bars being placed on bed.</p> <p>4) DON or designee will conduct monthly audits, for three months, on admissions with grab bar orders to ensure the assessments have been completed.</p> <p>5) DON or designee will audit alternating units weekly for four weeks, then monthly for three months to ensure grab bar assessments are complete.</p> <p>6) Audits will be taken to Quality Assurance meetings and reviewed to determine ongoing education needs, as needed.</p>		

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F 323	<p>Continued From page 13</p> <p>was served as residents wanted it and that staff put lids on the cups of residents with tremors, but that not all residents received lids.</p> <p>On 8/10/16 at 6:02 pm, CNA #6 stated she served residents coffee in lid-covered cups from the nutrition room.</p> <p>On 8/10/16 at 6:05 pm, CNA #1 and CNA #2 stated they pour the coffee and take it to residents in lid-covered cups.</p> <p>On 8/11/16 at 7:57 am, CNA #9 stated she served residents coffee in lid-covered cups from the nutrition room and would remind residents the coffee it might be a "little warm."</p> <p>On 8/11/16 at 7:59 am, CNA #10 stated she served residents coffee in lid-covered cups from the nutrition room.</p> <p>The facility was asked for, but did not provide, written documentation that hot beverage temperatures had been monitored on the 3 units (100 subacute, 200 and 400) or that staff were trained to cool the coffee before giving it to residents.</p> <p>On 8/11/16 at 10:20 am, during a meeting with the Regional Vice President (RVP), Administrator, DON, DFS, and consultant registered dietician (RD), the RVP voiced agreement that coffee served above 155 degrees F was not in keeping with the facility's policy or the regulations.</p> <p>2. Resident #9 was admitted to the facility on 6/15/16, and readmitted on 7/15/16, with</p>	F 323			

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F 323	Continued From page 14 diagnoses that included left pelvic fracture, osteopenia, and macular degeneration. Resident #9's 6/21/16 admission MDS assessment documented she was cognitively intact, required extensive assistance from 2 staff with bed mobility, and required limited assistance from 1 staff with transfers. Two 1/4 side rails were observed in the raised position on Resident #9's bed on 8/8/16 at 5:55 pm, on 8/9/16 at 11:15 am and 2:15 pm, and on 8/10/16 at 9:30 am. On 8/10/16 at 9:30 am, Resident #9, who was not assessed for safety with the side rails, said she used the side rails. On 8/10/16 at 2:30 pm, RCM #1 accompanied the surveyor to Resident #9's room and said side rails were indeed on Resident #9's bed. RCM #1 reviewed Resident #9's clinical record and was unable to locate a side rail safety assessment.	F 323			
F 329 SS=D	483.25(I) 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	F 329		9/15/16	

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F 329	<p>Continued From page 15</p> <p>who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a) Residents did not receive unnecessary blood pressure medications. This was true for 1 of 20 residents (#1) whose medications were reviewed. b) Non-pharmalogical interventions were initiated prior to administering antianxiety medications. This was true for 3 of 5 residents receiving antianxiety medications (#4, #12, and #14). These deficient practices created the potential Resident #1 to experience seriously low blood pressure and for residents to experience adverse outcomes from medications they do not require for optimal physical or mental health. Findings include:</p> <p>1. Resident #1 was admitted to the facility with diagnoses of hypertension, dementia, and liver cancer.</p> <p>Recapitulated physician orders for August 2016 documented Resident #1 received Metoprolol 25</p>	F 329	<p>1) Resident #1 discharged. Resident #14 is being offered alternate bathing methods. Ativan has been discontinued. Resident #12 non-pharmacological interventions are being documented prior to administration of PRN Ativan. Resident #4 diagnosis for Ativan has been clarified. Non-pharmacological interventions documented prior to administration of PRN Ativan.</p> <p>2) Other residents with PRN Ativan orders audited to ensure non-pharmacological interventions documented prior to administration of PRN Ativan.</p> <p>3) Staff in-service on proper documentation and initiation of non-pharmacological interventions prior to administration of PRN Ativan.</p> <p>4) DON or designee will audit that</p>		

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F 329	<p>Continued From page 16</p> <p>mg twice daily, which was to be held when Resident #1's systolic blood pressure exceeded 120. Losartan 50 mg daily was, also, ordered to be held when Resident #1's systolic blood pressure exceeded a 120.</p> <p>The August 2016 MAR documented Resident #1's systolic blood pressure was not assessed prior to Losartan administrations on:</p> <ul style="list-style-type: none"> * 8/1/16 * 8/3/16 * 8/4/16 * 8/7/16 <p>Resident #1's systolic blood pressure was not assessed prior to Metoprolol administrations on:</p> <ul style="list-style-type: none"> * 8/1/16 at 8 am and 8 pm * 8/3 at 8 am * 8/4 at 8 am * 8/5 at 8 pm * 8/6 at 8 pm * 8/7 at 8pm <p>On 8/10/16 at 3:50 pm, RCM #2 stated Resident #1's blood pressure had not been assessed on the above dates and times prior to the administration of the two medications.</p> <p>2. Resident #14 was admitted to the facility with diagnoses that included dementia with behavioral disturbances and failure to thrive.</p> <p>Resident #14's significant change MDS assessment, dated 6/9/16, documented her cognition was severely impaired and she did not exhibit behaviors.</p>	F 329	<p>non-pharmacological interventions are documented prior to administration of PRN Ativan. Audit will be conducted two times weekly for three weeks. Then weekly for four weeks. Then monthly for three months.</p> <p>5) DON or designee will audit blood pressures with parameters for appropriate administration. Will audit two times weekly for three weeks. Then weekly for four weeks. Then monthly for three months.</p> <p>6) Audits will be taken to Quality Assurance meetings and reviewed to determine ongoing education needs, as needed.</p>		

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F 329	<p>Continued From page 17</p> <p>A Social Service note, dated 7/12/16, documented the following:</p> <ul style="list-style-type: none"> * Resident was under review by a behavior committee * Currently received Depakote for BPSD * Easily agitated related to an inability to process information * Short- and long-term memory impairment * Physically aggressive with staff at times, but can be redirected with a change in caregivers <p>Nurses' notes, dated 7/25/16, documented Resident #14 was "combative" during a shower that day and exhibited "some aggression" when redirected to her own restroom.</p> <p>Resident #14's ADL flowsheet documented showers on 7/7/16, 7/18/16, 7/25/16, 8/1/16, and 8/8/16. A July 2016 Behavior/Intervention Monthly Flow Record documented Resident #14 did not exhibit behaviors on 7/7/16, 7/18/16, or 7/25/16.</p> <p>The August 2016 Behavior/Intervention Monthly Flow Record documented Resident #14 exhibited behaviors on 8/1/16; those behaviors included hitting, scratching, and/or screaming at staff during cares.</p> <p>A physician's orders, dated 8/1/16, documented Resident #14 was to receive Ativan 0.5 mg for anxiety 30 minutes prior to receiving showers.</p> <p>On 8/11/16 at 11:35 am, RCM #2 stated Resident #14's behavior sheets indicated interventions were working and, therefore, the Ativan should not have been initiated. RCM #2 stated new</p>	F 329			

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F 329	<p>Continued From page 18</p> <p>non-pharmalogical interventions should have been attempted if current efforts were unsuccessful.</p> <p>On 8/12/16 at 10:18 am, Social Worker #1 stated no new interventions were attempted or put into place for Resident #14 prior to the Ativan order.</p> <p>3. Resident #4 was admitted to the facility with diagnoses that included depression, anxiety, and insomnia.</p> <p>Recapitulated physician's orders for August 2016 documented Resident #4 was to receive liquid Ativan 2mg/ml, 1/4-1/2 cc, every 4 hours PRN for anxiety.</p> <p>An 8/3/16 physician's order documented Resident #4 was to receive Ativan 0.5 mg every 6 hours as needed for pain.</p> <p>On 8/10/16 at 9:15 am, RCM #2 stated Resident #4's physician changed the Ativan order because Resident #4 asked for the medication in pill, rather the liquid form.</p> <p>The July 2016 MAR documented PRN Ativan had been administered on 7/3/16 through 7/11/16, 7/13/16, 7/15/16, 7/17/16, 7/23/16, and 7/24/16; on 7/11/16 for insomnia and anxiety; on 7/13/16 for anxiety; and on 7/18/16 Resident #14 requested it for sleep.</p> <p>The July 2016 Behavior/Intervention Monthly Flow Record documented Resident #4 verbalized anxiety on 3/4/16 only, for which staff redirection was effective, and she had not exhibited "anxious body language/actions" during July 2016.</p>	F 329			

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F 329	<p>Continued From page 19</p> <p>The August 2016 MAR documented Resident #14 received PRN Ativan on 8/4/16, 8/5/16, and 8/9/16, and that the medication was administered for anxiety and insomnia on 8/4/16 and 8/5/16; no reason was provided for the 8/9/16 PRN Ativan administration.</p> <p>The August 2016 Behavior/Intervention Monthly Flow Record documented Resident #4 had not expressed feelings of anxiety or exhibited "anxious body language/actions."</p> <p>On 8/10/16 at 9:15 am, RCM #2 stated facility nurses should have documented the intervention on the behavior sheet prior to giving the medication and that the PRN Ativan should not have been administered for insomnia.</p> <p>4. Resident #12 was admitted to the facility with diagnoses that included depression and dementia with behaviors.</p> <p>Resident #12's annual MDS assessment, dated 5/12/16, documented severe cognitive impairment.</p> <p>Recapitulated physician's orders for August 2016 documented Resident #12 was to receive Ativan 0.5 mg every 6 hours PRN for anxiety.</p> <p>Resident #12's July 2016 MAR documented PRN Ativan had been administered on 7/4/16, 7/5/16, 7/8/16, 7/25/16, 7/27/16, and 7/28/16.</p> <p>Narcotic count sheets for July 2016 documented the PRN Ativan was administered to Resident #12 on 7/2/16, 7/3/16, 7/5/16, 7/7/16, 7/11/16,</p>	F 329			

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PRINTED: 09/19/2016
FORM APPROVED
OMB NO. 0938-0391

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F 329	Continued From page 20 7/12/16, 7/18/16, 7/20/16, and 7/21/16. The July 2016 Behavior/Intervention Monthly Flow Record documented non-pharmacological interventions were not attempted prior to PRN Ativan administrations on 7/2/16, 7/3/16, 7/5/16, 7/7/16, 7/11/16, 7/12/16, 7/18/16, 7/20/16, and 7/21/16. The August 2016 MAR documented Resident #12 received PRN Ativan on 8/9/16. Narcotic count sheets for August 2016 documented PRN Ativan was administered to Resident #12 on 8/3/16 and 8/4/16. August 2016 Behavior/Intervention Monthly Flow Records documented no interventions were attempted prior to the PRN Ativan administrations on 8/3/16 and 8/4/16. On 8/11/16 at 4:40 pm, RCM #3 stated she was unable to locate documentation that non-pharmacological interventions were attempted prior to the 8/3/16 and 8/4/16 PRN Ativan administrations. The facility's current Psychotropic Drug Reduction Program policy, dated March 2007, documented "behavior management is used prior to instituting any psychotropic drug therapy or PRN psychotropic drug administration ..." This policy was not followed.	F 329			
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive	F 364		9/15/16	

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F 364	<p>Continued From page 21</p> <p>value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, policy review, and meal tray test review, it was determined the facility failed to ensure foods were palatable for 3 of 14 residents in a group interview. This deficient practice had the potential to adversely affect the nutritional status of residents if they did not eat foods due to poor taste or dislike of them. Findings include:</p> <p>On 8/9/16 at 2:00 pm, 3 of 14 residents attending a group interview said they received cold food meant to be served hot, cold eggs, and melted ice cream. One resident stated the food was "bland."</p> <p>On 8/8/16 at 5:00 pm, 8/9/16 at 8:09 am, 8/9/16 at 4:49 pm, and 8/10/16 at 12:30 pm, uncovered meals were observed as they were delivered from the kitchen to the main dining room on a rolling tray cart.</p> <p>On 8/11/16 at 8:55 am, an uncovered test tray was received by surveyors from the DFS, who measured the temperatures of the following foods: Pureed French toast (135.3 degrees F); pureed eggs (142.7 degrees F); regular-textured French toast (104.1 degrees F); regular-textured eggs (119.2 degrees F); and coffee (133.6 degrees F). Surveyors determined the regular-textured eggs were rubbery and cold, the pureed eggs were grainy and not smooth, the</p>	F 364	<p>1) This practice affects residents that eat meal trays in the facility. Staff will be in-serviced that meals received from the kitchen for dining room service will be promptly taken to the residents for consumption, that food and beverages leaving the dining room should be properly covered, and the procedures for if a resident has concerns about the food temperature.</p> <p>2) Dietary Service Manager, or their designee, will conduct random weekly audits of ten meals for four weeks, then monthly for three months to verify accuracy of meal temperatures. Residents will be asked in resident council if food is being served at palatable temperature for on-going follow-up for three months.</p>		

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F 364	Continued From page 22 regular-textured French toast was barely warm and had a hard crust on two edges, and the pureed French toast was barely warm. On 8/11/16 at 2:00 pm, with the DFS and consultant RD present, the facility's RD stated that food trays to the main dining room were "never" covered, and that covers were only used when trays were sent to resident rooms. The facility's Resident Dining Services policy, dated 1/1/07, documented, "All food, beverages and flatware are completely covered before [being] transported through the hallways." This policy was not followed.	F 364			
F 368 SS=D	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 nourishing snack is served. This REQUIREMENT is not met as evidenced	F 368		9/15/16	

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F 368	<p>Continued From page 23</p> <p>by: Based on observation and staff and resident interview, it was determined the facility failed to ensure residents were offered snacks at bedtime. This was true for 12 of 14 residents who attended a group interview and had the potential to adversely affect residents' nutritional status and comfort. Findings include:</p> <p>On 8/9/16 at 2:00 pm, 12 residents identified as alert and oriented by the facility stated they were not offered a snack at bed time.</p> <p>On 8/9/16 bedtime snacks were not observed being offered to residents from 7:30 pm to 8:28 pm on the 100 unit.</p> <p>On 8/9/16 at 8:22 pm, CNA #4 stated nurse aides had already distributed snacks to those residents who were care planned to receive a bedtime snack. CNA #4 stated bedtime snacks were stored in a cooler with ice in the nutrition room. He stated that other residents not on the distribution list could still receive a bedtime snack upon request. A list with four resident names on it was observed in the nutrition room at the time of the interview with CNA #4.</p> <p>On 8/9/16 at 8:25 pm, LPN #2 stated nurse aides distributed snacks to those residents on the list and that she documented on MARs which residents accepted the snack..</p> <p>On 8/9/16 at 8:28 pm, CNA #3 stated bedtime snacks were distributed to those residents on the list and that she, CNA #3, did not pass snacks to any other residents.</p>	F 368	<p>1) Residents will be offered HS snacks.</p> <p>2) In-service staff that residents will be offered an HS snack.</p> <p>3) DON or designee will select five different residents, that are able to be interviewed, weekly for four weeks, then monthly for three months to ensure residents are being offered HS snacks. On a monthly basis, for three months, residents will also be asked at Resident Council if they are being offered "bedtime" snack.</p> <p>4) Audits will be taken to Quality Assurance meetings and reviewed to determine ongoing education needs, as needed.</p>		

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F 368	Continued From page 24 On 8/10/16 at 10:15 am, the DON stated bedtime snacks were given to those residents on the list and that staff would give snacks to other residents if they asked for one.	F 368			
F 371 SS=D	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 observation, staff interview, and policy review, it was determined the facility failed to ensure pans were clean and dry when stored and that dietary staff followed proper hand hygiene while preparing and serving foods. These deficient practices had the potential to place all residents eating meals prepared in the facility at risk of infections and food-borne illness. Findings include: 1. The US Food Code 4-601.11 - Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils - documented, "Equipment food-contact surfaces and utensils shall be clean to sight and touch. The food contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations."	F 371	1) An additional drying rack was installed in the kitchen, which allowed longer drying time for dishes. 2) Dietary staff will be in-serviced on proper dishwashing and drying procedures, proper hand washing procedures and safe food handling. 3)Dietary Services Manager will ensure dietary staff wear gloves at the appropriate times by conducting random weekly audits of staff for four weeks, then monthly for three months. 4)Dietary services Manager will ensure proper procedures are followed regarding cleanliness and dryness of pots and pans	9/15/16	

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F 371	<p>Continued From page 25</p> <p>The facility's Safe Food Handling policy, dated 1/1/07, documented, "All working surfaces, utensils and equipment are cleaned and sanitized appropriately after each use."</p> <p>On 8/9/16 at 11:20 am, 14 stacks of small and large silver metal pans were observed stacked on metal shelving along the back wall of the kitchen. Several pans on the top of each stack were observed with water dripping from the inside surfaces.</p> <p>On 8/9/16 at 11:35 am, Cook #1 was observed lifting and checking the inside of the pans, which were wet and dripped water onto the shelf below. The inside surfaces of the pans were also observed at this time with baked-on food substances and leftover crumbs. Cook #1 stated the pans were to be dry and clean because food could become contaminated from pans that were not properly cleaned and sanitized. He said wet pans could become moldy and contaminate food.</p> <p>2. The US Food Code, 2-301.14, documented employees must clean their hands and exposed portions of their arms immediately before engaging in food preparation with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles. Hand hygiene was also to be exercised after touching bare human body parts other than clean hands and clean, exposed portions of arms; using the toilet; caring for- or handling service animals or aquatic animals, coughing or sneezing using a handkerchief or disposable tissue, using tobacco, eating or drinking, handling soiled equipment or utensils, during food preparation as often as</p>	F 371	by conducting audits twice a week for four weeks and then weekly for three months.		

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F 371	<p>Continued From page 26</p> <p>necessary to remove soil and contamination and to prevent cross contamination when changing tasks, when switching between working with raw food and working with ready-to-eat-food, before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands.</p> <p>The facility's undated Nutritional Services - Suggestions on Nutrition Services for general orientation policy documented staff were not to "touch areas of utensils, dishware or flatware where food or mouth is placed."</p> <p>The facility's Safe Food Handling policy, dated 1/1/07, documented, "[Staff are to] wash their hands before handling or consuming food. All food is handled carefully to avoid contamination with potentially harmful debris, such as glass. Local, state and federal regulations are followed when handling food."</p> <p>On 8/11/16 at 8:00 am, Cook #2 was observed placing food onto breakfast plates. At 8:20 am, Cook #2 was observed not wearing gloves when he touched his nose, served food, cracked eggs onto a griddle, and touched the left side of his pants. Cook #2 did not wash his hands at any time during the observation. Cook #2 was then observed placing a fried egg on a plate and touching his pants again without washing his hands. At 8:30 am, Cook #2 said he was accustomed to having a towel hanging in the area where he touched his pants, but was not allowed to have the towel while working in this kitchen. When informed he was observed touching his nose during meal service without washing his hands, Cook #2 stated he was</p>	F 371			

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F 371	Continued From page 27 nervous and did not realize he did not observe proper food preparation hand hygiene. On 8/11/16 at 8:15 am, Cook #1 was observed assisting Cook #2 with food preparation. Cook #1 was observed touching the kitchen faucet and pureeing eggs without gloves and without washing his hands between contacts. Cook #1 was then observed touching kitchen equipment without gloves and without washing his hands before touching several utensils on the surfaces that come into direct contact with food. After locating the utensil he was looking for, Cook #1 then returned to preparing the pureed eggs, which he placed in the microwave oven where they were heated before being placed in the steamer. Cook #1 then touched his face, opened and entered the walk-in refrigerator, brought out a box of sausages, and placed two into a bowl which he then placed in the microwave oven. When the sausages finished heating in the microwave oven, Cook #1 placed them into a silver metal pan which he then put onto the steam table. Cook #1 then made a second batch of pureed eggs using the same method. During this second preparation, Cook #1 was observed touching the faucet, wiping his face with his arm, and touching the food contact area of several utensils without washing his hands between non-food and food/food contact surface areas.	F 371			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily	F 514		9/15/16	

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F 514	<p>Continued From page 28 accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure orders were accurately transcribed and a PRN medication was documented on the MAR. This was true for 1 of 14 sample resident (#12) and 1 random resident (#18). This created the potential for negative outcomes when Resident #12's anti-anxiety medication was not consistently documented on the MAR and Resident #18's BP medication was incorrectly marked as discontinued [DC'd]. Findings include:</p> <p>1. On 8/9/16 at 8:05 pm, LPN #4 was observed administering 5 medications, including Clonidine 0.1 mg prescribed to be given twice a day, to Resident #18.</p> <p>On 8/10/16 at 9:00 am, Resident #18's medications were reconciled with the Physician Orders for August 2016. The Clonidine 0.1 mg twice a day by mouth was documented as, "DC'd 7/22/16 New order." A new order for Clonidine was not in the resident's clinical record. However, the resident's MAR documented Clonidine 0.1 mg was administered twice a day from 8/1/16 through 8/9/16 and on 8/10/16 in the morning.</p>	F 514	<p>1) Resident #18 clonidine order obtained. Resident #12 will have Ativan documented on both MAR and behavior sheets.</p> <p>2) Other residents will have recap orders reviewed to ensure clonidine orders are accurate. Other residents with PRN Ativan orders will have Ativan documented on both MAR and behavior sheets.</p> <p>3) LN in-serviced on ensuring complete documentation of PRN Ativan on the MAR and behavior sheets.</p> <p>4) LN in-serviced to ensure medication orders are accurate on both MAR and recaps and to clarify and re-write any unclear orders.</p> <p>5) DON or designee will audit PRN Ativan to ensure documentation is complete on the behavior sheets, MAR, and narcotic log. Audits will be conducted two times per week for three weeks, then weekly for</p>		

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F 514	<p>Continued From page 29</p> <p>On 8/10/16 at 9:05 am, RCM #1 was unable to find a new order for Clonidine. At 9:25 am, the DON reviewed Resident #18's clinical record and was unable to find a new order for Clonidine. The DON said she would check with medical records.</p> <p>On 8/10/16 at 9:50 am, the DON said another medication was DC'd and the Clonidine was marked as DC'd by mistake. The DON said it was not a medication error.</p> <p>The 2014 Clinical Nursing Skills & Techniques, 8th edition, by Perry Potter and Ostendorf, documented the following regarding Evidence-Based Practice, "Accuracy of documentation is necessary to maintain patient safety."</p> <p>2. Resident #12 was admitted to the facility with diagnoses that included depression and dementia with behaviors.</p> <p>The August 2016 recapitulated physician's orders documented Resident #12 received Ativan 0.5 mg every 6 hours as needed for anxiety.</p> <p>The July 2016 MAR documented Ativan had been administered on 7/4/16, 7/5/16, 7/8/16, 7/25/16, 7/27/16, and 7/28/16.</p> <p>July 2016 narcotic count sheets documented Resident #12 also received Ativan on 7/2/16, 7/3/16, 7/7/16, 7/11/16, 7/12/16, 7/18/16, 7/20/16, and 7/21/16. The 8 administrations of Ativan were not documented on the MAR.</p> <p>The August 2016 MAR documented the PRN</p>	F 514	<p>four weeks, then monthly for three months.</p> <p>6) DON or designee will audit PRN Ativan to ensure documentation is complete on the behavior sheets, MAR, and narcotic log. Audits will be conducted two times per week for three weeks, then weekly for four weeks, then monthly for three months.</p> <p>7) Audits will be taken to Quality Assurance meetings and reviewed to determine ongoing education needs, as needed.</p>		

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F 514	<p>Continued From page 30</p> <p>Ativan was administered on 8/9/16.</p> <p>August 2016 narcotic count sheets for the Ativan documented Resident #12 also received the PRN Ativan on 8/3/16 and 8/4/16. The 2 administrations of Ativan were not documented on the MAR.</p> <p>On 8/11/16 at 3:37 pm, RCM #3 stated the nurses should have documented PRN medication on the MAR when given.</p> <p>LippincottNursingCenter.com documented "8 rights of medication administration ...6. Right documentation -Document administration AFTER giving the ordered medication. -Chart the time, route, and any other specific information as necessary ..."</p>	F 514			



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January 6, 2017

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1125 North Division Street,
Sandpoint, ID 83864-2148

Provider #: 135127

Dear Mr. Myers:

On **August 12, 2016**, an unannounced on-site complaint survey was conducted at Life Care Center Of Sandpoint. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007175

The complaint was investigated during the federal recertification survey conducted August 8, 2016 through August 12, 2016 at the facility.

Allegation #1: The facility said they could care for residents with dementia but after two weeks they said they could not meet the needs of an identified resident's wandering. The facility would not come up with appropriate care plan to address the wandering. Nurses said the wandering was not obtrusive and it was related to confusion and newness to the facility. The facility would not use stop signs and would not reinstate Clonazepam to help control the resident's wandering.

Findings #1: The resident identified by the Reporting Party no longer lived at the facility at the time of the investigation.

The identified resident's closed clinical record and the records of six other residents with similar behavior issues and/or medication use were reviewed. The facility's Grievance files, Incident and Accident reports, and investigations of allegations of abuse for September 2015 through the first week of August 2016 were also reviewed as were the Resident Council meeting minutes for June through August 2016 and a list of current residents who wandered and were at risk for elopement.

Nine Licensed Nurses and nine Certified Nursing Assistants (CNAs) were observed as they interacted with and/or provided care for ten individual residents. The staff in general were also observed as they interacted with residents in general. Stop signs across exit doorways on the 100 hall and several empty private and semi-private rooms, particularly in the 200 hall, were observed during the investigation.

Four individual residents and fourteen residents in a Resident Group Interview said current residents who wandered were not intrusive. In addition, several nurses, several CNAs, and the Director of Nursing were interviewed. The Social Worker was not available for interview.

Based on observations, resident and staff interviews, and review of clinical records, the facility implemented care planned interventions for the identified resident to wander safely, including signage for the resident's bathroom, redirection with activities in the resident's room or in group activities, hand holding, and line of sight monitoring in the evening. The Director of Nursing said stop signs across resident room doors had been used in the past for intrusive wandering. The Director of Nursing also said a stop sign at every resident's door was requested but was not appropriate. In addition, there were no documented episodes of anxiety for the identified resident; therefore, an anti-anxiety medication was not indicated.

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

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The facility would not place an identified resident in a private room even with an offer to pay the additional expense. The Director of Nursing and the Administrator said the resident was no longer appropriate for the facility and five days later they issued an eviction notice.

Findings #2: The Director of Nursing said there were no private rooms available at the time one was requested for the identified resident. The clinical record documented the facility assisted the identified resident with transfer to an Assisted Living Facility and provided paperwork for the new facility to the resident's interested party.

Based on record review and staff interview, the allegation was not substantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The identified resident never received an admission assessment.

Findings #3: The clinical record contained an admission nursing assessment dated the same day the identified resident was admitted to the facility. The allegation was not substantiated.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

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Allegation #4: The identified resident did not receive Coumadin for several days after admission and the facility had to administer another anticoagulant in order to counteract the missed Coumadin doses.

Findings #4: Based on record review and staff interview, the identified resident's Coumadin was missed for several days and Lovenox was administered when the error was discovered. The allegation was substantiated and deficient practice was cited a F 309.

Conclusion #4: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #5: The identified resident lost some weight due to not eating well. The resident had a good appetite prior to entering the facility.

Findings #5: Clinical record documented the identified resident weighted 185 pounds and his/her body mass index (BMI) exceeded the upper limits when he/she was admitted to the facility. One week after admission the resident gained a pound then lost three pounds two weeks later when diet condiments and half portion desserts were recommended and served. Deficient practice was not identified and the allegation was not substantiated.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,



NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt



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January 6, 2017

Rick Myers, Administrator
Life Care Center Of Sandpoint
1125 North Division Street,
Sandpoint, ID 83864-2148

Provider #: 135127

Dear Mr. Myers:

On **August 12, 2016**, an unannounced on-site complaint survey was conducted at Life Care Center Of Sandpoint. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00007185

The complaint was investigated during the federal recertification survey conducted August 8, 2016 through August 12, 2016 at the facility.

Allegation #1: An identified resident was independent with eating, able to stand with assistance, and signed paperwork when admitted to the facility but declined after admission and needed one on one care. The facility gave the resident heavy doses of sedatives and pain relievers. They were asked them to stop these medications. The resident couldn't participate in aggressive rehab treatment because s/he was heavily sedated.

Findings #1: The resident identified by the Reporting Party no longer lived at the facility at the time of the investigation.

The identified resident's closed clinical record and the records of six other residents with similar behavior issues and/or medication use were reviewed. The facility's Grievance files, Incident and Accident reports, and investigations of allegations of abuse for September 2015 through the first week of August 2016 were also reviewed as were the Resident Council meeting minutes for June through August 2016. In addition, staffing records and schedules for the three week period prior to the survey and for September and October 2015 were reviewed.

Nine Licensed Nurses and nine Certified Nursing Assistants (CNAs) were observed as they interacted with and/or provided care for ten individual residents. Staff interactions with residents in general were also observed.

Four individual residents and fourteen residents in a Resident Group Interview were interviewed in addition to several nurses, several CNAs, and the Director of Nursing. The Social Worker was not available for interview.

The clinical record documented that throughout the identified resident's stay in the facility, s/he required assistance with all activities of daily living, including bed mobility, transfers, ambulation, and eating. The record documented the resident frequently experienced anxiety, restlessness with little to no safety awareness, and pain. Non-pharmacological interventions were implemented with little to no relief and pain and anti-anxiety and pain medications were added with the Reporting Party's consent. The medications, administered on an as needed basis when non-pharmacological interventions did not work, frequently provided some temporary relief. The record also documented the resident was able to participate in therapies with frequent verbal and tactile cueing, but made minimal progress.

Based on observations, resident and staff interviews, and clinical record review, deficient practice was not identified and the allegation was not substantiated.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The identified resident fell eight times when the facility could not provide adequate care to prevent falls, including transferring the resident without the required equipment. New interventions implemented by the facility to prevent falls were ineffective, and the resident sustained minor injuries as a result.

Findings #2: The identified resident's clinical record and the facility's incident and accident reports documented the resident fell eight times while in the facility. The resident's clinical record also documented that fall interventions were care planned and implemented when s/he was admitted to the facility and they were modified or revised after each fall, in accordance with the circumstances of the falls. The modified fall interventions included moving the resident closer to the nurse's station, every fifteen minute checks, placing the resident's mattress on the floor. The facility implemented the use of a mechanical lift for transfers after the eighth fall. The resident was also assessed for pain and anxiety with interventions implemented for those conditions.

Based on observations, resident and staff interviews, and clinical record reviews, it was determined the allegation was substantiated but deficient practice was not identified.

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

Allegation #3: The facility lacked sufficient numbers of CNAs to meet the needs of the residents, including checking on the identified resident every fifteen minutes.

Findings #3: The identified resident's clinical record contained documentation of every fifteen minute checks.

Based on observations, interviews with residents and staff, and record reviews, including staffing records and schedules, there was no evidence the facility lacked sufficient staff.

The allegation could not be substantiated.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: A facility nurse called an identified resident's responsible party and said the facility could not care for an identified resident because s/he resident required too much care. The Director of Nursing confirmed the resident required more care than the facility could provide.

Findings #4: The identified resident's clinical record documented a nurse did call the identified resident's family and say the facility could not provide one on one care. However, the record also documented that brief one to one care was frequently provided when other interventions were not successful.

The Director of Nursing confirmed that the identified resident required more one to one care than the facility was able to provide, therefore the facility initiated a discharge planning process in order to find sufficient placement for the resident. However, a family member decided to take the resident home before discharge planning could be completed.

Based on record review and interview, it was determined the allegation was substantiated but deficient practice was not identified.

Conclusion #4: Substantiated. No deficiencies related to the allegation are cited.

Allegation #5: An identified resident did not receive medically related Social Services, in terms of care plan participation and discharge planning.

Findings #5: There is no regulatory requirement for a care planning conference during first month of a resident's stay.

The clinical record documented the Social Worker assessed the identified resident soon after admission and assisted with discharge planning less than a month later.

The allegation was substantiated but deficient practice was not identified.

Conclusion #5: Substantiated. No deficiencies related to the allegation are cited.

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Allegation #6: An identified resident's discharge was delayed when a physical therapist said the resident could not get in a car.

Findings #6: The clinical record documented the facility attempted to assist the identified resident to get into a private vehicle for transport home, but the resident was unable to safely complete the activity even with assistance. The facility arranged for a van to transport the resident home the next day, with a Certified Nursing Assistant in attendance. The allegation was substantiated but deficient practice was not identified.

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

Allegation #7: An identified resident had not had a bowel movement for four days when s/he was sent home.

Findings #7: The clinical record documented the identified resident had not had a bowel movement in the four days prior to discharge. However, the facility intervened with prune juice or fruit butter on the second day without a bowel movement, but the resident refused milk of magnesia on the third day without a bowel movement, and on the morning of fourth day the resident was discharged home.

The allegation was substantiated but deficient practice was not identified.

Conclusion #7: Substantiated. No deficiencies related to the allegation are cited.

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

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

Sincerely,



NINA SANDERSON, LSW, Supervisor
Long Term Care

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