



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
PHONE: (208) 334-6626
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October 14, 2016

Revised letter change in SS at F41

Joan Martellucci, Administrator
Coeur D'Alene Health Care & Rehabilitation Center
2514 North Seventh Street
Coeur D'Alene, ID 83814-3720

Provider #: 135052

Dear Ms. Martellucci:

On **September 8, 2016**, a survey was conducted at Coeur D'Alene Health Care & Rehabilitation Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 10, 2016**. Failure to submit an acceptable PoC by **October 10, 2016**, may result in the imposition of penalties by **October 31, 2016**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 13, 2016 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 7, 2016**. A change in the seriousness of the deficiencies on **October 23, 2016**, may

Joan Martellucci, Administrator
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result in a change in the remedy.

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

Denial of payment for new admissions effective **December 7, 2016**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 7, 2017**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **December 7, 2016** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

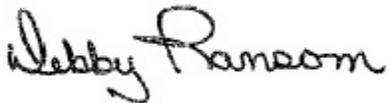
- BFS Letters (06/30/11)

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

This request must be received by **October 10, 2016**. If your request for informal dispute resolution is received after **October 10, 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,



Debby Ransom, RN, RHIT, Supervisor
Long Term Care

dr/
Enclosures

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

PRINTED: 10/24/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/08/2016
NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey of your facility conducted 9/6/16 through 9/8/16.</p> <p>The surveyors conducting the survey were:</p> <p>Amy Barkley, RN - Team Coordinator Teresa Kobza, RDN, LD</p> <p>Acronyms used in this report include:</p> <p>BID = Two times a day BM = Bowel Movement CHF = Congestive Heart Failure CKD = Chronic Kidney Disease CNA = Certified Nursing Assistant DCS = Director of Clinical Services DM = Diabetes Mellitus ESRD = End Stage Renal Disease HTN = Hypertension MAR = Medication Administration Record MD = Physician MDS = Minimum Data Set mg = Milligram mL = Milliliter MRSA = Methicillin-Resistant Staphylococcus Aureus M, W, & F = Monday, Wednesday, and Friday PO = by mouth RD = Registered Dietitian RN = Registered Nurse ROM = Range of Motion SBAR = Situation, Background, Assessment, Recommendation SNF = Skilled Nursing Facility SLP = Speech Language Pathologist s/s = Signs and Symptoms</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

10/10/2016

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

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F 000	Continued From page 1 ST = Speech Therapy TAR = Treatment Administration Record TID = Three times a day w/c = wheelchair WNL = Within Normal Limits	F 000			
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the	F 156		10/13/16	

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F 156	<p>Continued From page 2</p> <p>facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the</p>	F 156			

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F 156	<p>Continued From page 3</p> <p>physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents were provided advance notice of the reason their Medicare Coverage A was being terminated during their stay in the SNF. This deficient practice was true for 2 of 5 residents (#7 & #9) reviewed for notice of Medicare non-coverage. This failure created the potential for residents to experience financial distress and psychological harm when residents were not informed of why their Medicare coverage was ending. Findings include:</p> <p>a. Resident #7's Medicare Appeal letter documented Resident #7's Medicare coverage would end on 7/20/16 and included how she could appeal the decision. The letter did not include a reason for the coverage termination and was not signed by Resident #7 and or her POA.</p> <p>b. Resident #9's Medicare Appeal letter documented Resident #9's Medicare coverage would end on 7/26/16 and included how she</p>	F 156	<p>1. Time constraints do not allow for letters to be sent/completed for Residents #7 & #9.</p> <p>2. Residents with Medicare provided services have the potential to be affected by this alleged deficient practice.</p> <p>3. The Executive Director (ED) will re-educate the social Service Director(SSD, Business Office Manager (BOM) and the Resident Assessment Coordinator (RAC) on Notice of Medicare Provider Non-Coverage (Advance Beneficiary Notice of Non-coverage) by October 12, 2016.</p> <p>4. The BOM/ED will conduct Quality Improvement (QI) monitoring of regulation F156 to ensure residents are provided advance notice of the reason their Medicare coverage is being terminated and written confirmation of Medicare non-coverage appeal rights. QI monitoring will be conducted on residents with Medicare A provider 1 x weekly for 8 weeks then 1 x monthly for 4 months</p>		

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F 156	Continued From page 4 could appeal the decision. However, the letter did not include a reason for the coverage termination and was not signed by Resident #9. On 9/8/16 at 3:50 pm, the Administrator stated the facility did not currently have a demand letter that notified residents why their Medicare coverage was ending.	F 156	and/or until substantial compliance is obtained. The BOM will report the findings to two quarterly Assurance Performance Improvement committee meetings. The QAPI committee (consisting of the Director of Clinical Services, Medical Director, Executive Director and 3 other staff members) will determine if further action needs to be taken and determine the continued time schedule for further monitoring.		
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 staff interview and record review it was determined the facility failed to ensure a resident was administered medications consistent with physician orders. This was true for 1 of 8 (#6) sampled residents and had the potential for more than minimal harm if Resident #6 experienced adverse health outcomes at the dialysis facility or SNF due to receiving more, or less, medication than prescribed. Findings include: Resident #6 was readmitted to the facility on 3/23/16 with diagnoses that included systemic MRSA, post-surgical replacement dialysis catheter, CHF, DM, and ESRD with dialysis. Resident #6's 8/17/16 Quarterly MDS assessment documented he received injections of insulin 7 days a week and received dialysis.	F 281	1. The Director of Clinical Services will clarify #6's physician's orders for medication administration on dialysis days by 10/12/2106. 2. Those who reside in the facility have the potential to be affected by not administering medications consistent with the physician's orders. The DCS reviewed facility population for any other residents on dialysis with deferred medication orders on September 9th; none were identified. 3. The DCS/Designee will re-educate licensed nurses on medication administration and documentation practices of following physicians orders by 10/12/2016. Physician's orders and Medication Administration Records (MAR)	10/13/16	

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F 281	<p>Continued From page 5</p> <p>Resident #6's September 2016 Physicians' Orders included:</p> <ul style="list-style-type: none"> * Carvedilol 6.25 mg PO BID in the morning and at night for HTN, hold prior to dialysis, beginning 6/21/16. * Docusate Sodium 100 mg every morning for constipation, hold prior to dialysis, beginning 6/21/16. * Polyethylene Glycol 3350 powder in liquid form, 17 gm, twice daily for constipation. Hold prior to dialysis, beginning 6/21/16. * Gabapentin 200 mg PO TID for diabetic neuropathy, beginning 6/21/16. * Resident #6 went to a dialysis facility on Monday, Wednesday, and Friday. <p>Resident #6's Dialysis Care Plan, dated 8/5/16, documented he had altered renal function requiring dialysis Monday, Wednesday, and Friday. Interventions directed staff to give Resident #6 his medications as ordered.</p> <p>Resident #6's July - September 8, 2016 MAR documented the following medications were not administered per physician orders:</p> <ul style="list-style-type: none"> * The facility failed to hold Carvedilol prior to dialysis on 7/27/16 and 7/29/16. * The facility failed to hold Docusate Sodium prior to dialysis on 7/13/16, 7/25/16, 7/27/16 and 7/29/16. 	F 281	<p>for residents on dialysis with deferred medication orders will be reviewed during the morning clinical meeting to ensure medications are administered consistent with the physician orders.</p> <p>4. The DCS/designee will perform QI monitoring of the regulation F-281 to ensure medications are administered consistent with the physician's orders. QI monitoring will be conducted five times a week for four weeks, weekly for four weeks, then monthly for three months and/or until substantial compliance is obtained using a sample size of five random residents. The DCS will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine substantial compliance, determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p>		

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F 281	<p>Continued From page 6</p> <p>* Resident #6's July 2016 MAR, documented Gabapentin was held on 7/1/16, 7/4/16, 7/11/16, 7/15/16, 7/18/16, 7/20/16, and 7/22/16. There was no physician order to hold the Gabapentin prior to dialysis.</p> <p>* The facility failed to hold Polyethylene Glycol prior to dialysis on 7/11/16, 7/13/16, 7/15/16, 7/18/16, 7/20/16, 7/22/16, 7/25/16, 7/27/16 and 7/29/16.</p> <p>* The facility failed to hold Carvedilol prior to dialysis on 8/22/16, 8/24/16 and 8/26/16.</p> <p>* The facility failed to hold Docusate Sodium prior to dialysis on 8/24/16, 8/26/16, and 8/29/16.</p> <p>* The facility failed to hold Polyethylene Glycol prior to dialysis on 8/1/16, 8/8/16, 8/10/16, 8/17/16, 8/19/16, 8/22/16, 8/24/16, 8/26/16, 8/29/16 and 8/31/16.</p> <p>* Resident #6's September 2016 MAR through 9/8/16 documented the facility failed to hold Carvedilol prior to dialysis on 9/2/16.</p> <p>* Resident #6's September 2016 MAR through 9/8/16, documented the facility failed to hold Polyethylene Glycol prior to dialysis on the mornings of 9/2/16, 9/5/16, and 9/7/16.</p> <p>On 9/8/16 at 10:30 am, the DNS stated Resident #6's medications Carvedilol and Docusate Sodium were held the morning of the days he received dialysis. She stated she was not sure if he was to receive the medication after he got back from dialysis.</p>	F 281			

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F 325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review, and staff interview, it was determined the facility failed to ensure 1 of 4 residents (#2) sampled for weight loss received appropriate nutritional interventions to prevent unplanned weight loss. Resident #2 had the potential for harm when he experienced a 8.55% weight loss in 3 months. Findings include:</p> <p>Resident #2 was admitted to the facility on 6/27/01, with diagnoses which included CVA with hemiparesis, aspiration pneumonia, aphasia, dementia, and dysphagia.</p> <p>Resident #2's annual MDS assessment, dated 4/22/16, documented his weight was 169 pounds. Resident #2's 7/22/16 Quarterly MDS assessment, documented he was severely cognitively impaired and was completely dependent on staff for all cares, which included eating and drinking. The MDS documented</p>	F 325	<p>1. resident #2 was reviewed by the Medical Director on 9/30/2016. The Speech Therapist will re-evaluate Resident #2 and provide guidance for the direct care staff on the optimal feeding process for this resident by October 12, 2016. The Interdisciplinary Team (IDT) will review and update, as indicated, the careplan and nurse kardex for Resident #2 to ensure appropriate nutritional interventions in place by October 12, 2016. The DCS/designee will re-educate Certified Nursing Assistant (CNA) #1 on assisting residents' with meals and documenting resident meal consumption by October 12, 2016.</p> <p>2. Residents at risk for weight loss have the potential to be affected by not ensuring appropriate nutritional interventions to prevent unplanned weight loss.</p>	10/13/16	

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F 325	<p>Continued From page 8</p> <p>Resident #2's weight was 158 pounds.</p> <p>Resident #2's September 2016 Physicians' Orders included:</p> <ul style="list-style-type: none"> * Resident #2 was on a regular diet with a pureed texture and pudding thick liquids, beginning on 1/21/13. * Resident #2 was to receive Med-pass 2.0 [fortified nutritional shake] 60 mL's three times a day with meals. Staff were to offer the Med-pass on trays with thickener, beginning on 5/22/15. * Beginning 3/1/15, staff were to offer 60 mL alternative thickened fluids. <p>Resident #2's Physician Orders did not contain an order for Comfort Measures or End of Life Care.</p> <p>Resident #2's Nutrition Care Plan, dated 6/11/16, included a goal that he would not complain of hunger or thirst. Interventions included:</p> <ul style="list-style-type: none"> * Staff were to provide Resident #2's diet as ordered by the physician of pureed food with pudding thick liquids with meals. * Staff were to provide 60 mL of pudding thick Med-pass with all three meals. * Resident #2 was dependent on staff for his food and fluids needs. Staff were to alternate bites of food with sips of liquid, which allowed him to clear his throat between food and fluids. * The RD was to evaluate Resident #2, as 	F 325	<p>Resident Roster was reviewed by the IDT on 9/30/2016 for other residents with significant weight loss to ensure appropriate nutritional interventions were in place; issues identified were care planned as necessary.</p> <p>3. The DCS/Designee will re-educate the nursing staff on assisting residents with meals and documenting resident meal consumption by October 12, 2016. The IDT will review at risk resident weights weekly and ensure residents identified with weight loss have appropriate nutritional interventions and/or comfort care status , as appropriate.</p> <p>4. The DCS/designee will perform QI monitoring of the regulation F325 to ensure appropriate nutritional interventions to prevent unplanned weight loss. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for 3 months and /or until substantial compliance is obtained using a sample size of 5 random residents. The DCS will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine substantial compliance, determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p>		

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F 325	<p>Continued From page 9 needed, for nutritional recommendations.</p> <p>* ST was to evaluate and treat Resident #2, as needed.</p> <p>* Staff were to use a soup spoon while feeding Resident #2 and were instructed to tilt him back in his wheelchair. In addition, staff were instructed to talk him through his swallowing.</p> <p>Resident #2's Self Care Deficit care plan, initiated on 5/2/16, documented that while assisting Resident #2 to eat, staff were to give him small bites and allow him to swallow between bites.</p> <p>Resident #2's CNA Flowsheet, documented:</p> <p>* In May 2016, 30% of the time Resident #2 consumed between 25-50% of his meals.</p> <p>* In June 2016, 57% of the time Resident #2 consumed between 0-50% of his meals.</p> <p>* In July 2016, 56% of the time Resident #2 consumed between 0-50% of his meals.</p> <p>* In August 2016, 37% of the time Resident #2 consumed between 25-50% of his meals.</p> <p>* 9/1/2016 - 9/6/16, 41% of the time Resident #2 consumed between 0-50% of his meals.</p> <p>Resident #2's 6/1/16 through 9/7/16 MAR documented:</p> <p>* On 6/6/16, Resident #2's weight was 168.4 pounds.</p> <p>* On 6/13/16, Resident #2's weight was 167</p>	F 325			

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F 325	<p>Continued From page 10</p> <p>pounds.</p> <p>* On 6/20/16, Resident #2's weight was 167.8 pounds.</p> <p>* On 7/4/16, Resident #2's weight was 158.6 pounds.</p> <p>* On 7/11/16, Resident #2's weight was 165.6 pounds.</p> <p>* On 7/18/16, Resident #2's weight was 158 pounds.</p> <p>* On 7/25/16, Resident #2's weight was 154.2 pounds.</p> <p>* On 8/2/16, Resident #2's weight was 154 pounds.</p> <p>* On 8/8/16, Resident #2's weight was 154.8 pounds.</p> <p>* On 8/15/16, Resident #2's weight was 155 pounds.</p> <p>* On 8/29/16, Resident #2's weight was 154 pounds.</p> <p>* On 9/7/16, Resident #2's weight was 157 pounds.</p> <p>Resident #2 experienced a 14.4 pound or 8.55% weight loss between 6/1/16 and 8/29/16.</p> <p>Resident #2's Nutrition Progress Note, dated 4/8/16, documented his weight was stable, ranging from 165.8-175.5 pounds. The note documented his weight was stable for the past 1-3 months. The note documented Resident #2 had triggered for a significant weight change over a 6 month period and noted that was due to a weight error.</p> <p>Resident #2's MD note, dated 4/12/16, documented a routine follow up and the MD assessment documented Resident #2 experienced weight gain on Remeron.</p>	F 325			

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F 325	<p>Continued From page 11</p> <p>Resident #2's Nutrition Evaluation and Review, dated 5/13/16, documented he had a weight gain from last fall through February. The review documented Resident #2's diet had been adjusted; he was no longer on a fortified diet and Remeron was discontinued on 3/11/16. The review further stated his weight had recently plateaued at about 169.4 pounds and his oral intake was great. The note documented Resident #2's weight was currently stable and his weight range was about 165-170 pounds.</p> <p>Resident #2's MD note, dated 6/9/16, documented the chief complaint for the visit was weight loss and the MD assessment documented he had malnutrition with anticipated weight loss.</p> <p>Resident #2's Nutrition Review Note, dated 7/29/16, documented he weighed 158 pounds and the weight trend was slow and not significant.</p> <p>On 9/6/16 at 12:01 pm, Resident #2 was sitting in his wheelchair in the dining room and a CNA was assisting him with lunch. Resident #2 was sitting at a 90 degree angle with his head slightly slumped forward and his eyes were closed. Resident #2 had three cups of thickened fluids in front of him. One of the cups was Med-pass. The CNA was spooning heaping spoonfuls of fluids into Resident #2's mouth and encouraging him to swallow. Resident #2 started to cough. When the meal trays arrived CNA #1 was the only CNA at the table to assist the three residents with their various needs. Resident #2's meal tray arrived and CNA #1 scooped up a spoonful of mashed potatoes, touched it to her wrist, and put the food</p>	F 325		

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F 325	Continued From page 12 in Resident #2's mouth. Resident #2's eyes were closed and he appeared asleep. CNA #1 tapped Resident #2 on the shoulder and asked him to wake up. CNA #1's attention was divided and she was assisting the other two residents by cueing them to eat or cut up their food. At 12:08 pm, while CNA #1 was assisting another resident at the table, Resident #2's mashed potatoes began to spill out of his mouth and started to drip onto the clothing protector on his chest. At 12:14 pm, CNA #1 noticed the food coming from Resident #2's mouth and the food on his clothing protector. CNA #1 cleaned Resident #2's mouth off with a napkin and continued to spoon heaping spoonfuls into his mouth one after the other. Resident #2's food continued to drop out of his mouth and onto the clothing protector. CNA #1 did not cue Resident #2 to swallow as noted in his care plan. She cleaned the food off his mouth and placed it back into his mouth and followed it with another spoonful of food. At 12:16 pm, CNA #1 got up from her chair and moved closer to another resident at the table and assisted him with cutting up his fruit and cued him on how to use his utensils. Resident #2 sat in his chair with his eyes closed and food was dripping out of his mouth. At 12:20 pm, CNA #2 came to assist Resident #2. She gave him one bite of food which covered half of the spoon and the food did not come out of Resident #2's mouth. CNA #2 left the table to assist another resident after giving him the one bite. At 12:23 pm, CNA #1 noticed the food on his clothing protector, asked for a few more napkins, and cleaned Resident #2's mouth off. CNA #1 tapped him on the shoulder and asked him to wake up, picked up his spoon, and assisted Resident #2 with a few more heaping spoonfuls of food. At 12:26 pm, CNA #1 turned	F 325			

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F 325	<p>Continued From page 13</p> <p>her attention to another resident and directed the other resident to try to pick up his water cup. She attended to the other two residents until 12:40 pm, when she moved back to the other chair and started to give Resident #2 his Med-pass. She tapped him on the shoulder and asked him to wake up. She continued to put large spoonfuls of food into Resident #2's mouth. The food was dripping out of his mouth and CNA #1 used the spoon to wipe the food off of Resident #2's face and spooned the food back into his mouth. She followed each spoonful with another large spoonful of food. Resident #2's eyes were closed and CNA #1 continued to tap him on the shoulder and ask him to wake up while she assisted him with eating. At 12:53 pm, Resident #2's clothing protector was soiled and the food was on his shirt and blanket. At the end of the meal, Resident #2 had eaten a few bites of his food and consumed 1/2 of his Med-pass.</p> <p>On 9/6/16 at 1:20 pm, the DNS stated some aides could get Resident #2 to eat more of his meals than others. She stated a stand up meeting had occurred which discussed how to assist Resident #2 with eating. She stated the CNA flow sheets contained documentation of the amount of food residents ate at meals and that the Med-pass was not included on the form. She said the Med-pass was documented by nursing on the MAR/TAR. The MAR/TAR documentation for June, July, and August 2016, included a staff initial to indicate Med-pass was offered 3 times a day with meals. The amount of Med-pass consumed was not documented.</p> <p>On 9/6/16 at 1:30 pm, CNA #1 stated if she saw food spilling out of Resident #2's mouth, she</p>	F 325			

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F 325	<p>Continued From page 14</p> <p>continued to put bites of food in his mouth to try to stimulate him to swallow the first bite. In addition, she stated she judged how much he ate by how much food was gone from his plate. She did not account for the amount of food that spilled onto his clothing protector or that was wiped up with napkins. She stated he ate a few bites of his meal tray and part of his Med-pass, which she had not yet documented.</p> <p>On 9/6/16 at 4:05 pm, RN #2 stated the facility did not document the amount of Med-pass consumed by residents and she had no way to determine how much Resident #2 had consumed.</p> <p>On 9/6/16 at 4:10 pm, the RD stated the facility was focusing on Resident #2's comfort and not on hydration or weight concerns. In addition, the RD stated back in May 2016 Resident #2 experienced a significant change in regards to his ability to swallow, and due to the change the focus was on Resident #2's comfort.</p> <p>On 9/7/16 at 8:22 am, CNA #3 was assisting Resident #2 with his morning meal. Resident #2 coughed occasionally throughout the observation. Resident #2 had a little bit of food spill out of his mouth. The food was wiped up quickly into a napkin. Resident #2 had his meal and three liquids which, included his Med-pass, in front of him. At the end of the meal, Resident #2 had eaten approximately 25% of his meal tray and 1/4 of the Med-pass.</p> <p>On 9/7/16 from 9:30 - 10:39 am, Resident #2 was laying in his bed. Staff did not go into his room to offer him fluids.</p>	F 325			

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F 325	<p>Continued From page 15</p> <p>On 9/7/16 at 1:59 pm, Resident #2 was sitting in his w/c in the activities room and a staff member was assisting other residents in the room and did not offer him fluids. There were no thickened liquids in the activities room.</p> <p>On 9/7/16 at 4:29 pm, the DNS stated given the current documentation she could not determine the amount of fluids or food Resident #2 consumed throughout the day. She stated she had not thought about the fluids, food, and Med-pass all being offered at meal times (three times daily) and that might be a contributing factor to his recent decrease in weight.</p> <p>On 9/7/16 at 5:10 pm, the SLP stated Resident #2's swallowing declined a couple days in May. She stated when she assessed him again on 5/25/16, his swallow was back at his baseline. She stated the assessment was not in the chart but she had written a note that day [9/7/16] and back dated it. In addition, she stated on 5/25/16, she had educated the staff on how to assist Resident #2 with eating. The assessment she spoke of was not in his active chart and was in overflow.</p> <p>An Interdisciplinary Therapy Screen was documented by the SLP on 9/7/16 and noted it was for the screening of Resident #2's swallowing ability which was completed on 5/25/16. The note documented Resident #2's swallowing ability had returned to baseline. It also stated caregivers were educated to feed Resident #2 only when he was alert and participating. The instructions to staff were not included on Resident #2's care plan.</p>	F 325			

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F 325	Continued From page 16 An SLP Treatment Note, dated 7/29/15, documented "caregiver [education] [regarding] safe feeding positioning and strategies; up 90 degrees for all intake and thirty minutes post, alternate liquids and [solids], allow rest [breaks] during meals." On 9/8/16 at 9:45 am, the RD stated Resident #2's weight was discussed in a care meeting yesterday and the panel had changed the Med-pass to between meals, instead of with meals. Resident #2 experienced weight loss when the facility failed to ensure he was assisted with meals in a consistent manner; failed to ensure he received the opportunity to meet his calorie requirements throughout the day; and failed to ensure a nutrition assessment was completed and interventions initiated when he continued to lose weight.	F 325			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		10/13/16	

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F 441	<p>Continued From page 17</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the infection control protocol manual, the facility failed to ensure an Infection Prevention and Control Program was fully developed, implemented, and maintained to prevent the onset and spread of infections within the facility. This is true for 1 of 8 (#2) sampled residents residing in the facility and had the potential to impact all other residents residing in the facility. This failed practice resulted in the potential for residents, staff, and visitors to contract preventable infections. Findings include:</p>	F 441	<p>1. Resident #2 suffers no apparent harm. CNA#1 was immediately retrained regarding proper process to test food temperature on 9/6/2016 by the Director of Staff Development (DSD). 2. Those who reside in the facility have the potential to be affected by not ensuring an Infection Prevention Control program during meals is fully developed, implemented, and maintained to prevent the onset and spread of infections within the facility.</p>		

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F 441	Continued From page 18 1. On 9/6/16 at 12:01 pm, Resident #2 was in the dining room and a CNA was assisting him with his lunch. Resident #2's meal tray arrived and CNA #1 scooped a spoonful of mashed potatoes, touched it to her wrist, and then put the food in Resident #2's mouth. On 9/6/16 at 1:20 pm, the DNS stated aides should not be touching residents' food to their skin prior to assisting them with eating. On 9/6/16 at 1:30 pm, CNA #1 stated she was checking the temperature of the food when she put the spoon to her wrist. She stated she did not want Resident #2 to get burned by hot food. She did not realize it was an infection risk. She stated she always washes her arms before assisting residents to eat.	F 441	3. The DNS/designee will reeducate the nursing staff on proper feeding technique when assisting a resident with dining by October 12, 2016. 4. The DCS/designee will perform QI monitoring of the regulation F 441 to ensure and Infection Prevention Control Program is fully developed, implemented, and maintained to prevent the onset and spread of infections within the facility. QI monitoring will be conducted via random observations of random meal services five times a week for 4 weeks, three times a week for 4 weeks, then monthly for three months and/or until substantial compliance is obtained. The DCS will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine substantial compliance, determine if further action needs to be taken and determine the continued time schedule for further monitoring.		