



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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September 13, 2016

Remick "Mickey" Clark, Administrator
Good Samaritan Society - Idaho Falls Village
840 East Elva Street,
Idaho Falls, ID 83401-2899

Provider #: 135092

Dear Mr. Clark:

On **August 16, 2016**, a survey was conducted at Good Samaritan Society - Idaho Falls Village 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 in your facility to be **ISOLATED** and to constitute immediate jeopardy to residents' health and safety. You were informed of the immediate jeopardy situation verbally on **August 12, 2016** and in writing on **August 15, 2016**.

On **August 18, 2016**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, and an onsite revisit completed on August 30-31, 2016 it was determined that the immediate jeopardy to the residents had been removed.

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.) **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.

Remick "Micky" Clark, Administrator
September 13, 2016
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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 23, 2016**. Failure to submit an acceptable PoC by **September 23, 2016**, may result in the imposition of additional civil monetary penalties by **August 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.
- 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*.

Based on the immediate jeopardy cited during this survey:

F0225 -- S/S: J -- 483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey.

Remick "Micky" Clark, Administrator
September 13, 2016
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We are recommending to the CMS Regional Office that the following remedy(ies) be imposed:

Civil money penalty

Denial of Payment for New Admissions on **November 16, 2016**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 16, 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Your facility's noncompliance with the following:

F0225 -- S/S: J -- 483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents # **#3** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

If you believe the 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, 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.

Remick "Micky" Clark, Administrator
September 13, 2016
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In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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 **September 23, 2016**. If your request for informal dispute resolution is received after **September 23, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nina Sanderson, LSW, Supervisor
Long Term Care

NS/pmt
Enclosures

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

PRINTED: 11/02/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2016
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from August 8, 2016 to August 16, 2016.</p> <p>Immediate Jeopardy to residents' health and safety was identified at:</p> <p>* 42 CFR 483.13(c)(1)(ii)-(iii), (c)(2)-(4) [F225]</p> <p>The facility was verbally notified of the Immediate Jeopardy on 8/12/16 at 5:17 pm, and in writing on 8/15/16 at 1:41 pm. The Immediate Jeopardy was not removed prior to the survey exit date.</p> <p>The surveyors conducting the survey were:</p> <p>Amy Barkley, RN, BSN, Team Coordinator Sherry McElwain, RN Jenny Walker, RN Brad Perry, LSW</p> <p>Definitions include: ADL = Activities of Daily Living BIMS = Brief Interview Mental Status CDM = Certified Dietary Manager cm = Centimeter CNA = Certified Nurses Aide DNS = Director of Nursing GERD = Gastroesophageal Reflux Disease G-tube = Gastrostomy feeding tube I&A = Incident and Accident form kg = kilogram LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set (assessment) mg = milligram</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 09/23/2016
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 NN = Nurses' Notes NP = Nurse Practitioner PHQ9 = Patient Health Questionnaire for Depression ROM = Range of Motion RD = Registered Dietician RN = Registered Nurse SSD = Social Services Director TAR = Treatment Administration Record	F 000			
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.	F 157		10/28/16	

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F 157	<p>Continued From page 2</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure physicians were notified of a significant change in a resident's clinical condition. This was true for 1 of 8 residents (#3) sampled for resident rights and had the potential for more than minimal harm when the facility failed to notify Resident #3's physician that the resident had expressed suicidal thoughts. Findings include:</p> <p>Resident #3 was admitted to the facility with multiple diagnoses, including dementia without behavioral disturbance and depressive episodes.</p> <p>The comprehensive MDS assessment, dated 5/6/16, documented Resident #3 had thoughts that she would be better off dead, or thoughts of hurting herself for 12-14 days of the 14-day assessment period. The assessment documented the Social Services Director was informed there was the potential for the resident to harm herself.</p> <p>Resident #'3 clinical record documented the physician was not immediately notified of the 5/6/16 MDS assessment that identified suicidal-and/or self-harm ideation.</p> <p>Resident #3's clinical record documented:</p>	F 157	<ol style="list-style-type: none"> 1. Resident #3 -Upon notification during survey of licensed staff did a head to toe assessment which was negative. A psychological assessment was completed 8/16/16 by New Horizons Mental Wellness to ensure that statements made of suicidal thoughts were thoroughly investigated. GDR was initiated and medication changes made. Care plan was updated to reflect assessment and findings. 2. All residents have the potential to be affected by this practice. Progress note reviews have been initiated to ensure that physician has been notified of any significant change. 3. Progress notes are being reviewed by Administrative team and Charge nurses to ensure notification of physician for significant changes has occurred. <p>(LN) Licensed nurses were re-educated on 9/16/16 regarding notification of the resident, physician and family (legal representative) when there is a change in the resident's condition, when any accident/incident occurs, a need to alter treatment, or a decision to transfer or</p>		

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F 157	<p>Continued From page 3</p> <p>* 5/6/16: Resident #3 was having thoughts of harming herself and she was placed on 15-minute checks.</p> <p>* 5/12/16: Resident #3 was re-assessed for suicidal ideations, still had thoughts of harming herself, and continued on 15-minute checks.</p> <p>* 5/18/16: Resident #3 stated she continued having thoughts of harming herself, and would remain on 15-minute checks.</p> <p>A faxed communication to the Physician, dated 5/20/16, documented, "Resident [#3] has been having SI [suicidal ideations] since 5/6/16 (has been re-assessed on 5/12/16 and 5/18/16) and remains on 15-minute checks for SI..." On 5/23/16, the physician faxed the facility to re-start Resident #3's antidepressant medication.</p> <p>Resident #3's clinical record failed to document that the physician was notified of her suicidal ideations, expressed on 5/6, 5/12, 5/12, or 5/18/16, until 5/20/16.</p> <p>A Quarterly MDS assessment, dated 7/12/16, documented Resident #3 had thoughts that she would be better off dead, or thoughts of hurting herself for 7 - 11 of the previous 14 days and the Social Services Director was informed there was the potential for the resident to self harm.</p> <p>Resident #3 clinical record documented failed to document that the physician was notified of the 7/12/16 MDS assessment and the resident's expressed thoughts of being better off dead and/or thoughts of harming herself.</p> <p>Resident #3's clinical record documented on 8/1/16, "[Resident #3's family member] called and</p>	F 157	<p>discharge a resident from the facility occurs.</p> <p>4. Audits of progress notes for significant change will be completed by DNS or nursing designee, to ensure the proper notification of physician has occurred. Audits will be done Weekly x 4, then Bi-monthly x 2, then Monthly x 3, Quarterly x 2. All audit results will be reported to QAA Committee for further monitoring and modification based on audit findings.</p>		

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F 157	Continued From page 4 reported to the nurse that the resident had called her and stated she was going to kill herself. [Resident #3] was placed on every 15-minute checks."	F 157			
F 225 SS=J	<p>On 8/12/16 at 1:00 pm, the DNS and SSD did not respond or provide documentation the physician was immediately notified when Resident #3 expressed suicidal ideations. The SSD stated she placed the resident on 15-minute checks after she had assessed, or staff had reported, that Resident #3 was suicidal.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p>	F 225		10/28/16	

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F 225	<p>Continued From page 5</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and review of the facility's abuse policy and procedure, it was determined the facility failed to investigate and report four allegations of abuse to the State Agency involving 1 of 12 sampled residents (#3).</p> <p>The Administrative staff's lack of protective response and investigation of the reported allegations placed Resident #3 and the remaining fifty residents at the facility at risk for abuse/harm. The facility's failed practice resulted in Immediate Jeopardy to residents' health and safety.</p> <p>The facility was notified verbally of the Immediate Jeopardy on 8/12/16 at 5:17 pm and in writing on 8/15/16 at 1:41 pm.</p> <p>Findings include:</p>	F 225	<ol style="list-style-type: none"> 1. Resident #3- On 8/13/16 the Director of Social Services met with resident to discuss any concerns she might have and to verify that she felt safe in our facility. The allegations noted on 3/21/16, 5/10/16, 5/16/16 and 7/25/16 in the counselor's notes were investigated. Incident reports were completed and the State hotline was called for each incident. Staff were re-educated on the process of recognizing and reporting allegations of Abuse to the Administrator immediately, on 8/16/16. 2. All residents have the potential to be affected by this practice. 3. As of 8/16/16 the Senior Counselor and any other Mental Health provider who comes from outside of the facility will exit 		

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F 225	<p>Continued From page 6</p> <p>The facility's Abuse Policy and Procedure contained the following information:</p> <ul style="list-style-type: none"> * When a staff member receives an allegation of abuse and neglect...the staff member will then report it to the supervisor. The charge nurse or licensed nurse will be notified immediately, assess the situation...and complete an initial investigation. If this is an injury of unknown origin he/she will attempt to determine the cause of the injury. * Notify the administrator immediately of any incidents of alleged or suspected abuse and injury of unknown origin. * Notify the designated agencies in accordance with state law, including the state survey and certification agency. * Notify the physician and family regarding the facts of the situation. * The investigation team (social worker, administrator, and the director of nursing services) will review all incidents no later than the next working day following the incident. * The investigation "may" include interviewing staff, residents or other witnesses to the incident. "You may want to have each person write his or her memory of the event." If possible, get signed statements from any witnesses. * The social worker or designated staff will report the results of all investigations to the state survey and certification agency and other officials within five working days of the incident. * The social worker and other staff, as appropriate will provide ongoing support and counseling to the resident and family as needed. <p>Resident #3 was admitted to the facility with multiple diagnoses, including major depressive</p>	F 225	<p>verbally with the Licensed Social Worker (LSW) or Director of Nursing (DNS) if LSW is not available, before leaving the building to ensure all concerns and any potential allegations of abuse or neglect are addressed.</p> <p>When the hard copy provider notes are obtained, LSW and Administrator will review to ensure that all areas identified are followed up and documented.</p> <p>The Psychiatric Mental Health Nurse Practitioner -Board Certified (PMHNP-BC) and Senior Counselor were educated on 8/16/16 and 8/22/16 respectively, regarding the expectation of exiting, in person, with the LSW or DNS prior to leaving the building.</p> <p>4. Audits of progress notes of exit conferences and hard copy provider notes will be completed by The Quality Coordinator or nursing designee, to ensure exit conferences are occurring between the outside mental health providers and the LSW or DNS. Audits will occur Weekly x 4, then Monthly x 11. All audit findings will be reported to QAA Committee for further monitoring and modification based on findings.</p>		

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F 225	<p>Continued From page 7</p> <p>disorder without psychotic features, generalized anxiety disorder, and mild, late onset Alzheimer's disease.</p> <p>Resident #3's MDS assessments for Brief Interview Mental Status (BIMS) included:</p> <ul style="list-style-type: none"> * 11/10/15 - BIMS = 14 or cognitively intact * 2/10/16 - BIMS = 15 or cognitively intact * 5/6/16 - BIMS = 10 or moderate impairment * 7/12/16 - BIMS = 15 cognitively intact <p>Resident #3 received counseling services from an outside provider, whose progress notes included the following:</p> <ul style="list-style-type: none"> * 3/21/16 - "[Resident #3] had a red mark on her head and over her right eye. 'I think someone beat me up!' She said she did not know what happened. Talked with staff and it was noted that Resident #3 had neither fallen or been hit, but she had slept on her head with her arm under her forehead causing a red mark that staff reported to be 'clearing up.'" Resident #3's medical record did not include documentation that the red area was identified and monitored prior to the counseling session. * 5/10/16 - "[Resident #3] told me another resident had 'hit me and cracked some ribs.' She said she had felt afraid of this...I checked out [Resident #3's] report and found out it was not true. She appeared to be upset and I did try to calm her..." * 5/16/16 - "[Resident #3] was noted to have a bruise on her forehead and said, 'It came from another resident hitting me.' [Resident #3] spoke 	F 225			

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F 225	<p>Continued From page 8</p> <p>of 'avoiding him.' Staff reported she had fallen and had not been hit." An Incident Report dated 4/30/16, 16 days prior to the identification of the bruise, documented Resident #3 had fallen but did not state she had hit her head.</p> <p>* 7/25/16 - "[Resident #3] reported she had 'seen someone from Dallis [sic]." She told me, 'Don't go with him!' She would not say what was bothering her, but she seemed to not want anything to do with him. [Resident #3] appeared to feel afraid of the person from Dallis [sic]. She was able to talk about different things, but she was very concerned about the person."</p> <p>The facility's completed abuse investigations and incident reports from August 2015 to August 2016 did not include investigations related to the above allegations of abuse.</p> <p>Resident #3's clinical record from February 2016 to August 2016 did not include documentation related to the identified allegations of abuse.</p> <p>The State Agency's reportable incident faxes from March 2016 to August 11, 2016, did not include notification from the facility related to the identified allegations of abuse.</p> <p>On 8/12/16 at 11:15 am, the DNS stated she did not review the counselor's notes. She said the SSD reviewed the counselor's notes and notified her of any problem or concern.</p> <p>On 8/12/16 at 1:00 pm, the DNS and SSD were interviewed together. The SSD stated she skimmed through the counselor's notes, but did not read the whole note. When asked if they</p>	F 225			

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F 225	Continued From page 9 were aware of the allegations of abuse made by Resident #3, the DNS and SSD stated, "We were not aware of the allegations until now." They stated the allegations should have been identified as allegations of abuse, investigated, and reported to the State Agency. On 8/12/16 at 1:12 pm, the LCSW from the counseling service was interviewed. When asked if he had reported the identified allegations to the SSD he stated, "I know that we talked about them; however, I am not sure if it was that day it happened, that week, or a couple of weeks." He stated he had reported each incident to the nursing staff when it was brought to his attention by Resident #3. On 8/12/16 at 5:17 pm, the Administrator stated he was unaware of the allegations, otherwise they would have been investigated. The facility failed to ensure the identified allegations of abuse were thoroughly investigated. This failure directly impacted Resident #3 and had placed the remaining fifty residents at the facility at imminent risk of abuse.	F 225			
F 250 SS=G	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 250		10/28/16	

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F 250	<p>Continued From page 10</p> <p>Based on staff and resident interview and record review it was determined the facility failed to provide medically realted social services to recognize continued and worsening signs of depression after the discontinuation of an antidepressant medication; implement and revise the resident specific care plan related to depression; and ensure safety notifications were made to a qualified professional to rule out suicidal ideation, intent, or plan. This was true for 1 of 8 (#3) sampled residents. Resident #3 sustained psychosocial harm when she experienced a pattern of feeling "better off dead," which escalated after the her antidepressant was discontinued, without notification or assessment of a qualified professional and without revision of the care plan to address these feelings.</p> <p>Findings include:</p> <p>Resident #3 was admitted to the facility with multiple diagnoses including depression, non-Alzheimer's dementia, and schizophrenia.</p> <p>A Behavioral Committee Drug Review, dated 1/26/16, documented Resident #3 was cognitively intact, was currently taking Zoloft 100 mg daily for mild depression and the depression was "stable."</p> <p>Resident #3's Quarterly MDS, dated 2/10/16, documented:</p> <ul style="list-style-type: none"> - Cognitively intact. - Verbalized feeling tired or having little energy for 7-11 days; poor appetite or overeating for 7-11 days; moved/spoke more slowly than usual or was fidgety and moved around more than usual for 2-6 days; and had mild depression. 	F 250	<p>1. Resident #3's Zoloft was restarted on May 23, 2016. The resident has not expressed suicidal ideation since August 1, 2016, at which time the physician was notified and she was placed on 15 minute safety checks which were maintained until reassessment and removal of the checks on August 9, 2016. There have been no further incidents of suicidal ideation since that time.</p> <p>Senior counseling was notified of the resident status on September 5, 2016 during their visit with the resident. No suicidal ideation reported by the counselor to the facility.</p> <p>The Psychiatric Nurse Practitioner (PNP) was informed of the absence of suicidal ideation during their visit on Sept 7, 2016. No suicidal ideation reported to the facility by the PNP during that visit.</p> <p>Resident #3 was evaluated by a psychiatrist on August 19, 2016 and will be followed quarterly thereafter. The resident will also receive PNP visits every 2 weeks ongoing.</p> <p>2. Residents with diagnoses of depression or other psychiatric disorder have the potential to be affected by this practice.</p> <p>Interviews with and record reviews for all potentially affected residents revealed no reports of suicidal ideation.</p>		

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F 250	<p>Continued From page 11</p> <p>-Resident #3 denied she experienced thoughts she would be better off dead, or hurting herself in any way during the previous 14 days.</p> <p>Resident #3's current Mood care plan documented the following interventions:</p> <ul style="list-style-type: none"> - Monitor, record, and report to health care provider, as needed, risk for harm to self: Suicidal plan; past attempt at suicide; risky actions (stockpiling pills, saying good-bye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgement, or safety awareness. (Initiated 11/15/13) - Non-pharmalogical interventions for depression/self-isolation: Senior counseling weekly, encourage her to participate in activities, reminisce with her about her life/job experiences such as homemaking and speech therapist, and encourage familiar television shows. (Initiated 11/15/13) <p>Resident #3 was admitted to the hospital on 3/27/16 with multiple medical issues and was re-admitted to the facility on 4/8/16. Resident #3 did not have Zoloft included on the re-admission orders.</p> <p>From 4/9/16 through 4/11/16, due to a medication error, Resident #3 received Zoloft 100 mg daily. The Medication Administration Record (MAR) from 4/12/16 through 5/22/16 documented the Zoloft was place on "hold." Resident #3 did not receive an anti-depressant for at least 40 consecutive days.</p>	F 250	<p>Senior counseling notes for all 8 residents provided with services were reviewed with no documented incidents of suicidal ideation noted.</p> <p>Resident not included in the survey sample did express suicidal ideation once on 9/6/16. The physician was notified and 15 minute safety checks were initiated and maintained until reassessment on 9/12/16.</p> <p>Daily record review for reports of Suicidal ideation by both Social Services Director (SSD) and Nursing will be ongoing.</p> <p>3. See the POC at F309 for details on physician orders for system change.</p> <p>The SSD in conjunction with a LN will make all future physician notification, documenting the issues or concerns in progress notes and will also communicate verbally to the interdisciplinary team in the morning stand up meeting.</p> <p>The Administrator will meet formally with the SSD on a weekly basis to ensure performance standards are maintained in regard to recognizing critical concerns, communication and documentation are met.</p> <p>Education was provided to the SSD by the Skilled Rehabilitation Consultant on communicating results of MDS assessments on September 22, 2016.</p>		

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F 250	<p>Continued From page 12</p> <p>Resident #3's progress notes documented: On 4/8/16, "...[Resident #3 is not speaking [and] appears withdrawn. [She] closes her eyes when staff approach her..." On 4/22/16, "Uses call light in excess. Will push call light button repeatedly while receiving staff assistance and after staff leaves her room. When staff assessed her needs, she often lies there with her eyes closed and won't respond." On 5/5/16, "[Resident #3's family member] came to visit, due to [Resident #3] using her cell phone to continually call her. [In addition], the resident continued to use call light button when awake and repeatedly pushing it even when staff were in the room assisting her." On 5/16/16, "Resident calling her daughter continually and pushing call light continually...Daughter called the facility and asked to have residents phone placed on [the] top shelf of [her] bookcase. When entering [the] resident's room resident was on [the] phone. [The phone] was then given to this nurse and placed on [the] top shelf [of the bookcase]."</p> <p>A Behavior Committee Drug Review, dated 4/20/16, documented Resident #3 was cognitively intact and experienced mild depression. The review form did not address whether the facility monitored and evaluated Resident #3 for mood changes and/or increased suicidal ideation after the Zoloft 100 mg was placed on hold.</p> <p>On 5/6/16, a care plan change note documented Resident #3 told the Social Service director that she was having thoughts of harming herself and the facility initiated 15-minute checks, however</p>	F 250	<p>4. Audits will be completed on progress notes and scanned Psychiatrist and Senior Counseling provider notes, by Health Information Management Director or designee, Weekly X 4, Monthly X 2 Quarterly X 3. All Audit findings will be reported to QAA Committee for further monitoring and modification based on findings.</p>		

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F 250	<p>Continued From page 13</p> <p>the resident's clinical record did not document the physician, the contracting LCSW, and/or the NP had been notified to rule out suicidal ideation, intent, or plan.</p> <p>Resident #3's Comprehensive MDS assessment, dated 5/6/16, documented:</p> <ul style="list-style-type: none"> - Verbalized having little interest or pleasure in doing things for 7-11 of 14 days, felt down, depressed, or hopeless for 7-11 of 14 days, tired or had little energy for 7-11 of 14 days, poor appetite or overeating for 2-6 days; felt negative about herself for 7-11 of 14 days, trouble concentrating on reading or watching television, experienced thoughts she would be better off dead, or hurting herself in some way for 12-14 of 14 days; and experienced moderately severe depression. - The "safety notification" documented on the MDS as made, but there was no evidence any notification was done beyond the person who completed the assessment. <p>On 5/12/16, the Social Service Director (SSD) documented Resident #3 still had thoughts of harming herself, and continued on 15-minute checks. The LSW did not document whether Resident #3 had suicidal intent, or a plan. Resident #3's clinical record did not document the physician, the contracting LCSW, and/or the NP had been notified to further assess whether the Resident #3 experienced suicidal ideation, intent, or plan.</p> <p>Resident #3's clinical record from 4/8/16 through 5/12/16 did document the facility was monitoring and tracking Resident #3's suicidal thoughts determine if a pattern was present. In addition,</p>	F 250			

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F 250	<p>Continued From page 14</p> <p>the record did not document attempted interventions with outcomes to determine which interventions were successful and/or which interventions needed to be revised.</p> <p>Resident #3's LCSW Progress Notes, dated 5/10/16, 5/16/16, 5/30/16, 6/13/16, 6/27/16, 7/25/16 and Treatment plans, dated 5/25/16 did not document the LCSW had been notified regarding Resident #3's psychosocial distress manifested by expressed hopelessness, worthlessness, and suicidal ideations. In addition the progress note did not document the LCSW had addressed Resident #3's depression during his weekly visits.</p> <p>On 5/18/16, the SSD documented Resident #3 was re-assessed for continued 15-minute checks, as the resident stated she continued to have thoughts of harming herself. 15-minute checks were continued at that time, but Resident #3's clinical record did not document the physician, the contracting LCSW, and/or the NP had been notified to rule out suicidal ideation, intent, or plan.</p> <p>On 5/20/16, a fax sent to Resident #3's physician documented, "[Resident #3] has been having suicidal ideations since 5/6/16 (was re-assessed on 5/12/16 and 5/18/16) and remained on 15-minute checks for suicidal ideations. Her Zoloft 100 mg ... has been on hold since 5/1/16 [NOTE: The resident's clinical record documented Zoloft had been on "hold" since 4/12/16]. [Resident #3 remained in a state of] moderately severe depression. Do you think it would benefit her to start the Zoloft again?"</p>	F 250			

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F 250	<p>Continued From page 15</p> <p>NOTE: The facility failed to recognize a pattern regarding Resident #3's expressions of suicide, complete further assessments, and implement further interventions, other than 15-minute checks from 5/6/16 to 8/3/16. In addition, Resident #3's clinical record did not address her prolonged period of psychosocial distress, to the point of hopelessness, worthlessness, suicidal ideation, without social service interventions.</p> <p>Resident #3's Treatment Plan, dated 5/25/16, documented, Resident #3 required continued treatment from the LCSW to keep her, "mental health symptoms in check and [Resident#3] needs consistent monitoring by staff and through therapy." The LCSW documented Resident #3's visits would be decreased from weekly to monthly visits. It was unclear how this determination was made based on Resident #3's continued expressions of suicidal ideations documented in her clinical record.</p> <p>On 5/23/16, a physician order was received to resume the Zoloft 100 mg daily.</p> <p>On 6/23/16, the Nurse Practitioner (NP) documented, "[Resident #3] indicated that her moods were a little depressed. [Resident #3] stated she struggled with feelings of hopelessness and worthlessness daily. When asked about thoughts of suicide or death, she did not respond which may have been the result of not hearing the question."</p> <p>Resident #3's Quarterly MDS assessment, dated 7/12/16, documented: - Verbalized feeling tired or having little energy for 2-6 days; felt bad about herself for 2-6 days;</p>	F 250			

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F 250	<p>Continued From page 16</p> <p>moved/spoke more slowly than usual or was fidgety and moved around more than usual for 2-6 days; thoughts that she would be better off dead, or hurting herself in some way for 7-11 days; and experienced mild depression.</p> <p>- The "safety notification" documented on the MDS as made, but there was no evidence any notification was done beyond the person who completed the assessment.</p> <p>A nurse's note, dated 8/1/16, documented, "[Resident #3's family member] called and reported to the nurse that the resident had called her and stated she was going to kill herself. [Resident #3] was placed on every 15 minute checks."</p> <p>An 8/3/16 Nurse's Note documented, "Physician noted that he reviewed the suicide watch note [related to Resident #3]."</p> <p>On 8/12/16 at 1:00 pm, during an interview with the DNS and SSD, when asked if the facility had recognized a pattern in Resident #3's continued and worsening signs of depression after the discontinuation of the Zoloft, the DNS stated the SSD was responsible for assessing Resident #3's mental health and would notify nursing staff if needed. The SSD stated the facility had not attempted to determine if there was a pattern. When asked if the care plan interventions were reviewed/revised; if other interventions were considered in addition to the 15-minute checks; and or further basements were completed after Resident #3 experienced prolonged periods (from May 2016 to July 2016) of psychosocial distress as manifested by hopelessness, worthlessness, and suicidal ideations, the SSD</p>	F 250			

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F 250	Continued From page 17 did not respond. The DNS stated, "I see what you are saying." The facility was asked and did not provide evidence the "safety notification" was made or further assessments were conducted to ascertain the resident's status in terms of suicidal ideation, intent, or plan. When asked if the facility had attempted to rule out suicidal ideation, intent, or plan, the SSD stated she was not sure.	F 250			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure professional standards of practice were followed for 1 of 1 resident (#9) whose medications were observed being administered via G-tube. This failed practice created the potential for harm when Resident #9's medications were mixed and administered together. instead of separately. Findings include: Nursing Interventions and Clinical Skills (Elkin, Perry, Potter, 3rd Ed.) states each medication should be individually dissolved in water and administered by syringe via gravity into the	F 281	1. Resident #9 - medication and flush information on MAR, was reviewed to ensure that resident was having medications administered separately and flushed between medications. Consistent assignment Licensed nursing staff was re-trained and return demonstration completed on process of administering one medication at a time with sterile water flush between each medication on 9/16/16. 2. All residents with G tubes have the potential to be affected by this practice.	10/28/16	

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F 281	<p>Continued From page 18</p> <p>G-tube. The G-tube should be flushed with 10 ml of water before and after each medication.</p> <p>The facility's Medication Administration via Tube policy and procedure, dated November 2013, included, "Administer each medication separately and flush the tubing between each medication. Flush with 5 ml of sterile water after each individual medication is given."</p> <p>Resident #9 was admitted to the facility on 10/16/14, with multiple diagnoses including malignant neoplasm of the dorsal surface of the tongue and nutritional deficiency.</p> <p>On 8/10/16 at 11:25 am, LN #1 was observed flushing Resident #9's G-tube with 60 ml of sterile water, administering Tramadol 100 mg and Gabapentin 300 mg together in 30 ml of sterile water, and then flushing the G-tube with 60 ml sterile water.</p> <p>Resident #9's July 2016 Physician's Medication Review Report documented staff were to flush the G-tube with sterile water before and after each medication.</p> <p>On 8/10/16 at 2:40 pm, LN #1 stated she mixed medications together when administering them to residents with a G-tube.</p> <p>On 8/10/16 at 2:40 pm, the DNS stated medications administered via G-tube should be administered one medication at a time with sterile water flushed in between each medication.</p>	F 281	<p>3. All Medication administration records for residents with G tubes have been updated to include the following instructions: Flush g tube with 5-10cc sterile water before and after each medication. All medications must be given separately.</p> <p>Licensed nurses have been re-educated regarding the correct procedure for administering medications via G tubes on 9-16-16.</p> <p>Licensed Nurses were re-educated on the expectations of practice regarding medication administration via G tube and re- demonstration occurred on or before 9/21/16.</p> <p>4. Observational audits of Licensed Nurses , G-tube medication administration practices by Director of Nursing or RN designee , will be done to ensure procedures is correct Weekly x 4 weeks, then Bi-monthly x 2, then Monthly x 2 then Quarterly x 3. All audit results will be reported to the QAA Committee for further monitoring and modification based audit findings.</p>		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		10/28/16	

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F 309	<p>Continued From page 19</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, observations, record review, and facility policy review, it was determined the facility failed to ensure:</p> <ol style="list-style-type: none"> 1. Medications were not administered without a physician order for 1 of 4 (#3) sampled residents; 2. Bowel Care was provided to prevent constipation and/or impaction for 1 of 6 (#4) sampled residents; and 3. Medications administered through a G-tube were given per professional standards of practice and in accordance with the facility's policy for 1 of 1 (#9) resident who received medications via G-tube. <p>These deficient practices placed Resident #3 at risk for harm when medications were administered without physicians orders; placed Resident #4 at risk for harm when he experienced prolonged periods of constipation without assessment or interventions to promote bowel evacuation; and placed Resident #9 at risk for harm when her medications were administered incorrectly. Findings include:</p> <ol style="list-style-type: none"> 1. Resident #3 was admitted to the facility with multiple diagnoses, including major depressive 	F 309	<ol style="list-style-type: none"> 1. Resident 3-Physican orders were clarified and MAR updated to ensure all medications administered had current physician orders. <p>Resident 4 - upon notification of concern resident was given prune juice and assisted to the bathroom toilet to help with bowel evacuation. Toileting Care plan update to use sit to stand lift to allow resident to void in the bathroom. Progress note updated for bowel and abdomen assessment 9/23/16. Physician notified of refusals of bowel medication regimen, abdominal and bowel tones assessment and current bowel status on 9/23/16.</p> <p>Resident #9 - medication and flush information on MAR was reviewed to ensure that resident was having medications administered separately and tube flushed between medications.</p> <p>Consistent assignment of Licensed Staff and were re-trained and return demonstration completed on process of</p>		

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F 309	<p>Continued From page 20</p> <p>disorder, schizophrenia, dementia without behavioral disturbance, and delusional disorder.</p> <p>Resident #3's medication orders, dated 3/1/16 through 3/27/16 and Medication Administration Orders documented:</p> <ul style="list-style-type: none"> - Depakene (Valproic Acid) 375 mg at bedtime for Parkinson's; - Haldol 2.5 mg daily for delusional disorder; - Haldol 7.0 mg daily for catatonic schizophrenia; - Risperdal 4.0 mg daily for catatonic schizophrenia; - Risperdal 0.25 mg daily in the afternoon for delusional disorder; and - Zoloft 100 mg daily for depressive episodes. <p>Resident #3's clinical record documented she was hospitalized from 3/27/16 through 4/8/16.</p> <p>On 4/8/16, Resident #3 was re-admitted to the facility with the following medication orders:</p> <ul style="list-style-type: none"> - Depakote DR 375 mg at bedtime for Parkinson's; - Haldol 5 mg at bedtime for schizoaffective disorder; and - Risperidone 2 mg in the morning for schizoaffective disorder. <p>Resident #3's Admission Medication Orders, dated 4/8/16, and the April 2016 MARs documented the resident received medications not ordered and/or incorrect doses of following medications:</p> <ul style="list-style-type: none"> * Depakene 375 mg at bedtime from 4/8/16 to 4/30/16. The order was for Depakote DR 375 mg at bedtime. * Haldol 7 mg at bedtime from 4/8/16 to 4/11/16. The order was for Haldol 5 mg. * Haldol 2.5 mg in the morning from 4/9/16 to 	F 309	<p>administering one medication at a time with sterile water flush between each medication on 9/16/16.</p> <p>2. All residents with medication orders, bowel care plans and medications received via G tube have the potential to be affected by this practice.</p> <p>3. All medication orders received will be double noted. Initially when orders are received they are noted by licensed nurse entering the orders and the following nurse will double check all entered orders. The Nurse putting in the orders will physically sign the hard copy admit orders with the following: First initial, last name, title, date and the word 'noted'. The second nurse will also review the orders and EMR input and once it is determined that all orders have been addressed, they will sign the hard copy of the order in the same manner. The orders will be verified by the HIM Director or designee, prior to scanning into resident spaces.</p> <p>When admitted to the hospital all orders will now be discontinued and when resident returns from the hospital admission orders will be processed as above.</p> <p>Bowel care: Resident's documentation of pattern of bowel movements quality and quantity will be reviewed to determine bowel schedule. Schedule will be reported to physician to</p>		

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F 309	<p>Continued From page 21</p> <p>4/11/16. There was no order for Haldol 2.5 mg until 4/14/16.</p> <p>* Risperdal 4 mg in the morning from 4/9/16 to 4/11/16. The order was for Risperdal 2 mg.</p> <p>* Zoloft 100 mg in the morning from 4/9/16 to 4/11/16. The re-admission orders did not include an order for Zoloft.</p> <p>On 8/12/16 at 1:00 pm, the DNS stated she was not aware Resident #3 had received the wrong medication and/or wrong doses of medications until it was brought to her attention by the survey team. The DNS stated it was not the facility's policy to re-admit residents from a hospital on the same medications prior to discharge unless those medications and dosages were ordered upon readmission to the facility.</p> <p>2. Resident #4 was admitted to the facility with diagnoses that included a history of intestinal cancer, constipation, pain, and heart failure.</p> <p>The 7/26/16 MDS assessment documented Resident #4 was cognitively intact.</p> <p>Resident #4's Care Plan documented constipation related to decreased mobility, medication side effects, and pain and evacuation of a soft, formed stool was desired every other day. Care Plan interventions directed staff to:</p> <p>* Encourage the resident to sit on the toilet to evacuate bowels if possible.</p> <p>* Observe/monitor/document/report to health care provider any signs and symptoms of complications related to constipation, such as a change in mental status, or new symptoms such as confusion, sleepiness, inability to maintain posture, agitation, bradycardia, swollen abdomen, vomiting, small loose stools, fecal</p>	F 309	<p>determine individualized intervention needed. Physician directed interventions will be care planned. For residents with deviation in physician directed pattern of bowel movements licensed nurses will perform abdominal review, including bowel tones and document review outcomes and follow-up results.</p> <p>Health Information Manager (HIM) and Licensed Nurses have been educated on the change to this process on or before 10/6/2016.</p> <p>4. Audits by HIM or designee, of Medication orders and double noting process will occur as new orders are received. This auditing will occur till 100% compliance and then the following schedule will be put in place. Weekly x 4 weeks, then Bi-monthly x 2, Monthly x 2. Quarterly x 3.</p> <p>Audits by DNS or designee, of Point of Care documentation-bowel alerts and documentation of intervention and documented results will be done daily till 100% compliance and then the following schedule will be put into place: Weekly x 4 weeks, then Bi-monthly x 2, Monthly x 2, Quarterly x 3.</p> <p>All audit results will be reported to QAA Committee for furthering monitoring and modification of audit schedule based on findings.</p>		

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F 309	<p>Continued From page 22</p> <p>smearing, decrease in bowel sounds, sweating, abdominal tenderness, guarding, and/or rigidity.</p> <p>The Clinical record documented Resident #4 did not experience a bowel movement from 7/21/16 to 8/1/16 (11 days). Milk of Magnesia was administered once during that time, on 7/28/16.</p> <p>Physician's Order, dated 8/3/16, directed staff to provide Resident #4 with one dose of MiraLax Powder two times a day for constipation. Miralax was given for constipation twice a day from 8/3/16 to 8/10/16, however there clinical record documented Resident #4 did not experience a bowel movement between 8/2/16 and 8/10/16 (9 days). Magnesium Citrate was ordered and administered on 8/9/16.</p> <p>On 8/8/16 at 8:40 am, the DNS stated the physician was notified that morning of Resident #4's lack of bowel movements. There was no documentation in Resident #4's record, or provided by the facility, that Resident #4 was encouraged to sit on the toilet or was assessed for signs and symptoms of constipation, as directed in his care plan.</p> <p>On 8/10/16 at 8:45 am, Resident #4 stated his constipation and the facility's attempts to promote bowel evacuation were "lousy." Resident #4 stated staff repeatedly told him to "take Miralax" when he complained of constipation and that he went 2 weeks without a bowel movement while in the facility. Resident #4 stated he could not recall staff listening for bowel sounds, assisting him to the toilet, or whether staff notified his physician.</p> <p>3. Resident #9 was admitted to the facility on 10/16/14 with multiple diagnoses, including</p>	F 309			

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F 309	Continued From page 23 malignant neoplasm of top surface of the tongue and nutritional deficiency. On 8/10/16 at 11:25 am, LN #1 was observed flushing Resident #9's G-tube with 60 ml of sterile water, administering Tramadol 100 mg and Gabapentin 300 mg together in 30 ml of sterile water, and then flushing the G-tube with 60 ml of sterile water. Resident #9's July 2016 Physician's Medication Review Report documented staff were to flush the G-tube with sterile water before and after each medication. The facility's Medication Administration via Tube policy and procedure, dated November 2013, documented, "Administer each medication separately and flush the tubing between each medication. Flush with 5 ml of sterile water after each individual medication is given." On 8/10/16 at 2:40 pm, LN #1 stated she mixed medications together when administering medication through the G-tubes. On 8/10/16 at 2:40 pm, the DNS stated medications administered via G-tube should have been administered one medication at a time with sterile water flushed in between each medication.	F 309			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314		10/28/16	

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F 314	<p>Continued From page 24</p> <p>they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, policy review, and record review, it was determined the facility failed to ensure:</p> <ul style="list-style-type: none"> a) Residents did not develop new avoidable pressure ulcers; b) Physician orders for the treatment of existing pressure ulcers were followed; c) Pressure ulcers were consistently assessed and monitored to promote healing; d) Interventions were revised when existing pressure ulcers deteriorated; and; e) A medical device was properly positioned to prevent development of a Stage IV pressure ulcer. <p>These deficient practices were true for 1 of 4 residents (#2) sampled for pressure ulcers and resulted in harm when three Stage IV pressure ulcers further deteriorated and Resident #2 developed three new unstageable pressure ulcers. Findings include:</p> <p>Resident #2 was readmitted to the facility on 2/16/16, with multiple diagnoses including Multiple Sclerosis (MS), diabetes mellitus, colostomy, neurogenic bladder, and multiple pressure ulcers which were present prior to her hospitalization on 2/7/16.</p> <p>The Minimum Data Set assessment (MDS), Care</p>	F 314	<ol style="list-style-type: none"> 1. Resident # 2 was evaluated by PT/OT for positioning in bed for off-loading. Resident's refusals were reviewed and accommodations were made to include iPad stand, longer iPad cord, and two televisions, allowing one on each side of her bed. Registered Dietician (RD) requested new Albumin from physician on 9/6/19. Care plan updated to offer resident hot cocoa or chocolate milk with snacks. Resident willing to drink chocolate ensure supplement, Physician ordered daily X2 on 9/19/16. Resident's information has been sent to SIACH in Boise, ID with her permission to review for further assessment and treatment of her wounds. Resident discharged to SIACH on 9/27/16. 2. Residents at risk for skin breakdown as evidenced by a score of 18 or less for risk on the Braden scale. All residents were reviewed for risk status and care plans were revised for those with needed changes. 3. Weekly skin observations by Licensed nurse (LN) have been scheduled, as well as, weekly skin checks by the Certified Nursing Assistants (CNA). 		

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F 314	<p>Continued From page 25</p> <p>Plan (CP), Wound Data Collection form (WDC), Wound Clinic Notes (WCN), Wound Clinic Orders (WCO), Treatment Administration Records (TAR), Progress Notes (PN), Dietary Notes (DN), Dietician Assessment (DA), and the facility's pressure ulcer policy and procedure documented the following.</p> <p>* Resident #2's quarterly MDS assessment, dated 2/22/16, documented she:</p> <ul style="list-style-type: none"> - Was Cognitively intact - Required extensive assistance of one staff for bed mobility - Was totally dependent on two or more staff for transfers - Had impairment to bilateral lower extremities - Had one Stage II pressure ulcer present on admission - Had three Stage IV pressure ulcers present on admission - Did not have unstageable pressure ulcers - Did not have suspected deep tissue injuries - Required a pressure reducing device for her chair and bed, turning and repositioning program, nutrition or hydration interventions to manage skin problems, and pressure ulcer care <p>* Resident #2's quarterly MDS assessment, dated 5/24/16, documented differences in the number and stage of pressure ulcers on admission. It stated she:</p> <ul style="list-style-type: none"> - Had one Stage III pressure ulcer present on admission; - Had two Stage IV pressure ulcers present on admission; 	F 314	<p>TARS have been updated with schedules to measure the wounds and document the findings on the RN Wound Data Collection tool. Weekly interdisciplinary team meetings are being held to discuss all wounds/skin issues and will include Licensed Social Worker (LSW) and Dietary Manager participation. The interdisciplinary team (IDT) will document follow up on any dietary recommendations and/or behavioral issues impacting skin. An interdisciplinary wound team structured progress note has been developed to guide the IDT in addressing each area of concern that could impact wound care.</p> <p>Licensed nursing staff and CNA education was started on 9/22/16 on skin observation, weekly checks and expectations of documentation.</p> <p>4. For active wounds, care provided by LN's will be visualized by the DNS or RN designee Weekly x 4, Bi-monthly x 2, Monthly x 2, Quarterly x 3. Audit results will be reported to the QAA committee for further monitoring and modification based on findings.</p> <p>Audits of the documentation for wounds using the Wound Data collection, RN Wound assessment tool and weekly skin observations will be completed by DNS or RN designee Weekly x 4, Bi-monthly x 2, Monthly x 2, Quarterly x 3. Audit results will be reported to the QAA</p>		

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F 314	<p>Continued From page 26</p> <p>* The facility's wound and pressure ulcer policy stated:</p> <ul style="list-style-type: none"> - An individualized repositioning schedule was required for a resident unable to position herself/himself and was to be based on nutrition, hydration, incontinence, diagnoses, mobility, and observations of the resident's skin over a period of time. - When a pressure ulcer was identified, the Registered Nurse should record the type of wound and the degree of tissue damage on the Wound RN assessment. The licensed nurse was to record the location of the wound, measurements, and ulcer/wound characteristics. - Dietary staff would be automatically notified. - The interdisciplinary team should determine any modifications necessary to the resident's care plan. Interventions were to focus on physical, mental, and psychosocial concerns that could be affected. - Pressure ulcers should be assessed at least weekly and include measurements, characteristics of the ulcer, presence of pain, and current treatments. <p>* Resident #2's physician orders and/or wound clinic orders, from 11/24/15 to 8/9/16, documented:</p> <ul style="list-style-type: none"> - Keep weight off affected area/limb at all times; - Bed rest and up only for meals and bathroom; - Wear blue heel booties or foam heel lifts at all times on bilateral lower extremities as tolerated to protect feet from skin breakdown; - Turn and reposition every two hours; - Avoid positioning directly on pressure wound site; and 	F 314	<p>committee for further monitoring and modification based on findings.</p> <p>Audits, by DNS or designee, of Progress notes or Care Plans interventions related to issues impacting skin including dietary recommendations or behavioral issues will be completed Weekly x 4, Bi-monthly x 2, Monthly x 2, and Quarterly x 3. Audit results will be reported to the QAA committee for further monitoring and modification based on findings.</p>		

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F 314	<p>Continued From page 27</p> <ul style="list-style-type: none"> - Limit side lying to 30 degree tilt; and limit head of bed elevation to 30 degrees in bed. <p>* Resident #2's skin care plan for August 2016 documented:</p> <ul style="list-style-type: none"> - Foam wedge to be placed between knees when up in a wheelchair and pillows for positioning off buttocks when in bed. - Educate to causes of skin breakdown and the importance of remaining off the areas of pressure wounds. - Assist to turn/reposition at least every 2 hours, remind to shift position as needed, and encourage to be in wheelchair only for meals and in bed the rest of the time. - Provide air bed with low air loss mattress, wheelchair cushion, and blue boots on both feet while in bed. - Provide supplemental protein, amino acids, vitamins, minerals to promote wound healing. - Do not leave sling behind resident in wheelchair. <p>* Resident #2's medical record documented the following wounds were facility acquired:</p> <ul style="list-style-type: none"> - Wound #3 was acquired on 10/6/14; - Wound #5 was acquired on 12/8/14; - Wound #8 was acquired on 8/4/15; - Wound #9 was acquired on 11/23/15; - Wound #10 was acquired on 12/21/15; - Wound #11 was acquired on 3/23/16; - Wound #12 was acquired on 7/7/16; and - Wound #13 was acquired on 8/4/16. <p>Resident #2's record included the following documentation regarding wounds #3, #5, #8,</p>	F 314			

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F 314	<p>Continued From page 28 #11, #12, and #13:</p> <p>a) Wound #3 - Stage IV distal left ischial (lower buttocks) pressure ulcer which deteriorated:</p> <p>* WCN/WCO - 11/24/15: The wound increased in diameter and measured 2.0 cm x 1.4 cm x 2.0 cm. The wound clinic assessed the wound and determined Resident #2's wheelchair cushion was over-inflated, which contributed to the deterioration of the wound. The note documented Resident #2 was repositioned in her electric wheelchair and air was released from the wheelchair cushion until proper inflation was reached. The manufacturer's specifications for use of the wheelchair cushion documented, "DO NOT sit on an improperly inflated cushion. Under-inflated and over-inflation of the cushion sections reduce or eliminate the cushion's benefits and could increase risk to the skin and other soft tissue." Physician orders directed facility staff to check the cushion 1-2 times daily for proper inflation and positioning, and wound dressing changes were to be performed twice daily, and as needed. Resident #2's wound measurements were documented as the length x width x depth of each wound, in that sequence. For reference, 1 inch is equal to 2.54 cm, and 4 inches is equal to 10.16 cm.</p> <p>* WCN - 12/29/15: The wound measured 1.5 cm x 1.5 cm x 2.0 cm.</p> <p>* WCN - 1/19/16: The wound measured 3.0 cm x 1.6 cm x 2.5 cm.</p> <p>* WCN - 1/28/16: The wound measured 3.0 x 2.0 cm x 5.0 cm.</p>	F 314			

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

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F 314	Continued From page 29 * A Dietician Assessment (DA), dated 2/22/16, documented Resident #2 weighed 68 kg (150 pounds) and her estimated protein requirement was 1.0 gram of protein per kilogram (kg). Resident #2 at this time was assessed with two Stage IV pressure ulcers, one Stage III pressure ulcer, and one unstageable pressure ulcer. * WCN - 3/10/16: Dressing changes were decreased to once daily and as needed. * WCN - 3/15/16: The dressing was intact and dated 3/10/16, indicating Resident #2's wound dressing had not been changed daily, as ordered. The periwound (area around the wound) was irritated/red with a rash and maceration (softening and breaking down of the skin resulting from prolonged exposure to moisture), had a mild odor, and a moderate amount of yellow/brown drainage. The wound had not been measured. * WCN/WCO - 3/23/16: The periwound was moist, red, and with a rash. The wound measured 2.4 cm x 1.1 cm x 0.4 cm. New orders included a dietary consult related to inadequate protein intake and decreased Prealbumin and Albumin levels. * DN - 3/23/16: The RD spoke with Resident #2 about her low albumin, magnesium, and potassium levels and discussed food interventions for each deficient lab value. Resident #2 stated she wanted 2 glasses of whole milk with each meal and milk offered with snacks. She stated she liked most protein rich foods, "but they didn't like her." The note did not	F 314			

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F 314	<p>Continued From page 30</p> <p>include the reason Resident #2 was unable to tolerate protein rich foods, protein alternatives available to her, or that the need for increased protein intake was to promote wound healing.</p> <p>* WCN - 3/30/16: The periwound was excoriated with a mild odor, the dressing was "bunched up on arrival today and the wound measured larger" at 3.0 cm x 2.0 cm x 1.7 cm.</p> <p>* WCN/WCO - 4/4/16: The dressing was intact, "very" moist and measured 3.0 cm x 2.8 cm x 2.8 cm, the periwound was pink with skin irritation, the tissue was "shiny" red, friable (easily tears, fragments, or bleeds when gently palpated or manipulated), and palpable to the bone.</p> <p>b) Wound #5 - Stage IV sacral (low back directly above tailbone) pressure ulcer which deteriorated, bone palpable:</p> <p>* WCN - 12/29/15: The wound measured 2.7 cm x 1.4 cm x 2.0 cm.</p> <p>* WCN - 1/19/16: The wound measured 3.0 cm x 2.0 cm x 1.3 cm and had increased slough (a layer of dead tissue, typically yellow, separated from the surrounding underlying tissue).</p> <p>* WCN - 1/28/16: The wound measured 2.3 cm x 1.8 cm x 1.2 cm.</p> <p>* WCN - 3/10/16: The wound measured 2.8 cm x 1.0 cm x 1.0 cm.</p> <p>* WCN - 3/15/16: The dressing removed by the wound clinic was dated 3/10/16, indicating the dressing had not been changed daily, as</p>	F 314			

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F 314	<p>Continued From page 31</p> <p>ordered. The wound measured 2.0 cm x 1.1 cm x 0.4 cm.</p> <p>* WCN - 3/23/16: The wound measured 2.0 cm x 1.1 cm x 0.4 cm.</p> <p>* WCN - 3/30/16: The wound measured 2.0 x 1.5 cm x 0.4 cm.</p> <p>* WCN/WCO - 4/4/16: The wound measured 2.4 cm x 1.0 cm x 0.8 cm, the dressing was intact and very moist, the tissue was red and friable, and the sacral bone could be felt.</p> <p>c) Wound #8 - Stage III right ischial pressure ulcer deteriorated to Stage IV with bone exposed:</p> <p>* WCN - 12/29/15: The wound measured 0.7 cm x 0.3 cm x 2.0 cm; unable to visualize wound bed due to characteristics of wound; and periwound was light pink and irritated, which appeared to be from friction.</p> <p>* WCN - 1/19/16: The wound measured 2.0 cm x 1.5 cm x 4.0 cm, had a strong odor, moderate amounts of dark brown drainage, and there was slough present in the wound bed. The periwound was moist, red, "very" tender, and hard.</p> <p>* WCN - 1/28/16: The wound measured 2.5 cm x 3.0 cm x 3.8 cm, had a strong odor; necrotic (dead tissue), purulent (pus) drainage; induration (hard mass); and circumferential erythema (redness) that measured 6.0 cm x 9.0 cm.</p> <p>* WCN/WCO - 3/10/16: The wound measured 11.8 cm x 5.0 cm x 4.6 cm; the dressing was not intact on arrival; the wound had a strong odor;</p>	F 314			

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

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F 314	<p>Continued From page 32</p> <p>the muscle and bone were exposed; and the wound vacuum track pad (foam applied directly into the wound bed) was secured on the resident's buttocks, which created the potential for pressure injury. Resident #2 returned to the facility with orders for staff to change the dressing 2-3 times a week and as needed.</p> <p>* WCN - 3/15/16: The wound measured 9.3 cm x 4.0 cm x 4.0 cm, had a strong odor and the muscle and bone were exposed. The wound dressing was dated 3/10/16, when the resident was last seen by the wound clinic for wound care, indicating the dressing had not been changed, as ordered.</p> <p>* WCN - 3/23/16: The wound measured 8.8 cm x 3.4 cm x 3.2 cm; had a strong odor; and the wound vacuum was intact, "but had leaked on arrival.</p> <p>* WCN/WCO - 3/30/16: The wound measured 10.0 cm x 5.0 cm x 3.0 cm with undermining (erosion under the wound edges); had a strong odor; and the wound vacuum was turned off when the resident arrived at the wound clinic. "[Resident #2] reported the wound vacuum had been leaking so much lately that 'it was ruining my underwear.'" The entire base of the wound was exposed bone, bone darkly discolored and desiccating (moisture was removed from the bone and it was drying out) superiorly. The order for the facility was to change the wound vacuum dressing every other day and as needed. If the vacuum registered a leak alarm, the WCN/WCO instructed facility staff to change the dressing immediately to maintain negative pressure to the wound at all times. Facility staff were also</p>	F 314			

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F 314	<p>Continued From page 33</p> <p>instructed to not turn the vacuum unit off for any reason other than dressing changes.</p> <p>* TAR - 4/1/16, 4/2/16, 4/3/16: Resident #2 went 3 days, from 4/1/16 to 4/4/16, without a wound dressing change.</p> <p>* WCN - 4/4/16: The wound measured 8.5 cm x 4.0 cm x 3.2 cm; had a strong odor; a large amount of drainage; the wound vacuum track pad was not attached at the inferior edge of the wound; the ischial bone was prominent and soft; perimeter granulation tissue was spongy in areas and friable with scattered slough.</p> <p>* TAR - The dressing change scheduled for 4/10/16 was not completed until 4/11/16.</p> <p>d) Wound #11 - Unstageable left inferior (low) buttock/left perineum (area between the anus and vulva or scrotum) pressure ulcer developed in facility:</p> <p>* WCN - 3/23/16: New unstageable pressure ulcer on Resident #2's left inferior (low) buttock. The wound had black eschar and measured 1.7 cm x 1.2 cm. "New area of pressure that could be coming from [Resident #2's] catheter when she sits." Orders for the facility to inspect/ensure Resident #2 was not sitting on the catheter tubing.</p> <p>* WCN - 3/30/16: The left inferior buttock wound measured 3.0 cm x 3.8 cm x 0.1 cm and had bridged with wound #3 (left ischial wound).</p> <p>* WCN - 4/4/16: The wound measured 3.5 cm x 4.0 cm x 0.1 cm, was red and very moist, and</p>	F 314			

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F 314	<p>Continued From page 34</p> <p>perineal care to the labia was needed, a 0.5 cm x 0.5 cm area of slough to the left labia "looked like it was from pressure related to her catheter."</p> <p>e) Wound #12 - Deep tissue injury to the middle of the left lower leg which developed into an unstageable wound:</p> <p>* NN - 7/7/16: A CNA informed the License Nurse (LN) Resident #2 had a suspicious area to her left lower extremity. The LN evaluated the area and identified a quarter sized non-blanching black area on the resident's leg that was surrounded by redness, induration, and was hot to the touch. "Concerned it is the start of a pressure ulcer and soft tissue infection." No documented wound measurements.</p> <p>* NN - 7/8/16: Order for Keflex 500 mg three times daily related to signs and symptoms of soft tissue infection to left lower extremity and wound care evaluation.</p> <p>* WCN/WCN - 7/11/16: New deep injury to Resident #2's left medial lower leg. The wound clinic did not include measurements. Orders from the wound clinic to the facility included daily wound treatment and dressing changes.</p> <p>* TAR - On 7/9/16 the facility received orders from the wound clinic for dressing changes to the wound, however, the orders were not transcribed to Resident #2's TAR until 7/14/16. Therefore, treatment of Resident #2's wound was delayed 5 days (7/9/16 - 7/14/16).</p> <p>* WCN - 7/25/16: The wound measured 10.0 cm x 6.0 cm x 0.1 cm; the wound bed was covered</p>	F 314			

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F 314	<p>Continued From page 35</p> <p>with eschar; signs and symptoms of infection were present as evidenced by purple streaks observed distally to wound (away from the center). Orders included Rocephin (antibiotic) 1 gram and that Physician #1 would follow-up on 7/26/16 to address the left lower extremity wound. Resident #2's clinical record showed she did not receive the Rocephin on 7/26/16 or 7/27/16, and had not been evaluated by Physician #1.</p> <p>* MAR - 7/27/16: Order for Rocephin 1 gram daily for seven days.</p> <p>* WCN/WCO - 8/4/16: The wound was unstageable (obscured full-thickness wound with skin and tissue loss) and measured 10.4 cm x 5.5 cm x 0.3 cm. Orders included Daptomycin (antibiotic) 300 mg IV every 24 hours for seven days related to lower leg extremity cellulitis and referral to a plastic surgeon due to lack of wound improvement.</p> <p>* WCN - 8/8/16: Documented the wound measured 11.5 cm x 6.0 cm x 0.6 cm. The physician removed the eschar covering the wound bed and sent it to the lab for evaluation. Once the eschar was removed, slough was observed over the majority of the wound bed.</p> <p>f) Wound #13 - Unstageable left heel pressure ulcer developed in the facility:</p> <p>* WCN - 8/8/16: Resident #2 had a new unstageable pressure ulcer on the left heel measuring 5.0 cm x 5.0 cm x 0.1 cm that had bridged to several smaller areas of pressure on the lateral (side) and posterior (back) ankle.</p>	F 314			

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F 314	Continued From page 36 On 8/9/16, at 9:15 am, Resident #2 stated she was seen by the wound clinic for her wounds and that she felt frustrated and discouraged. She stated the facility found a new pressure sore on her left lower the previous month that started very small and then grew to what is was now. Resident #2 stated she thought the wound might be related to the catheter tubing placed between her legs, which were contracted and had decreased sensation, and she would not have felt the tubing. On 8/15/16, at 1:50 pm, the DNS stated the floor nurses and MDS coordinator were responsible for care plans. The DNS stated the RD was responsible for nutritional care and had not related any concerns regarding Resident #2's nutrition. The DNS stated she was not aware of the wound clinic physician's order for Resident #2 to be evaluated by the RD for concerns about inadequate protein intake. * Please refer to F325 as it relates to the facility's failure to ensure Resident #2's nutritional needs were met.	F 314			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		10/28/16	

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F 318	<p>Continued From page 37</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and record review, it was determined the facility failed to ensure treatment and services to increase range of motion and/or prevent further decrease in range of motion were provided for 2 of 6 residents (#5 and #7) reviewed for range of motion and contractures. This deficient practice created the potential for more than minimal harm if residents' decreased ROM deteriorated further as a result of not receiving treatment and services. Findings include:</p> <p>1. On 8/8/16 at 2:45 pm, Resident #5 was observed with contracted fingers on each hand.</p> <p>On 8/9/16 at 10:30 am, Resident #5 was observed sitting in an alcove eating breakfast. He displayed difficulty with the use of utensils and stated he needed therapy for his hands.</p> <p>A Suggestion or Concern form, dated 6/7/16, documented Resident #5 reported his fingers were contracted and that he needed a splint.</p> <p>An MDS assessment, dated 7/11/16, documented Resident #5 had moderately impaired cognition and range of motion therapy was performed during 3 of the preceding 7 days for at least 15 minutes a day.</p> <p>Resident's #5's care plan, initiated on 10/13/15, documented a need for restorative interventions due to ADL self-care performance deficit, limited physical mobility, communication difficulties, bilateral extremity weakness, and impaired</p>	F 318	<p>1. Resident #5-was evaluated and treatment plan created by Physical Therapist (PT) and Occupational Therapist (OT). Resident is currently working with them on hands contractures, strengthening, use of splints and need for adaptive dining equipment to maintain or improve functional ability. Plan is once PT /OT active treatment is complete resident will be placed on restorative plan per Therapy and Physicians recommendations.</p> <p>Resident # 7- has received order by physician for evaluation and potential treatment by PT and OT. Licensed nurse (LN) has reassessed restorative plan and Resident continues on restorative therapy plan to maintain or prevent decrease in functionality mobility of hands.</p> <p>2. All residents requiring range of motion have the potential to be affected by this practice.</p> <p>3. System: Restorative Nurse has been appointed; Restorative Nursing Assistant (RNA) will report to Restorative nurse any deviation in plan of care and plan outcomes. Restorative Nurse will weekly review restorative plans and complete documentation as needed. Quarterly progress notes will be completed timely.</p> <p>Restorative Nurse, Restorative Nursing</p>		

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F 318	<p>Continued From page 38</p> <p>balance. Goals included ensuring Resident #5 maintained his current level of function with bed mobility, transfers, eating, dressing, toileting, and personal hygiene by 7/20/16. Restorative nursing interventions were to include: Active range of motion 3 times weekly with weights or therabands, initiated on 10/13/15, and active range of motion for up to 5 minutes three times weekly, revised on 7/6/16.</p> <p>Monthly tasks sheets documented Resident #5 did not receive restorative nursing 3 times a week for 9 of the 31 weeks reviewed. The monthly task sheets documented the following number of times restorative nursing was provided to Resident #5:</p> <ul style="list-style-type: none"> * Week of 2/21/16-2/27/16 - 2 times * Week of 3/13/16-3/19/16 - 1 time * Week of 4/3/16 - 4/9/16 - none * Week of 4/10/16 - 4/16/16 - 1 time * Week of 4/17/16 - 4/23/16 - none * Week of 4/24/16 - 4/30/16 - 2 times * Week of 5/1/16 - 5/7/16 - 1 time * Week of 5/8/16 - 5/14/16 - 2 times * Week of 7/31/16-8/6/16 - 2 times <p>The clinical record did not document the reasons Resident #5 failed to receive restorative ROM therapy as care planned.</p> <p>2. Resident #7's MDS assessment, dated 6/29/16, documented she received passive range of motion therapy.</p> <p>Resident #7's current care plan documented restorative interventions were necessary to address ADL self-care deficits, limited physical</p>	F 318	<p>Assistant will be educated on the change to this process on Tuesday 9/27/16</p> <p>4. Audits by Restorative Nurse or designee, of restorative documentation will occur weekly x 4 weeks, then Bi-monthly x 2, then Monthly x 2 then Quarterly x 3. All audit results will be reported to QAA committee for further monitoring and modification based on findings.</p>		

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F 318	Continued From page 39 mobility related to bilateral extremity weakness, and limited mobility. Resident #7's goals included maintaining her current level of function in bed mobility, transfers, eating, dressing, toileting, and personal hygiene. Restorative nursing interventions included passive range of motion to extremities for at least 15 minutes 3 days a week. The restorative nursing task form documented Resident #7 did not receive restorative nursing 3 days a week for 12 of the 31 weeks reviewed; no explanation for services not being provided per care plan was provided. On 8/10/16 at 12:20 pm, the QA Coordinator stated she was unable to locate a physician's order or an assessment by physical or occupational therapies for Resident #7.	F 318			
F 323 SS=G	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. This REQUIREMENT is not met as evidenced by: Based on record review, review of I&As, and staff interview, it was determined the facility failed to ensure a resident at risk for falls was adequately assessed, and interventions were implemented, and monitored for effectiveness, to prevent repeated falls. This was true for 1 of 5	F 323	1. Resident #11 - Was reassessed and Physician orders were received for physical therapy to increase strengthening. LN completed assessment for bed height and bed exchange for full electric bed was completed on 9/19/16.	10/28/16	

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F 323	<p>Continued From page 40</p> <p>(#11) residents sampled for falls. This failed practice resulted in harm to Resident #11 when over the course of two months she experienced nine falls, two of which involved injury, including one fall that resulted in a laceration to her ear requiring sutures. Findings include:</p> <p>Resident #11 was admitted to the facility with multiple diagnoses, including gout, cervicalgia [neck pain], torticollis [an abnormal, asymmetrical head or neck position], and pain.</p> <p>Quarterly MDS assessments, dated 5/23/16 and 8/10/16, documented Resident #11 was independent with bed mobility, transfers, ambulation, and locomotion; required limited assistance of one person for dressing, toileting, and hygiene; had no impairment in upper or lower extremities; had not received physical therapy or restorative therapy; and had received occupational therapy from 6/3/16 to 7/1/16 for left wrist pain.</p> <p>Resident #11's current fall care plan documented:</p> <ul style="list-style-type: none"> * Licensed nurses and social services would educate her about safety reminders and what to do if a fall occurred. The safety reminders and "what to do if a fall occurred" were not included on the care plan. * The activities department and physical therapy would encourage Resident #11 to participate in activities which promoted exercise, physical activity for strengthening and improved mobility such as yoga. * Licensed nurses would monitor Resident #11 for significant changes in gait, mobility, positioning device, standing/sitting balance, and lower extremity joint function. 	F 323	<p>Physician ordered medication change was done 8/24/16. With resident assistance clutter reduction was began and care plan updated.</p> <p>2. Residents assessed as being at risk for falls, have the potential to be affected by this practice.</p> <p>3. System: LNs will assess resident potential hazards and supervision needed to prevent accidents. Interventions will be implemented and monitored for effectiveness. Falls scene investigations will be completed by LN at time of the fall to ensure interventions are implemented and care plan is updated as needed. Falls Committee will meet on an as needed basis up to daily if necessary to review fall scene investigations for completion, root cause analysis, and appropriate fall interventions. On 9/22/16 - LN staff and Falls Committee members were re-educated on tools for assessment of risk and in-serviced on completion of the fall scene investigation tools and process for committee involvement on in intervention implementation and monitoring for effectiveness.</p> <p>4. The monitoring of fall scene investigations and fall interventions will be completed by the falls committee to help prevent repeated falls. Audits will be completed by the Environmental Services Director or designee Weekly x4, Monthly x2, Quarterly x3. All audit results will be reported to QAA Committee for further</p>		

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F 323	<p>Continued From page 41</p> <p>* A Registered Nurse would review and modify environmental hazards that could cause or contribute to a fall.</p> <p>Resident #11's I&A reports, and nurses' notes from 4/8/16 to 8/1/16, documented:</p> <p>* On 4/8/16 at 12:20 pm, Resident #11 was found on the floor in her room and stated "she lost her balance while trying to walk towards her walker and landed on her bottom." The time between last staff member and resident contact before fall was at 10:00 am. The facility documented the fall was an "isolated incident" and no corrective actions were taken to prevent future falls.</p> <p>* A nurses' note, dated 4/15/16, documented the RN/MDS nurse spoke with Resident #11 regarding fall prevention and offered her restorative therapy. The nurse documented, "[Resident #11] politely refused stating this was an isolated incident, and that she just needs to slow down and take her time."</p> <p>* On 5/23/16 at 10:20 pm, Resident #11 was found on the floor in her room and stated "she was [reaching] trying to hang a picture on the wall [lost her balance] and fell scraping her left leg on the arm chair." Resident #11 sustained abrasions to her left knee and left lower leg. The area on the form to document the time between last staff member and resident contact before fall was blank. The form documented Resident #11's dose of Depakote had been changed within the previous 30 days [5/13/16]. Corrective actions implemented to prevent future falls included encouraging Resident #11 to remove the stacks of magazines from the floor and to ask for assistance and allow maintenance to help.</p> <p>* On 6/4/16 at 3:30 pm, Resident #11 was found</p>	F 323	<p>monitoring and modification based on audit results.</p>		

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F 323	<p>Continued From page 42</p> <p>on the floor in her room without her walker in front of her and stated "she was too tired and missed the bed!" The area on the form to document the time between last staff member and resident contact before fall was blank. Corrective actions implemented to prevent future falls included employee education. The content of the education was not included. Resident #11 was "talked to about the use of the walker in front of her especially when she was so tired."</p> <p>* On 6/23/16 at 10:50 am, Resident #11 was found on the floor in her room and stated "she was walking with her walker and couldn't remember what she was doing when she fell." The form identified there were numerous newspapers and papers scattered over the floor. Corrective actions implemented to prevent future falls included educating Resident #11 about the hazards of collecting and storing newspapers on the floor in her room and keeping the floor cluttered. In addition, maintenance and social services were notified, but the form did not document what their involvement would include.</p> <p>* On 6/30/16 at 5:15 am, Resident #11 was found on the floor in her room and stated "she was asleep in the chair and slipped out onto the floor." Resident #11 complained of right knee pain and the inside of her right ankle was red. The corrective action to prevent future falls was to obtain a urine analysis and blood work. The urinalysis was negative for bladder infection.</p> <p>* On 7/9/16 at 7:45 am, Resident #11 was found on the floor in her room and it was determined "she fell asleep in the chair and fell forward onto the floor." A corrective action was taken to prevent future falls by "looking at more blood work."</p> <p>* On 7/10/16 at 4:45 pm, Resident #11 was found</p>	F 323			

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F 323	<p>Continued From page 43</p> <p>on the floor in her room. Resident #11 was not sure how she ended up on the floor. There were no corrective actions implemented.</p> <p>* On 8/1/16 at 10:45 pm, Resident #11 was found on the floor in her room and stated "she couldn't remember what happened." Resident #11 sustained a laceration to her right ear and complained of neck pain. Resident #11 was transported to the Emergency Room at a local hospital.</p> <p>An Emergency Room report, dated 8/1/16 at 11:26 pm, documented Resident #11 "presented with jaw pain which began earlier today. Patient was bending over to pick up the newspaper off the floor when she fell, hitting the right side of her face on the ground. Reports bleeding from her left ear..." Resident #11 sustained a small laceration to her right ear which required sutures.</p> <p>A nurses' note, dated 8/11/16 at 4:30 pm, documented Resident #11 was found on the floor with her raised toilet seat sitting next to her on the floor and stated "she fell asleep."</p> <p>On 8/15/16 at 2:40 pm, the DNS stated after each fall Resident #11 received increased supervision, including 15-minute checks continuing for 72 hours. The DNS stated Resident #11 was moved to a room closer to the nurses' station for increased supervision and she became very upset over the move. The DNS stated she did not remember if Resident #11 was involved in the decision making process about changing rooms, but the facility felt it was best to move her. When asked if therapy services were consulted to evaluate Resident #11 after any of the falls, the DNS stated on 8/13/16 the facility</p>	F 323			

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F 323	Continued From page 44 received an order from the physician for Physical Therapy to evaluate and treat Resident #11. Resident #11 did not receive supervision and/or services necessary to prevent falls. This failure resulted in injuries, including a laceration requiring sutures.	F 323			
F 329 SS=G	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 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:	F 329		10/28/16	

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F 329	<p>Continued From page 45</p> <p>Based on observations, staff interview, and record review, it was determined the facility failed to ensure antidepressant therapy was not discontinued when residents presented with signs and symptoms of severe depression. This failed practice resulted in harm when Resident #3, expressed suicidal ideation on at least four occasions after her long standing antidepressant medication was discontinued without a gradual dose reduction. Additionally, the facility failed to confirm Resident #3 was exhibiting "aggressive behaviors" related to dementia prior to initiating a medication ordered to address those types of behaviors.</p> <p>Findings include:</p> <p>1. Resident #3's psychological evaluation, dated 8/22/14, documented she had severe and recurrent major depressive disorder and problems with interpersonal relationships accompanied by strong feelings of loneliness.</p> <p>A Behavioral Committee Drug Review, dated 1/26/16, documented Resident #3 was cognitively intact; had mild depression; was "stable"; and her target behaviors included paranoid ideations and hallucinations. Medications included Zoloft 100 mg daily for depression.</p> <p>Resident #3's Quarterly MDS, dated 2/10/16, documented:</p> <ul style="list-style-type: none"> - Cognitively intact. - Verbalized feeling tired or having little energy for 7-11 days; poor appetite or overeating for 7-11 days; moved/spoke more slowly than usual or was fidgety and moved around more than usual 	F 329	<p>1. Resident #3 Physician was contacted and orders received to restart Zoloft 5/23/2016, a gradual dose reduction Risperdal was initiated on 8/16/16 and diagnosis for use of Namenda was changed to dementia on 9/19/16. Resident has not expressed suicidal ideation (SI) since 8/1/16 plan is to continue to receive senior counseling every other week, see Psychiatric Nurse Practitioner every 2 week and Psychiatrist quarterly.</p> <p>2 All residents have the potential to be affected by this practice. A review of all resident's drug regimens has been conducted to identify any unnecessary medications in any category.</p> <p>3. Psychoactive medication side effect monitoring has been added to the MARS; Target behaviors and interventions for each resident displaying behaviors have been identified and added to the MARs for tracking purposes. For every resident on a psychotropic review Interdisciplinary Team progress notes will be written for each resident reviewed in the psychotropic drug committee meetings held quarterly. Licensed Nurses and LSW were trained on the change to process on 9/22/16.</p> <p>4. Audits will be completed by Health Information Manager or designee on completeness of Psychiatric medication monitoring Weekly x 8, Monthly x 2, and Quarterly x3. All audit results will be</p>		

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F 329	<p>Continued From page 46 for 2-6 days; and had mild depression.</p> <p>Physician Orders from 3/1/16 through 3/27/16 included Zoloft 100 mg in the morning for depressive disorder and the Medication Administration Record (MAR) documented Resident #3 received Zoloft 100 mg daily from 3/1/16 through 3/27/16.</p> <p>Resident #3's current Mood care plan documented the following interventions: - Monitor, record, and report to health care provider, as needed, risk for harm to self: Suicidal plan; past attempt at suicide; risky actions (stockpiling pills, saying good-bye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgement, or safety awareness. (Initiated 11/15/13) - Non-pharmalogical interventions for depression/self-isolation: Senior counseling weekly, encourage her to participate in activities, reminisce with her about her life/job experiences such as homemaking and speech therapist, and encourage familiar television shows. (Initiated 11/15/13)</p> <p>Resident #3 was admitted to the hospital on 3/27/16 with multiple medical issues and was re-admitted to the facility on 4/8/16. The re-admission orders did not include and order Zoloft.</p> <p>A Progress Note, dated 4/8/16, documented Resident #3 was re-admitted to the facility and the Zoloft was not included on the re-admission</p>	F 329	reported to QAA Committee for further monitoring or modification based on audit results.		

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F 329	<p>Continued From page 47 orders.</p> <p>The Medication Administration Record (MAR) documented from 4/9/16 through 4/11/16, Resident #3 received Zoloft 100 mg daily which was not ordered. The MAR from 4/12/16 through 5/22/16 documented the Zoloft was place on "hold."</p> <p>A Behavior Committee Drug Review, dated 4/20/16, documented Resident #3 was cognitively intact and experienced mild depression. The review form did not address whether the facility monitored and evaluated Resident #3 for mood changes and/or increased suicidal ideation after the Zoloft 100 mg was placed on hold.</p> <p>On 5/6/16, a care plan change note documented Resident #3 told the Social Service director that she was having thoughts of harming herself and the facility initiated 15-minute checks.</p> <p>Resident #'3 clinical record documented the physician had not been notified on 5/6/16 about the resident's suicidal thoughts, or that the facility had assessed, evaluated, and/or monitored the resident for a "suicidal plan" and/or the means to commit suicide as directed by the mood care plan.</p> <p>Resident #3's Comprehensive MDS assessment, dated 5/6/16, documented: - Verbalized having little interest or pleasure in doing things for 7-11 of 14 days, felt down, depressed, or hopeless for 7-11 of 14 days, tired or had little energy for 7-11 of 14 days, poor appetite or overeating for 2-6 days; felt negative</p>	F 329			

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F 329	<p>Continued From page 48</p> <p>about herself for 7-11 of 14 days, trouble concentrating on reading or watching television, experienced thoughts she would be better off dead, or hurting herself in some way for 12-14 of 14 days; and experienced moderately severe depression.</p> <p>- The "safety notification" documented on the MDS as made, but there was no evidence any notification was done beyond the person who completed the assessment.</p> <p>On 5/12/16, the Social Service Director (SSD) documented Resident #3 was re-assessed for suicidal ideations, still had thoughts of harming herself, and continued on 15-minute checks. Resident #3 clinical record documented the physician had not been notified on 5/13/16 about the resident's suicidal thoughts, or that the facility had assessed, evaluated, and/or monitored the resident for a "suicidal plan" and/or the means to commit suicide as directed by the mood care plan.</p> <p>On 5/13/16, the Director of Nursing documented Resident #3 had no thoughts of harming herself. Resident #3's clinical record from 5/14/16 to 5/17/16 did not document staff performed any additional evaluation and/or assessment of the resident's increased suicidal and/or self-harm ideation.</p> <p>On 5/18/16, the SSD documented Resident #3 was re-assessed for continued 15-minute checks, stated she continued to have thoughts of harming herself, and would remain on 15-minute checks.</p> <p>On 5/20/16, a fax sent to Resident #3's physician</p>	F 329			

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F 329	<p>Continued From page 49</p> <p>documented, "[Resident #3] has been having suicidal ideations since 5/6/16 (was re-assessed on 5/12/16 and 5/18/16) and remained on 15-minute checks for suicidal ideations. Her Zoloft 100 mg ... has been on hold since 5/1/16 [NOTE: The resident's clinical record documented Zoloft had been on "hold" since 4/12/16]. [Resident #3 remained in a state of] moderately severe depression. Do you think it would benefit her to start the Zoloft again?"</p> <p>A physician order, dated 5/23/16, documented staff were to resume administering Zoloft 100 mg daily. The clinical record documented Resident #3 had not received Zoloft since 3/24/16, except for three days, 4/9/16 through 4/11/16.</p> <p>On 5/23/16, the SSD documented Resident #3 was re-assessed for suicidal ideations and she stated she was no longer suicidal. The 15-minute checks were discontinued at this time.</p> <p>On 6/23/16, the Nurse Practitioner (NP) documented, "[Resident #3] indicated that her moods were a little depressed. [Resident #3] stated she struggled with feelings of hopelessness and worthlessness daily. When asked about thoughts of suicide or death, she did not respond which may have been the result of not hearing the question."</p> <p>Resident #3's Quarterly MDS assessment, dated 7/12/16, documented: - Verbalized feeling tired or having little energy for 2-6 days; felt bad about herself for 2-6 days; moved/spoke more slowly than usual or was fidgety and moved around more than usual for 2-6 days; thoughts that she would be better off</p>	F 329			

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F 329	<p>Continued From page 50</p> <p>dead, or hurting herself in some way for 7-11 days; and experienced mild depression.</p> <p>- The "safety notification" documented on the MDS as made, but there was no evidence any notification was done beyond the person who completed the assessment.</p> <p>The clinical record did not include documentation the physician had been notified on 7/12/16 about the resident's thoughts of suicide, or that the facility had assessed, evaluated, and/or monitored the resident for a "suicidal plan" and/or the means to commit suicide as directed by the mood care plan.</p> <p>On 7/20/16, the SSD documented, "Psychosocial well-being discontinued as Resident #3 has not made statements of having little interest in doing things."</p> <p>A nurse's note, dated 8/1/16, documented, "[Resident #3's family member] called and reported to the nurse that the resident had called her and stated she was going to kill herself. [Resident #3] was placed on every 15 minute checks."</p> <p>On 8/2/16, the NP documented, "[Resident #3] says she is ok [sic]. She continues to have the agitation she was experiencing last month, but feels she is more able to cope with it and is able to answer questions appropriately."</p> <p>On 8/2/16 a Nurse's Note documented, "No attempts [by Resident #3] to injur (sic) self through this shift ..."</p>	F 329		

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F 329	<p>Continued From page 51</p> <p>On 8/3/16 a Nurse's Note documented, "Physician noted that he reviewed the suicide watch note [related to Resident #3]."</p> <p>A social service note, dated 8/9/16, documented, "[Resident #3] reassessed for suicidal ideation. She was asked if she was having thoughts of harming herself and she stated no [sic]. Every 15 minute checks were discontinued."</p> <p>On 8/12/16 at 1:00 pm, when asked if the physician had been notified upon completion of the MDS assessments and Resident #3's expression of suicidal ideation, the SSD and DNS did not respond. Please refer to F 157.</p> <p>2. Resident #3's Comprehensive and Quarterly MDS assessments, dated 5/6/16 and 7/12/16 respectively, documented the resident:</p> <ul style="list-style-type: none"> - Did not display physical, behavioral, and/or other behavioral symptoms towards others. - Did not reject evaluation or care that were necessary to achieve the resident's goals for health and well being. <p>A physician order, dated 5/31/16, documented the resident was to receive Namenda 5 mg at bedtime for aggressive behaviors related to dementia. No "aggressive behaviors" were documented in the resident's clinical record prior to the initiation of this medication.</p> <p>Resident #3's MARs dated 5/26/16 to 8/9/16 documented she received Namenda 5 mg at bedtime related to "aggressive behaviors."</p> <p>Resident #3's outpatient mental health NP progress notes, dated 5/31/16, 6/23/16, and</p>	F 329			

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F 329	Continued From page 52 8/2/16, did not identify concerns regarding "aggressive behaviors related to dementia." A Behavioral Committee Drug Review, dated 7/25/16, documented Namenda was ordered for aggressive behaviors related to Alzheimer's disease, however the review did not identify specific aggressive behaviors. On 8/12/16 at 1:00 pm, the DNS and SSD did not respond when asked to explain why Resident #3 was started on Namenda for aggressive behaviors when none had been documented as present. When asked if Resident #3 was monitored for adverse reactions related to the Namenda, the SSD and DNS again did not respond.	F 329			
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this	F 353		10/28/16	

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F 353	<p>Continued From page 53</p> <p>section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on Resident Group interview, staff interview, and review of facility Suggestion or Concern forms and Resident Council minutes, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of each resident. This affected 12 of 13 residents who attended the group interview and had the potential to affect all other residents who lived in the facility. This failed practice created the potential for psychosocial harm if residents toileting, activity, and other needs continued to go unmet due to lack of staff. Findings include:</p> <p>On 8/10/16 at 3:00 pm, when the resident group was asked if there were enough staff at the facility to take care of everyone, twelve of the residents said, "No!" Six of the residents stated they ask to sit outside in the courtyard every day when it is nice and are told there is not enough staff to take them outside. The six residents stated the activities staff are the staff that take them outside and it is usually at a time when it is convenient for them. One resident stated they used to have a garden and flowers for the residents take care of and the flowers and garden died due to lack of staffing. Ten residents stated there is not enough staff across all shifts to answer the lights in timely manner. When asked what was meant by a timely manner, three residents stated 15 minutes and the other seven</p>	F 353	<ol style="list-style-type: none"> 1. A doorbell has been installed in the courtyard area for those residents who can independently go outside so that if they are unable to open the door they can be assisted by staff. The DNS will communicate with nursing staff after standup the results of call light logs focusing on call light times over 10 minutes and getting their input on how we can reduce these times for those residents identified. 2. All residents have the potential to be affected by this practice. 3. We will monitor call lights at standup to address call light times for each resident which is over 10 minutes. We will then address prolonged call lights identifying specific residents, time of day and staff on shift during those times. Once specific needs are identified we will put into place a plan of care to meet those specific needs during those specified times of day. <p>Due to call light times being higher during nursing staff shift change we will implement changes on how shift change</p>		

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F 353	<p>Continued From page 54</p> <p>residents agreed. Six of the residents stated they have waited 45-65 minutes for assistance. Ten of the residents stated the CNAs answer call lights, turn the call lights off, tell the residents they will be right back and never come back. Two of the residents stated after waiting 45 minutes to use the bathroom, they were unable to wait any longer and voided in their pants. The two residents stated it embarrassed and upset them, "We should not have to wait that long to use the bathroom. We can't help it that we require two CNAs to help us."</p> <p>The facility's Suggestion or Concern Forms documented:</p> <ul style="list-style-type: none"> * 5/4/16 - "Not enough staff and call lights are not answered quickly." * 5/8/16 - "My grandpa needs to use the bathroom. It has been 20 minutes since talking to the nurse and turning his call light on, my grandpa still hasn't got to go to the bathroom." * 5/11/16 - "Family member complained about resident not getting her evening medications due to short staff." * 5/18/16 - During a family interview it was reported, "Resident has to wait 20 minutes to use the restroom and it is hard for her to wait that long." * 6/7/16 - "Resident reported that there is not enough staff on the weekends to meet needs without having to wait a long time." * 6/13/16 - "Resident stated on 6/11/16 around 9:30 pm the CNA left the resident's room and left the call light out of reach. Because of this the resident could not call for help and did not get to use her c-pap. Resident was without her call light until 8:00 am when the laundry department 	F 353	<p>report is given to ensure ample amount of staff remain on the floor to meet residents' needs during those times.</p> <p>We will take a comprehensive look at all of the nursing schedule to make sure that breaks and lunches are being staggered and taken appropriately so as to assure there is enough staff on the floor at all times.</p> <p>We have completed an analysis of the scheduling of our Licensed Nurses and CNAs to determine the right number of each that are needed for each shift and are hiring appropriately based upon those findings. This included developing a FTE worksheet, staffing ladder and position controls to guide us.</p> <p>Residents who wish to go outside will be assessed to determine needed level of assistance. Care plans will be updated to include level of assistance needed.</p> <p>LN and CNAs were educated on shift change procedures on 9/22/16 during staff meeting.</p> <p>Nursing, Activities , Social services have been reeducated on change to process on or before 10/6/2016.</p> <p>4. An audit of resident call light times will be completed by the HR Coordinator or designee weekly for 8 weeks and monthly for 10 months.</p>		

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F 353	Continued From page 55 entered her room." The Resident Council Meeting minutes documented: * On 7/19/16, one resident in attendance stated, if her door was closed it could take up to 45 minutes for her call light to be answered. The Social Service Director told the residents the facility had hired more staff and the call light response times should get better. * On 6/21/16, one resident in attendance stated, "her call light was on for 45 minutes," before it was answered. The Social Service Director stated the facility had hired more staff and the call light response times should be get better. On Thursday, 8/11/16 at 10:00 am, CNA #1 was asked about the staffing and stated halls 1, 2, and 3 have only three CNAs most of the time and have four CNAs this week because the surveyors are at the facility. CNA #1 stated Administration is aware and tell staff they have been receiving applications. CNA #1 stated, "The CNAs are constantly having to turn call lights off and leave the residents and the residents get upset because they have to wait so long." CNA #1 stated the facility has had "call lights on for up to an hour at times." On 8/11/16 at 11:30 am, the Staffing Coordinator stated the facility did have increased staffing during the week of the survey. On 8/15/16 at 1:50 pm, the DNS stated staffing had been a problem but they were working on getting more CNAs and nurses hired.	F 353	An Audit of Care plans for residents wishing to go outside needing assistance will be done Weekly X4, Monthly X2 , Quarterly X 3 All audit results will be reported to QAA Committee for further monitoring and modification based on finding.		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME	F 368		10/28/16	

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F 368	<p>Continued From page 56</p> <p>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on the Resident Group interview and staff interview, it was determined the facility failed to ensure bedtime snacks were offered to all residents. This was true for 13 of 13 residents in a resident group interview, and had the potential to affect all residents in the facility who desired a bedtime snack. The deficient practice had the potential to cause harm if residents experienced hunger between dinner and breakfast or did not receive adequate nutrition to support healing or prevent weight loss. Findings include: On 8/10/16 at 3:00 pm, during the Resident Group interview, residents said they were not offered bedtime snacks. The residents said the evening snack cart was left in the hallway and</p>	F 368	<ol style="list-style-type: none"> All residents will have bedtime snack offered. Snack times have been posted on activities board. Snacks are accessible in the Station 1 refrigerator and Rehabilitation refrigerator for between meal snacks. Snack cart will be passed by designated staff and intake documented by the Licensed Nurse (LN). Residents refusing will be re-approached and response documented. All residents who could receive bedtime snacks have the potential to be affected by this practice. Passing snacks, including HS snacks, 		

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F 368	Continued From page 57 residents had to "fend for themselves." On 8/11/16 at 10:00 am, CNA #1 stated snack carts were brought to the hallways between 8:00 pm and 9:00 pm, but that snacks were not passed out or offered to residents. CNA #1 said residents wanting a snack were required to ask for one.	F 368	has been added to the Certified Nursing Assistant (CNA) shift routine. The expectation to use cart to pass snack and document amount taken has also been added to Licensed Nurse and Certified Nursing Assistant orientation. Certified Nursing Assistant will pass snacks using the snack cart. Licensed Nurse will check during shift that snack was given, or if refused a re-approach was done and intake was documented. On 9/22/2016 Dietary and Nursing staff were educated on the change to this process. 4. Audits by Dietary Director or designee of snack intake will occur daily till 100% compliance, then Weekly X4, Monthly X2, Quarterly X3. All audit results will be reported to QAA for further monitoring and modification based on results.		
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 accessible; and systematically organized. 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.	F 514		10/28/16	

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F 514	<p>Continued From page 58</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to fully and accurately monitor meal intakes for a resident who was at risk for weight loss. This was true for 1 of 12 (#3) residents sampled for weight loss and created the potential for nutritional decisions to be based on inaccurate information. Findings include:</p> <p>Resident #2 was admitted to the facility with multiple diagnoses including diabetes mellitus (DM), multiple sclerosis, anemia, and GERD.</p> <p>The nutrition report for 7/11/16 through 8/9/16 (30 days) documented 90 meals with the following percentages of the meal eaten: 25 meals at 0-25% 36 meals at 26-50% 10 meals at 51-75% 7 meals at 76-100% 6 meals - resident refused 2 meals - resident unavailable 1 meal - not applicable</p> <p>On 8/12/16 at 10:00 am, when the Registered Dietician was asked what percent of the meal was consumed that staff documented at 0-25%, the RD stated between 1% and 25%. When asked how accurate and helpful those intake categories were in assisting the facility to address the resident's potential for weight loss, the RD stated the facility had previously documented meal intakes as either 25%, 50%, 75%, or 100%. The RD stated the current</p>	F 514	<ol style="list-style-type: none"> 1. Resident #3- was identified on citation but no information given to follow-up. Resident #2- Registered Dietician (RD) reassessed residents nutritional meal intake based on the known percent meal consumed (0%, 25%, 50%, and 75%) and averaging the most recent 7 days meal intake and documenting the known actual percentage. RD then reviewed food preferences at meal times/snacks and discussed supplementation with resident. 2. All residents have the potential to be affected by this practice. 3. System: Evaluation of meal intakes will be addressed according to the known mal consumed using know actual percentage meal intake (0%, 25%, 50%, and 75%). Education: On 9/22/2016, registered dietician, Dietary department and Nursing staff were educated on the changes to this process. 4. Audits of Nutrition status and weight change notes will be done by QAA Coordinator or designee Weekly X 4, Monthly X2, Quarterly X 3. Audit results will be reported to QAA Committee for further monitoring and modification based on audit findings. 	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 514	Continued From page 59 categories were a more accurate means of determining residents' average meal intakes. When asked how meal intakes are calculated, the RD stated she averaged the number of meals consumed with the intake percentages to determine the average intake based on that information.	F 514			
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 520		10/28/16	

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F 520	<p>Continued From page 60</p> <p>Based on observation, record review, review of the facility's compliance history, Resident Group interview, and staff interview, it was determined the facility's quality assessment and assurance (QAA) committee failed to take actions which identified and resolved systemic problems for 2 of 12 sampled residents (#2 and #4) and had the potential to affect all residents in the facility. This failure resulted in the QAA committee providing insufficient direction and control necessary to ensure residents' quality of care needs were met, and additionally, had the potential to harm residents due to insufficient and/or inadequate care. Findings include:</p> <p>The QAA committee failed to provide sufficient monitoring and oversight to sustain regulatory compliance as evidenced by the following citations for the current 8/16/16 annual recertification survey.</p> <p>1. On 8/12/16 at 5:17 pm, the facility was cited at F225 for Immediate Jeopardy when it failed to identify and investigate allegations of abuse. Refer to F225 for additional information.</p> <p>2. On 8/12/16 at 5:17 pm, the facility was cited at F329 for Immediate Jeopardy when it failed to ensure antipsychotic and psychotropic medications had adequate indications of use, used at the lowest possible dose, and monitored for potential adverse consequences. The facility was cited at F329 on the three previous recertification surveys conducted on 3/30/15, 12/20/13 and 12/14/12. Refer to F329 for additional information.</p> <p>3. The facility failed to provide sufficient staffing</p>	F 520	<p>1. The QAA Committee met on 9/14/16 to discuss the process and actions were developed for a plan for compliance with the current survey and specifically with citations for residents' #2 and #4 – see plan of corrections for F309, F314, and F514.</p> <p>2. All residents have the potential to be affected by this practice.</p> <p>3. The QAA committee will be streamlined to include only essential members of the leadership team, with other essential staff or department heads to be brought in as needed. The essential QAA committee members will be made up of the Administrator, DNS, Quality Coordinator, HIM Coordinator, LSW, Medical Director and Pharmacy Consultant. In the QAA meeting current survey issues, audit results, center committee and data reports will be discussed to identify and prioritize areas to take action with proper follow up and delegation to be made based upon QAA committee recommendations.</p> <p>4. An audit of QAA committee minutes will be completed to ensure facility concerns are identified, resolved, and corrections sustained through the QAA process. The audit will be completed by Good Samaritan Society</p>		

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F 520	<p>Continued From page 61 to meet the residents' needs and the facility was cited at F353. The facility was cited at F353 on the three previous recertification surveys conducted on 3/30/15, 12/20/13 and 12/14/12. Refer to F353 for additional information.</p> <p>4. The facility failed to ensure residents' did not experience severe weight loss and the facility was cited at F325. The facility was cited at F325 on the two previous recertification surveys conducted on 3/30/15 and 12/20/13. Refer to F325 for additional information.</p> <p>On 8/15/16 at 3:35 pm, the Administrator indicated he did not know the reason the same deficient practices identified during the prior recertification survey, were again identified during the current recertification survey. He stated he felt the QAA committee had done a good job in identifying and correcting areas of concern.</p>	F 520	Quality/Performance Improvement Consultant or designee monthly for 12 months.		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135092	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 8/16/2016
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 364	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive 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 and staff interview, it was determined the facility failed to ensure nutritional supplements past their expiration dates were not available for resident use. The nutritive value of supplements with protein decreases after the expiration date, compromising the benefit to residents who consume them. Findings include:</p> <p>On 8/10/16 at 11:50 am, during the tour of the kitchen with the CDM, outdated food items were observed in the dry storage area which included:</p> <p>*19 cans of Nepro nutritional supplement with protein with an expiration date of September 2015, and *24 cans of Nepro nutritional supplement with protein with an expiration date of May 2016.</p> <p>On 8/10/16 at 11:50 am, the CDM said she did not know the reason the Nepro supplements were left on the shelf for possible use.</p>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved

The above isolated deficiencies pose no actual harm to the residents