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 19, 2016

Darwin Royeca, Administrator
Oak Creek Rehabilitation Center Of Kimberly
500 Polk Street East,
Kimberly, ID 83341-1618

Provider #: 135084

Dear Mr. Royeca:

On **September 23, 2016**, a survey was conducted at Oak Creek Rehabilitation Center Of Kimberly 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 **WIDESPREAD** and to constitute immediate jeopardy to residents' health and safety. You were informed of the immediate jeopardy situation(s) in writing on **September 22, 2016**.

On **September 23, 2016**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the residents had been removed. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction. The most serious deficiency now constitutes actual harm that is not immediate jeopardy and that is isolated in scope, as evidenced by the Form 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.)

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 28, 2016**. Failure to submit an acceptable PoC by **October 28, 2016**, may result in the imposition of additional civil monetary penalties by **November 10, 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: L -- 483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals
F0226 -- S/S: L -- 483.13(c) -- Develop/implement Abuse/neglect, Etc Policies

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey. We are recommending to the CMS Regional Office that the following remedy(ies) be imposed:

Civil money penalty

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 23, 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:

F0253 -- S/S: F -- 483.15(h)(2) -- Housekeeping & Maintenance Services;
F0225 -- S/S: L -- 483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals;
F0226 -- S/S: L -- 483.13(c) -- Develop/implement Abuse/neglect, Etc Policies

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 and 11** 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.

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 **October 28, 2016** . If your request for informal dispute resolution is received after **October 28, 2016** , the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

David Scott, RN, Supervisor
Long Term Care

DS/pmt
Enclosures

cc: Chairman, Board of Examiners - Nursing Home Administrators

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135084		09/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK REHABILITATION CENTER OF KIMBERLY	500 POLK STREET EAST KIMBERLY, ID 83341

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Federal Recertification and Complaint survey was conducted at the facility from September 19 to September 23, 2016. Immediate Jeopardy was identified at: * 42 CFR 483.13(c) [F225] * 42 CFR 483.13(c) [F226] The immediate jeopardy was removed prior to the exit conference. The surveyors conducting the survey were: Presie C. Billington, RN, Team Coordinator Edith Cecil, RN Nina Sanderson, LSW Definitions include: AA - Activities Assistant ADM - Administrator BG - Blood Glucose BIMS - Brief Interview Mental Status BILAT - Bilateral BLE - Bilateral Lower Extremities BP - Blood Pressure cc - cubic centimeter CCD - Consistent Carbohydrate Diet CNA - Certified Nursing Assistant DNS - Director of Nursing Services ESRD - End Stage Renal Disease HRS - Hours HS - At Bedtime ICN - Infection Control Nurse LN - Licensed Nurse MDS - Minimum Data Set OOB - Out of Bed	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/28/2016

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 MAR - Medication Administratin Record MWF - Monday, Wednesday, Thursday OTA - Open to Air PRN - When Necessary q2 - every 2 hours ROM - Range of Motion RSM - Resident Services Manager RUE - Right Upper Extremity TAR - Treatment Administration Record w/c - Wheelchair WOCN - Wound/Ostomy/Continence/Nurse	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	F 157		11/1/16

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F 157	Continued From page 2 regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined that the facility failed to ensure the physician was notified when a resident experienced a significant change of condition as evidenced by marked hallucinations, increased verbal agression, delusions and resistance to care. This was true for 1 of 12 sampled residents (#1). Resident #1 was placed at risk of more than minimal harm when her physician was not promptly notified. Findings include: 1. Resident #1 was readmitted to the facility on 1/8/16, following an acute care stay at a hospital for urosepsis [potentially life-threatening infection of the bloodstream]. A 6/14/16 Physician Progress Note documented Resident #1 experienced recurrent UTIs with recurrent urosepsis. Resident #1 provided a urine sample for a culture and antibiotic sensativity test and was started on antibiotic therapy. Facility Nursing Notes documented the following: * 8/19/16 - 4:44 am: Resident #1 stated the walls were "falling down" in her room.	F 157	F 157 NOTIFY OF CHANGES (INJURY/ DECLINE/ROOM,ETC). This facility will ensure that the resident's physician will be notified when a resident experiences a significant change of condition. Affected Residents: On September 22, 2016, Resident□'s physician ordered to start resident #1 on antibiotic therapy for suspected UTI. The UTI is now resolved. The care plan has been updated for staff to observe for symptoms such as decreased cognition and hallucinations. Potential Residents: All resident have the potential to be affected by this practice. Residents with significant change of condition documentation have been reviewed to ensure physician notification. Systemic: Staff were in serviced on Federal citation and deficient practice. Licensed Staff were educated on the importance of physician notification when a resident experiences a change of condition.	

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F 157	Continued From page 3 * 8/22/16 - 3:26 am: Resident #1 slid partially out of her bed and was found with her hips and legs on the bed and her upper torso hanging over the side of the bed. The nurse's note stated the top of Resident #1's head was touching the floor. * 8/31/16 - 5:50 am: Resident #1 was "very confused," hallucinating that things were falling in her room and there were several cats in her room. Staff redirected her at that time, but failed to notify the physician or resident's family. * 9/4/16 - 4:16 pm: Resident #1 was delusional and hallucinating, stating there were people in the bed next to her doing "bad things." Staff was unsuccessful at redirecting the resident, but continued to observe the resident throughout the shift. * 9/10/16 - 4:19 am: Resident #1 exhibited increased confusion throughout the night with delusions and hallucinations, told staff to take her "toes" off multiple times, and that there was a lady in a red blouse "watching the children tonight." * 9/17/16 - 10:45 pm: Nurses completed a condition change form for Resident #1, which noted increased confusion, foul urine odor, and that she complained of burning with urination. * 9/18/16 - 1:52 am: Resident #1 had increased confusion, trying to climb out of bed as she was "leaving this place, couldn't sleep here tonight." Staff offered to help her into a wheelchair, but she refused, stating she "could walk." Resident #1 was incontinent with foul-smelling urine, and complained of burning with urination. Resident #1	F 157	All resident progress notes will be reviewed on the department heads morning meeting to ensure that resident□s primary physician has been notified when a change of condition occurs. Monitoring and QA audits: All changes are reviewed and audited for physician notification at daily stand-up meeting (Monday through Friday) and weekends by the supervisor for 2 weeks or until substantial compliance. Residents with significant changes in behaviors, increase verbal aggression, hallucinations, delusion and resistance of care will be reviewed in the weekly Interdisciplinary team meeting to ensure proper notification and treatment have been provided. Audits will be reviewed in the Monthly QAPI meeting for 12 months to ensure substantial compliance. The DNS is responsible.	

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F 157	Continued From page 4 stated she had a UTI. The physician ordered a urinalysis and directed staff to catheterize Resident #1 "if needed." Resident #1 refused to allow nurses to catheterize her for a urine sample on three occasions. The physician was not notified for 34 days of Resident #1's increased behavioral symptoms of hallucinations, increased verbal agression, delusions, and resistance to care.	F 157		
F 225 SS=L	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225		11/1/16

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F 225	Continued From page 5 prevent further potential abuse while the investigation is in progress. 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff, family, and resident interview, record review, employee file review, employee time card reports, and review of the facility's video records, it was determined the facility failed to ensure a resident's report of mistreatment was identified as an allegation of abuse, the allegation was investigated, and residents were protected from further contact with the alleged perpetrator. The deficient practice directly impacted 2 of 12 sampled residents (#3 and #11). The failures placed Resident #3, Resident #11, and all residents receiving services from AA #1, in immediate jeopardy of psychological and/or physical abuse. Findings include: Resident #3 was admitted to the facility on 7/24/15. Resident #3's Quarterly MDS assessment, dated 6/20/16, documented her cognition was moderately impaired. On 9/19/16 at 2:45 pm, Resident #3 stated she	F 225	F 225 Abatement Plan of Correction September 22, 2016 F 225 and F226, Staff Treatment of Residents. The facility will ensure to recognize and investigate an allegation of abuse, protect residents after the allegation is received and report the allegation and investigation results to the State Agency. On September 21, 2016, the staff member involved was removed from the facility and was suspended pending investigation. Abuse investigation is on process for this incident dated July 22, 2016 and was already called in to the H & W Abuse Hotline and investigation report will be sent to State Survey and certification agency within 5 Working Days to ensure the alleged violation is verified and the appropriate corrective action has been	

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F 225	Continued From page 6 was upset by the way AA #1 treated Resident #11 during a Bingo game "a couple of months ago." Resident #3 stated she was sitting at a table in the dining room with Resident #11, playing Bingo, when AA #1 approached Resident #11 and took his Bingo card away in the middle of the game to give to another resident who had just joined the game. Resident #3 stated when she objected to the removal of the card, AA #1 stated, "It doesn't matter. He [Resident #11] doesn't know how to play anyway." Resident #3 stated when she continued to object, AA #1 became angry, began to point her finger in Resident #3's face, and told her she could either calm down or leave the activity. Resident #3 stated when she refused to leave, AA #1 came closer to her, and began to pound on the table and "she was yelling at me." Resident #3 stated she stayed in the activity for a few minutes, but was so upset she left to call a family member. Resident #3 stated, "[Resident #11] shouldn't be treated like that. And [AA #1] shouldn't have yelled at me." On 9/19/16 at 3:00 pm, Resident #3's family member stated she remembered the day of the event, and identified the date as Friday 7/22/16. Resident #3's family member stated Resident #3 was so upset when she called that the family member immediately came to the facility, and went with Resident #3 to talk to the RSM. The family member stated the RSM assured them she would "take care of this," and that AA #1 left the building shortly after the report was made, but "she was back at work the following Monday morning, as usual, and nothing happened." The family member stated, "They caught it all on the video camera they have in the dining room." The family member stated she repeatedly went to the	F 225	taken. Facility will ensure that all staff, residents, family and visitors are informed of the new complaint, grievance and allegation process. Information to include: All Grievance and/or complaints and any allegation of abuse can be submitted orally or in writing to the facility Administrator 24 hours a day to the contact information posted on the bulletin board. The resident, or person filing and/or complaint on behalf of the resident will be informed of the findings of the investigation and the actions that will taken to correct any identified problem. The administrator or his or her designee will make such report orally within 5 working days of filing of the grievance or complaint with the facility. A written summary of the investigation will also be provided within 10 working days to the resident or resident responsible party and a copy will be filed in the business office. Staffs were in service on abuse Policy and reporting process on September 22, 2016 and all staff will be in service on abuse policy and reporting process prior to working. All resident and/or responsible party will be provided a copy of the updated abuse policy and reporting process either in person or through mailing service. Facility Administrator will ensure to call in any abuse allegation within 24 hours to the State Abuse Hotline. Also Report all allegations of abuse to Systems Consultant or Medical director within 24	

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F 225	Continued From page 7 Administrator to report a concern that both Resident #3 and Resident #11 had been "abused" during this event, and to ask what had been done to follow up. The family member stated she could not get a response as to the results of the facility's investigation into the incident. There was no documentation of this report in Resident #3's clinical record, Resident #11's clinical record, the facility's grievance file, or the facility's incident investigations. There was no documentation of this event in the State Agency's reportable incident file. On 9/20/16 at 10:00 am, the 4 residents in the Resident Group expressed concern over AA #1's conduct in the exercise group the previous day. The group stated a confused resident had tried to join the circle of residents exercising, but AA #1 would not let her into the circle. One resident stated, "There was plenty of room for her, and she would do the best she could to do the same thing as the rest of us. [AA #1] should have let her in." On 9/20/16 at 10:01 am, AA #1 was observed in the dining room, preparing for an activity. AA #1 was standing less than 5 paces from a resident who was repeatedly trying to stand from his wheelchair. AA #1 was asked if the resident was safe to stand unassisted, and stated, "No. But he always does that." AA #1 continued preparing for the activity without addressing the resident or summoning someone else to assist him. On 9/21/16 at 10:00 am, the AD stated she was AA #1's direct supervisor. The AD stated she was	F 225	hours to ensure monitoring. Facility Administrator will report all abuse allegations to appropriate officials in accordance with State Law including State Survey and certification agency within 5 Working Days of the incident and will ensure the alleged violation is verified and the appropriate corrective action has been taken. On September 22, 2016 Residents #3 and 11 were observed and assessed by an LCSW to ensure the deficient practice has not caused ongoing affects to their physical and psychological well-being. Residents that usually attend to activity programs were also observed and assessed by an LCSW to assess whether the deficient practice has caused ongoing affects to their physical and psychological well-being. Resident activities participation records have been reviewed to ensure that the deficient practice has not caused negative affects to their physical and psychological well-being. The facility will continue to provide ongoing and routine assessments and counseling by an LSCW or by an LCPC to all residents and a record of this assessments or counseling sessions will be recorded to the resident medical records to ensure proper monitoring of residents psychosocial well-being. Resident # 3 was scheduled for counseling by an LCPC, but had refuse today. Resident # 3 was assessed by an LCSW and from resident # 3□s answers from	

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F 225	Continued From page 8 aware of a complaint regarding AA #1 in July, but was not in the facility at the time the allegation occurred. The AD stated she became aware of some kind of issue the following Monday morning [7/25/16] and, "when somebody wrote her up and I had to sit in when it was presented." The AD stated she was not exactly sure what the write-up entailed, but "[AA #1] said she knew she over-reacted and was annoyed towards [Resident #3]." On 9/21/16 at 11:00 am, AA #1 stated she recalled the event. AA #1 stated when she conducted a Bingo game in the facility, all of the residents playing had to have the same color of cards so as to not have duplicates. AA #1 stated Resident #11 was sitting at a table that day with a Bingo card, but was not playing the game correctly. AA #1 stated shortly after the game started, another resident wanted to join, and could play the game correctly, so AA #1 took the Bingo card from Resident #11 and gave it to the other resident. AA #1 stated this action caused Resident #3 to become upset. AA #1 stated, "The rule is, if a resident becomes upset in an activity they have to leave, so I told her to calm down or leave. I got angry, and you could see it in my face, but I didn't yell at her. It was investigated. and all they found out was that I was angry. I know that wasn't right." During the above interview, AA #1 stated the resident was barred from joining the exercise class, as described by the Resident Group, "because she rocks back and forth in her wheelchair and might bump into someone. I had her sit at a table across the room and watch."	F 225	numerous conversations and assessments the facility feels that the resident is still bothered by the incident. Resident # 3□s care plan was reviewed and updated to include a regular meeting or counseling with either LCPC or LCSW to monitor resident□s psychosocial well being. Record of this assessments or counseling sessions will be recorded to the resident medical records to ensure proper monitoring of resident□s #3 psychosocial well-being. All Abuse allegations will be reviewed and audited in the weekly interdisciplinary team meeting to ensure proper reporting and investigative procedure is being followed and implemented. Medical director and/or system consultant will sign the log book or binder monthly. The abuse reportable log will be filled out for all allegations of abuse per occurrence and the log and investigation report will be reviewed in the monthly QAPI meeting for 12 months to ensure the alleged violation is verified and the appropriate corrective action has been taken and to ensure that the facility is on substantial compliance. Completion date: September 23, 2016 INVESTIGATE/REPORT ALLEGATIONS/ INDIVIDUAL This facility will ensure that a resident□s report of mistreatment is identified as an allegation of abuse, the allegation is investigated, residents are protected from further contact with the alleged perpetrator and the incident is reported in	

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F 225	Continued From page 9 On 9/21/16 at 12:55 pm, the current Administrator stated he had only been working in the facility for 20 days, and was not familiar with the event. The Administrator stated he would look to see if the facility had done an investigation, and any resulting employee actions. The Administrator looked in AA #1's personnel file and found a "Documented Penalty for a Class 2 Offense" form, dated 7/27/16. The form documented AA #1 received a "Final Written Warning." Three of 23 potential violations were circled, with hand-written explanations of each. One of the violations selected was, "Inconsiderate care of any resident/patient of the facility not considered by management to be abuse." A hand-written explanation documented, "Mishandled situation during an activity causing it to escalate." The "Supervisor Comments" area of the form documented, "Emphasis must be on professional attitude [and] body language." The form was signed by the facility's previous Administrator, the AD, the DNS, and AA #1. There was no documentation as to the nature of the "inconsiderate care," which resident or residents were impacted, when it occurred, how abuse was ruled out, or whether AA #1 was suspended while the issues were investigated. On 9/21/16 at 1:30 pm, the RSM stated she remembered getting a report from one of the nurses that, "[Resident #3] was upset with [AA #1]." The RSM stated the DNS and Administrator did interviews, and "did an education" with AA #1. At 1:45 pm, the RSM stated she recalled talking to Resident #3 and her family member the day of the event. The RSM stated Resident #3's family member reported AA #1 was "in [Resident #3's] face," and that Resident #3 was so upset at the	F 225	accordance with requirements. Affected Residents:	

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F 225	Continued From page 10 time she had to go outside to try to calm down. The RSM stated she did not know whether or how the facility ruled this out as an allegation of abuse. The RSM stated she believed she suspended AA #1 at the time, although did not document the suspension. The RSM stated she was not AA #1's immediate supervisor or the facility's abuse coordinator, and was not authorized to suspend AA #1. The RSM stated she did not document the interaction with Resident #3 or her family member in Resident #3's clinical record or on a grievance form. The RSM indicated she did not know where it would be documented that AA #1 was removed from resident contact or suspended when the allegation was received. AA #1's Individual Employee Time Card documented she worked until 4:24 pm on Friday, 7/22/16; returned to work on Monday, July 25 at 9:24 am; and worked the remainder of the work week. The Time Card documented AA #1 worked Monday through Friday throughout the month of August, 2016. In September 2016, AA #1's Time Card documented she worked 9/1/16, 9/2/16, 9/12/16 - 9/16/16, and 9/19/16 - 9/21/16. On 9/21/16 at 1:35 pm, the DNS stated she recalled that the event was reported to her, as the former Administrator was on vacation at the time. The DNS stated she viewed the video from the event. The DNS stated her recollection was that Resident #11 was "sedated," and that there was, "a transition of [Bingo] cards for some reason just beforehand." The DNS recalled AA #1 approached Resident #3 with her hand out, but the facility ruled out abuse. The DNS stated, "We couldn't show intent, just bad body language."	F 225		

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F 225	Continued From page 11 The DNS stated if there was an investigation, the former Administrator would have kept that information. The DNS stated she thought the former Administrator had conducted an investigation into the event, and would look for the documentation. On 9/21/15 at 1:50 pm, the DNS stated she could not find evidence that the allegation had been investigated. The DNS stated her recollection was that Resident #3 "did not seem scared or intimidated" when the event was reported, but could not recall for sure. The DNS stated, "I'm not sure why [AA #1] did what she did...I was definitely unhappy with [AA #1's] performance, and I worked as closely as I could with her supervisor." The DNS stated the former Administrator made the final decision as to how the matter should be handled. On 9/21/16 at 2:45 pm, the surveyors and the current Administrator, DNS, and Systems Consultant reviewed the video recording from the Bingo game starting on 7/22/16 at 3:00 pm. There was no audio recording of the event. The video showed AA #1 initiate a Bingo activity. Resident #3 and Resident #11 were sitting at a table together. Each had a pink Bingo card in front of them. The table was square, with Resident #11 sitting on the north side of the table, and Resident #3 to his right, on the west side of the table. AA #1 was shown moving between the table where Resident #3 and Resident #11 were sitting, and an adjacent table to the west. Resident #11 was seen sitting upright in his wheelchair, placing chips on his Bingo card. Approximately 5 minutes into the game, AA #1 approached the table where Resident #3 and	F 225	On September 21, 2016, the staff member involved was removed from the facility and was suspended pending investigation. On September 23, 2016, the staff member involved was terminated from employment. On September 22, 2016 Residents #3 and 11 were observed and assessed by an LCSW to ensure the deficient practice has not caused ongoing affects to their physical and psychological well-being. Potential Residents All resident have the potential to be affected by this practice. Residents that usually attend to activity programs were also observed and assessed by an LCSW to assess whether the deficient practice has caused ongoing affects to their physical and psychological well-being. Resident activities participation records have been reviewed to ensure that the deficient practice has not caused negative affects to their physical and psychological well-being. Activities staffs were educated on 10/24/16 by the Administrator about notifying a Licensed Nurse or summoning staff member for help to assist a resident or to promote safety during activity program. Systemic: Our policies have been reviewed and updated to include the following: Abuse prevention programs policies and	

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F 225	Continued From page 12 Resident #11 were sitting and removed a Bingo card from Resident #11. While AA #1 took the card to a resident at the table to the west, Resident #3 turned abruptly in her chair towards AA #1 and appeared to be speaking. AA #1's back was to the video camera. AA #1 was seen to point forcefully multiple times in Resident #3's direction. Resident #3's face displayed a distressed expression, and she appeared to continue talking to AA #1. AA #1 then walked to the table where Resident #3 was sitting, and stood on the east side of the table, facing Resident #3. At this point, Resident #3's body blocked the camera's view of AA #1's abdomen. AA #1 was observed to lean forward into the table with an angry expression on her face. She reached out with her right arm, and made a repetitive, firm and abrupt pounding motion on the table in front of Resident #3. Resident #11 was also at the table. Resident #3 flinched each time AA #1 made the pounding motion on the table. Resident #3 continued to verbally respond to AA #1. The Bingo game was observed to continue for a minute or so, then Resident #3 suddenly stood and walked quickly and forcefully from the room. The video recording showed AA #1 to continue conducting the Bingo activity until 4:00 pm. On 9/22/16 at 3:00 pm, Resident #3 was in her room, seated at the edge of her bed, fidgeting and restless. Resident #3 stated, "Did you see the video? Did it happened the way I remember? I worry that no one believes me or that I made it up, because I told them and told them about it and nothing happened." Resident #3 stated the current Administrator and DNS had come to talk to her on 9/21/16 and asked her about the event.	F 225	procedures have been revised and updated. Facility Administrator now assumes the responsibility for overall coordination and implementation of the facility Abuse Prevention Programs policies and procedures. We are reinforcing our policies through education and daily supervision. Staff were educated on Federal citations and deficient practice. Facility Administrator will ensure to report any abuse allegation within 24 hours to the State Abuse Hotline or Website and Report investigative result allegations to appropriate officials in accordance with State Law including State Survey and certification agency within 5 Working Days of the incident and will ensure the alleged violation is verified and the appropriate corrective action has been taken. Facility will ensure that all staff, residents, family and visitors are informed of the new complaint, grievance, and allegation process. Information to include: All Grievance and/or complaints and any allegation of abuse can be submitted in writing or orally to the facility Administrator 24 hours a day to the contact information posted on the bulletin board. The resident, and/or person filing complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problem. The administrator or his/her designee will make such report orally within 5 working days of filing of the grievance or	

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F 225	Continued From page 13 Resident #3 stated, "They asked me if [AA #1] yelled at me, and I told them, 'I've told you and told you. Yes, she did yell at me.'" The facility's failure to recognize the allegation of abuse, investigate it, report it, and protect residents from further exposure to the identified abuser, placed Resident #3 and Resident #11 at risk of further abuse, and all residents receiving services from AA #1 at risk of abuse. Removal of Immediate Jeopardy: On 9/22/16 at 12:10 pm, the facility's Administrator was informed in writing of the immediate jeopardy and the need to develop and implement a plan to remove the immediacy. On 9/23/16 at 1:05 pm, the facility provided an acceptable removal plan and evidence the immediacy had been removed. The removal plan included: * AA #1 was suspended from duty pending a complete investigation from the event. * The facility's Abuse Prevention Policy and Procedure was updated to designate the facility Administrator as the responsible party for coordinating the investigation and reporting of all allegations of abuse, neglect, or mistreatment of residents. * The facility's grievance policy was updated to include verbal as well as, written grievances. * All residents and family members were provided with the updates above. * All staff were in-serviced, or will be in-serviced prior to working, regarding the above policy changes.	F 225	complaint with the facility. A written summary of the investigation will also be provided within 10 working days to the resident or resident's responsible party and a copy will be filed in the business office. Staff were educated on abuse Policy and reporting process on September 22, 2016 and all staff will be educated on abuse policy and reporting process prior to working. Monitoring and QA audits: All Abuse allegations will be reviewed and audited daily at the stand-up meeting and reviewed on weekends by the supervisor to ensure proper reporting and investigative procedure is being followed and implemented. Medical director and/or system consultant will review all Grievance and/or complaints and any allegation of abuse to ensure proper reporting and investigative procedure was being followed and implemented. Medical director and/or system consultant will sign the log book or binder monthly. The abuse reportable log will be filled out for all allegations of abuse per occurrence and the log and investigation report will be trended and analyzed in the monthly QAPI meeting to ensure the alleged violation is verified and the appropriate corrective action has been taken and to ensure that the facility is in substantial compliance. Administrator is responsible.	

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F 225	Continued From page 14 * Resident #3 and Resident #11 were assessed by the facility social worker for latent effects of the event. The facility social worker will continue to follow up with Resident #3. * All residents who attended the 7/22/16 Bingo game were interviewed for latent effects of the event. * All residents having contact with AA #1 between 7/22/16 and 9/23/16 were interviewed to rule out further allegations of abuse, neglect, and mistreatment. * All staff were interviewed, or will be interviewed prior to working again, to rule out further allegations of abuse, neglect, or mistreatment.	F 225		
F 226 SS=L	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility grievance file, review of accident and incident reports, and resident, family, and staff interviews, it was determined the facility failed to ensure its policies and procedures to identify, investigate, and report allegations of abuse were operationalized, training was provided to the facility Abuse Preventionist, and residents were protected from further abuse while an investigation was conducted. These deficient practices directly impacted 2 of 12 sampled residents (#3 and #11). The failures placed	F 226	F 226 DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES. This facility will ensure that its policies and procedures to identify, investigate, and report allegations of abuse were operationalized. Affected Residents On September 21, 2016, the staff member involved was removed from the facility and was suspended pending investigation.	11/1/16

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F 226	Continued From page 15 Resident #3 and Resident #11 and all other residents receiving services from AA #1, in immediate jeopardy of serious harm, injury or death. Findings include: The facility's undated Abuse Prevention Program Policies and Procedures, revised February 2008, documented: * "Overview...The resident has the right to be free from mistreatment...verbal abuse...mental abuse...and involuntary seclusion...All reports of resident abuse, mistreatment...shall be promptly and thoroughly investigated..." * "Implementation...The Director of Nursing Services who is designated as the facility's Abuse Prevention Coordinator...assumes the responsibility for the overall coordination and implementation of the facility Abuse Prevention Program policies and procedures..." * "Identification...all employees are mandated to report immediately any signs and symptoms of abuse/neglect or suspected alleged violations to their supervisor, the Director of Nursing Services and the Director of Nursing Services [sic]...When in doubt, report it...Signs of/Actual or Potential Abuse...Involuntary Seclusion...Caregiver indifferent to resident's personal care and needs..." * "Investigation...All reports of resident abuse, neglect...shall be promptly and thoroughly investigated by the Director of Nursing or his/her designee...The Director of Nursing Services will provide to the person in charge of the investigation a copy of the investigation and any supporting documents relative to the alleged incident..." * "Protection...employees accused of	F 226	On September 23, 2016, the staff member involved was terminated from employment. On September 22, 2016 Residents #3 and #11 was observed and assessed by an LCSW to ensure the deficient practice has not caused ongoing affects to their physical and psychological well-being. Resident # 3 and # 11 now have been actively participating on facility□s activity programs of their choice. Potential Residents All resident have the potential to be affected by this practice. Residents that usually attend to activity programs were also observed and assessed by an LCSW to assess whether the deficient practice has caused ongoing affects to their physical and psychological well-being. Resident activities participation records have been reviewed to ensure that the deficient practice has not caused negative affects to their physical and psychological well-being. Systemic Our policies have been reviewed and updated to include the following: Abuse prevention programs policies and procedures have been revised and updated. Facility Administrator now assumes the responsibility for overall coordination and implementation of the facility Abuse Prevention Programs policies and procedures. We are reinforcing our policies through education and daily supervision. Staffs were educated on Federal citation	

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F 226	Continued From page 16 participating in the alleged resident abuse...will be suspended immediately...The Director of Nursing or his/her designee will keep the resident and his/her representative informed of the progress of the investigation...The Director of Nursing shall inform the resident and his/her representative of the results if the investigation and any corrective action taken..." * "Reporting...When an alleged or suspected case of mistreatment...or abuse is reported, the Director of Nursing Services...shall notify...The State licensing/certification agency responsible for surveying/licensing the facility...A person shall not knowingly...Attempt...to induce another to fail to report an incident of mistreatment or other offense...Fail to report an incident of mistreatment or other offense...destroy or render unavailable a report made by another...Screen reports or withhold information to reporting agencies..." The facility's Organizational Chart, dated March 2008, documented the Medical Director, DNS, and RSM answered directly to the facility Administrator. On 9/19/16 at 2:45 pm, Resident #3 stated she had witnessed AA #1 deprive Resident #11 of supplies during an activity on 7/22/16, then was intimidated and threatened with involuntary seclusion when she objected to Resident #11's treatment. Resident #3 stated she reported this event to the RSM within minutes of its occurrence, but "nothing happened." Resident #3 called a family member to come to the facility and help make a report. On 9/19/16 at 3:00 pm, Resident #3's family	F 226	and deficient practice. Facility Administrator will ensure to report any abuse allegation within 24 hours to the State Abuse Hotline or Website and Report investigative result allegations to appropriate officials in accordance with State Law including State Survey and certification agency within 5 Working Days of the incident and will ensure the alleged violation is verified and the appropriate corrective action has been taken. Previous RSM no longer working as RSM and a new RSD that is very knowledgeable with Abuse reporting process have been hired. Facility will ensure that all staff, residents, family and visitors are informed of the new complaint, grievance and allegation process. Information to include: All Grievance and/or complaints and any allegation of abuse can be submitted in writing or orally to the facility Administrator 24 hours a day to the contact information posted on the bulletin board. The resident, or person filing and/or complaint on behalf of the resident will be informed of the findings of the investigation and the actions that will taken to correct any identified problem. The administrator or his or her designee will make such report orally within 5 working days of filing of the grievance or complaint with the facility. A written summary of the investigation will also be provided within 10 working days to the resident or resident responsible party and a copy will be filed in the business office.	

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F 226	Continued From page 17 member stated when Resident #3 called on 7/22/16, she was angry, upset, and tearful due to the event Resident #3 witnessed, and her treatment afterwards. The family member stated over the next few days and weeks, she asked the former Administrator "over and over what happened, but she never told me. And [AA #1] kept working as if nothing happened." Resident #3's family member stated Resident #3 continued to be upset about the event for a number of weeks, and stopped attending activities for a while. On 9/21/16 at 11:00 am, AA #1 stated she recalled the event. AA #1 stated the former Administrator had asked her some questions afterwards and had made some notes. AA #1 stated, "It was investigated, and all they found out was that I was angry. I know that wasn't right." On 9/21/16 at 12:55 pm, the current Administrator stated he had only been working at the facility for 20 days, and the allegations took place prior to his employment. The Administrator reviewed the facility's abuse investigation file, but did not find evidence of the allegations or investigation. The Administrator was unable to locate documentation the allegations had been reported to the State Agency. On 9/21/16 at 1:30 pm, the RSM stated she recalled sometime in July, one of the facility nurses came to her to report that Resident #3 was upset with AA #1. The RSM stated she told the former Administrator and the DNS about the LN's report, but that was the extent of her involvement. The RSM returned at 1:45 pm, and	F 226	Staffs were educated on abuse Policy and reporting process on September 22, 2016 and all staff will be in service on abuse policy and reporting process prior to working. Monitoring and QA audits All Abuse allegations will be reviewed and audited daily at the stand-up meeting and reviewed on weekends by the supervisor to ensure proper reporting and investigative procedure was being followed and implemented. Medical director and/or system consultant will review all Grievance and/or complaints and any allegation of abuse to ensure proper reporting and investigative procedure was being followed and implemented. Medical director and/or system consultant will sign the log book or binder monthly. The abuse reportable log will be filled out for all allegations of abuse per occurrence and the log and investigation report will be reviewed in the monthly QAPI meeting to ensure the alleged violation is verified and the appropriate corrective action has been taken and to ensure that the facility is on substantial compliance with the implementation of the facility Abuse Prevention Programs policies and procedures. The Administrator is responsible.	

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F 226	Continued From page 18 stated she now recalled that she was approached by Resident #3 and her family member after the LN's report. The RSM stated Resident #3 and her family member wanted to report that AA #1 had been "inappropriate." The RSM stated Resident #3 was upset, and excused herself to go outside and smoke. The RSM stated after Resident #3 left, her family member reported Resident #3 was so upset because, "[AA #1] was in [Resident #3's] face after she objected to the way [Resident #11] was treated." On 9/21/16 at 1:35 pm, the DNS stated she was aware of the allegation at the time it was made. The DNS stated she called the former Administrator to inform her of the allegation. The DNS stated she recalled viewing the facility's video recording of the event the following Monday (7/25/16) with the former Administrator. The DNS stated the former Administrator made the determination that abuse had not occurred and the allegation should not be reported to the State Agency. The DNS stated she believed the former Administrator had spoken to some of the staff and residents, and the documentation should be included in the facility's abuse allegations log. The DNS was unable to locate documentation of the allegation, investigation, or report to the State Agency in the facility's abuse investigation log. On 9/21/16 at 2:45 pm, two surveyors, the current Administrator, the Systems Consultant, and the DNS viewed the facility's video recording of the event. The Administrator, DNS, and Systems Consultant all stated the facility should have reported the event as an allegation of abuse, and should have conducted an	F 226		

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F 226	Continued From page 19 investigation. On 9/21/16 at 3:00 pm, the DNS stated she had only been in her current position for approximately 3-4 months, and this event occurred shortly after she had assumed her duties. The DNS stated she was aware the facility's abuse policy designated her as the Abuse Preventionist, but she had encountered some barriers in being successful in that role. The DNS stated while she was trained on abuse recognition and reporting requirements in her role as a nurse, she had not received any formalized training on what, specifically, the role of the facility "Abuse Preventionist" entailed. The DNS stated she had also not received training on what needed to be reported as it pertained to the regulatory requirement of reporting allegations and investigations to the State Agency. The DNS stated the most difficult barrier to overcome, however, was the facility's organizational structure and administrative chain of command. The DNS stated she reported directly to the facility's Administrator. The DNS stated she did not necessarily agree with the way the investigation was conducted in this event, the conclusion of the investigation, or the decision not to report the allegation to the State Agency. The DNS stated the former Administrator had made it clear the decision of what and when to report was the Administrator's role. The DNS stated because the Administrator was her direct supervisor, she was concerned taking any further steps in this instance could cost her job. The DNS stated she had placed many calls to the former Administrator since the issue was brought to the facility's attention by the survey team, and had received a number of conflicting responses	F 226		

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F 226	Continued From page 20 from that person. The facility placed all residents in immediate jeopardy of serious injury, impairment, or death when staff failed to operationalize its policies and procedures for Abuse Prevention. The facility failed to provide specialized training to their Abuse Preventionist; failed to recognize, investigate, or report allegations of abuse; and failed to protect residents from the risk of further abuse from an employee accused of abuse. Removal of Immediate Jeopardy: On 9/22/16 at 12:10 pm, the facility's Administrator was informed in writing of the immediate jeopardy and the need to develop and implement a plan to remove the immediacy. On 9/23/16 at 1:05 pm, the facility provided an acceptable removal plan and evidence the immediacy had been removed. The removal plan included: * AA #1 was suspended from duty pending a complete investigation from the event. * The facility's Abuse Prevention Policy and Procedure was updated to designate the facility Administrator as the responsible party for coordinating the investigation and reporting of all allegations of abuse, neglect, or mistreatment of residents. * The facility's grievance policy was updated to include verbal as well as, written grievances. * All residents and family members were provided with the updates above. * All staff were in-serviced, or will be in-serviced prior to working, regarding the above policy	F 226		

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F 226	Continued From page 21 changes. *Resident #3 and Resident #11 were assessed by the facility social worker for latent effects of the event. The facility social worker will continue to follow up with Resident #3. * All residents who attended the 7/22/16 Bingo game were interviewed for latent effects of the event. * All residents having contact with AA #1 between 7/22/16 and 9/23/16 were interviewed to rule out further allegations of abuse, neglect, and mistreatment. * All staff were interviewed, or will be interviewed prior to working again, to rule out further allegations of abuse, neglect, or mistreatment. Please also refer F225 as it relates to the above abuse allegations.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure the dignity of residents was maintained during incontinence care and meals. This was true for 3 of 3 sampled residents (#6, #7 and #9) whose incontinence care was reviewed and 4 of 4 residents who attended Resident Council meetings and all residents who requested a meal substitute. The practice of leaving incontinent	F 241	F 241 DIGNITY AND RESPECT OF INDIVIDUALITY. This facility will ensure that dignity of residents are maintain during incontinent care and meals. Affected Residents 1. Resident # 6, 7 and 9 care plans were	11/1/16

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F 241	Continued From page 22 residents open-to-air had the potential to cause harm when residents were not provided care consistent with their past and embarrassed when their private parts were exposed. The failure to serve all residents at one table at the same time created the potential for harm if residents were uncomfortable eating in front of their tablemates, or disliked eating alone after their companions were finished dining. Findings include: 1. Observation and staff interview identified those residents who were unable to tell staff when they needed to use the bathroom received open-to-air incontinence care at night. This practice results in residents being naked from the waist down with the intent to allow airflow on the skin in the perineal and surrounding area. The facility was unable to provide a facility policy or procedure to support when such a practice was clinically appropriate, and/or consistent with the residents' wishes. a. Resident #9 was admitted to the facility on 1/12/09, and was readmitted on 11/1/10 with multiple diagnoses including, brain injury, and epilepsy. Resident #9's Quarterly MDS assessment, dated 7/17/16, documented he had severe cognitive impairment, was totally dependent on 1-2 staff for all of ADLs, and was always incontinent of bowel and bladder. Resident #9's care plan, initiated on 11/16/12, documented an intervention "OTA at night - May have [incontinence brief] on during the day/evening..."	F 241	updated to eliminate OTA or open to air terminology. Staffs were in service that no residents would be open to air and all residents with incontinence would utilize least restrictive incontinence product necessary to meet their needs. Staffs were in service to best provide for resident□s privacy while providing cares and the use of clean linens to cover resident is necessary in addition to the use of privacy curtains, closing door and etc. Staffs were in service of having all incontinence supplies ready when planning to do incontinence care to limit the resident being exposed. Resident #6, 7 and 9 incontinence care have been observed by department head nurses and cares were provided with privacy using privacy curtain, closing door and clean linen that are readily available. 2. Staffs were in service about the importance of the resident□s dignity to be eating in the same time with their peers. Potential Residents All resident have the potential to be affected by this practice. 1. An audit on all residents with incontinence have been completed and all care plans have been updated to eliminate OTA or open to air terminology. Care plans were also updated to include appropriate use of incontinence pads or briefs. All residents are provided with routine peri	

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F 241	Continued From page 23 On 9/22/16 at 1:36 pm, CNA #5 and CNA #6 were inside Resident #9's room to change his incontinence brief. The CNAs pulled the privacy curtain and when they removed Resident #9's sheet and blanket, he was not wearing an incontinent brief. Resident #9's private parts were seen as soon as the CNAs removed his sheet. A blue incontinence pad was underneath Resident #9's bottom, which was soaked and his sheet was wet. The CNAs proceeded to provide perineal care to Resident #9. When the CNAs finished they put one new incontinence pad under Resident #9's bottom and another one across the top of the first. The CNAs said Resident #9's care plan was for him open to air when in bed. CNA #5 then went out to get a new sheet for Resident #9. While waiting for CNA #5, Resident #9's private parts were exposed. When CNA #5 arrived with the new sheet, they covered Resident #9's body from his waist down. On 9/22/16 at 4:05 pm, the ICN said the CNAs should have folded the second incontinence pad to cover Resident #9's private parts to protect his dignity. b. Resident #7 was admitted to the facility on 5/3/12, with multiple diagnoses including, restless leg syndrome. Resident #7's Quarterly MDS assessment, dated 7/20/16, documented she had severe cognitive impairment, was totally dependent on 1-2 staff with most of her ADLs, and was always incontinent of bowel and bladder. Resident #7's incontinence care plan documented an intervention "[resident name]	F 241	cares, incontinence pads or briefs and or liner. 2. All resident are provided with and advance menu to be able to determine of their choices of food for meals. In addition, dietary department will have at least 4 alternate meals ready every meal time to ensure quick serving to resident that change their mind on the last minute or during tray line. Systemic Staffs were in serviced on Federal citation and deficient practice 1. Staffs were in service that no residents would be open to air and all residents with incontinence would utilize least restrictive incontinence product necessary to meet their needs. Staffs were in service in best practice to provide for resident□s privacy while providing cares and the use of clean linens to cover resident is necessary in addition to the use of privacy curtains, closing door and etc. Staffs were in service of having all incontinence supplies ready when planning to do incontinence care to limit the resident being exposed. 2. Dining room audit to include alternate meal serve time after requested will be done weekly and randomly by department heads to ensure that residents dining experience are pleasant and all meals are serve on time. Monitoring and QA audits	

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F 241	Continued From page 24 wears incontinence briefs - check q2 hrs and change prn OTA with air-flow [incontinence pad] when in bed." On 9/22/16 at 2:05 pm, Resident #7 was observed in bed with a white sheet covering her body up to her waist. CNA #3 pulled the privacy curtain and removed the sheet covering her. Resident #7 was not wearing an incontinence brief. Underneath her bottom was a soiled incontinence pad, and her sheet was wet. CNA #3 and CNA #4 removed the soiled pad and provided perineal care to Resident #7. They then placed two new incontinence pads, one across the other, underneath her bottom. CNA #3 went out to get a new sheet. Resident #7 was uncovered from her waist down with her private part exposed while waiting for a clean sheet to arrive. On 9/22/16 at 4:05 pm, the ICN said the CNAs should have folded the second incontinence pad to cover Resident #7 private parts to protect her dignity. c. Resident #6 was admitted to the facility on 2/6/12, and readmitted on 5/7/12, with multiple diagnoses including Alzheimer's disease and history of mental and behavioral disorders. Resident #6's Quarterly MDS assessment, dated 7/1/16, documented she had severe cognitive impairment and was totally dependent on staff for most of her ADLS, and was always incontinent of bowel and bladder. Resident #6's incontinence care plan documented an intervention "check q 2 hours	F 241	1. Director of Nursing and/or licensed staff designee will do a weekly random audit for 8 weeks or until substantial compliance, then monthly for 10 months to ensure that staffs are providing resident□s privacy while providing cares and using clean linens to cover resident in addition to the use of privacy curtains, closing door and etc. Audits will be reviewed in the monthly QAPI meeting for 12 months to ensure substantial compliance. DNS is responsible. 2. Dining room audit to include alternate meal serve time after requested will be done weekly and randomly by department heads or until substantial compliance to ensure that residents dining experience are pleasant and all meals are serve on time. Audits will be reviewed in the monthly QAPI meeting for 12 months to ensure substantial compliance. Administrator and DNS are responsible.	

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F 241	Continued From page 25 and change incontinence brief as needed. Good pericare with each episode of incontinence...OTA [open to air] when in bed...Use of incontinence briefs." On 9/19/16 at 2:50 pm, CNA #1 and CNA #2 were observed providing perineal care to Resident #6. CNA #1 wrote the time and date on the clean incontinence brief before putting it on Resident #6. Resident #6 was then covered with a clean sheet and positioned on her right side. On 9/20/16 at 5:15 pm, LN #2 said the CNAs should have provided Resident #6 with a liner instead of an incontinence brief when in bed. LN #2 said when a liner was used CNAs did not secure it to Resident #6 with tape like an incontinence brief. On 9/20/16 at about 4:35 pm, the MDS nurse stated the OTA practice was for residents who had skin issues. On 9/22/16 at 10:10 am, the DNS stated she did not consider the facility practice as open-to-air, because residents were covered with a sheet. On 9/22/16 at about 4:05 pm, the ICN stated the facility did not have a policy and procedure for the practice of open-to-air incontinence care. The facility implemented an open-to-air practice, which, per staff interview, was used for residents who were incontinent of urine and who were unable to ask to go to the toilet. The facility did not develop a policy to describe when and how the open-to-air practice should be implemented and monitored, and the potential negative	F 241		

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F 241	Continued From page 26 psychosocial outcomes of residents being left exposed and with the bed linen wet and/or soiled. 2. Homelike dining environment a. On 9/20/16 at 10:00 am, 4 of the 4 residents in the Resident Group stated substitute or replacement meals were available from the kitchen upon request, but once a substitute was requested, they had to wait until all of the other residents had been served before they received the substitute. The residents stated depending on where the kitchen was in the process of serving up trays when they requested their substitutes, they could wait as much as half an hour for their replacement meal to arrive. The residents reported that meant they had to sit and watch their tablemates eat, then were left to eat their meal with no companions. On 9/22/16 at 11:30 am, the DM stated the CNAs took resident lunch and dinner orders after the breakfast meal, so the kitchen had an idea how much of each to prepare. The DM stated if a resident requested a different meal after they had been served, the kitchen would dish it up and serve it after all of the other residents had been served. The DM stated if the delay was going to be longer than "20 minutes or so", she would talk to the resident. She stated usually the residents told her they understood why they had to wait.	F 241		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and	F 244		11/1/16

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F 244	Continued From page 27 operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview and review of Resident Council Meeting Minutes, it was determined the facility failed to confirm residents were aware of and agreeable to the resolution of concerns brought forward by the Resident Council. This was true for 4 of 4 residents in the Resident Group meeting, and had the potential to impact all residents residing in the facility. The deficient practice created the potential for harm if residents' call lights were not answered promptly or residents felt they had no voice in facility daily life, such as food and activity options. Findings include: On 9/20/16 at 10:00 am, the four residents in the Resident Group stated they had expressed concerns in past Resident Council meetings, but did not know what the facility had done to address or resolve those concerns. Resident Council Meeting Minutes documented: * 7/14/16 - No old business. New concerns included a desire for higher quality bread; and the residents would like fresh fruit, nuts, and chips available for snacks. The form documented a plan to consult with the food vendors regarding bread options and in-service staff to keep a variety of snacks available. * 8/11/16 - No old business. New concerns were delayed call light response times. The form documented a plan to conduct call light response	F 244	F 244 LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION. This facility will ensure to confirm that residents are aware of and agreeable to the resolution of concerns brought forward by the resident council. Affected Residents No specific residents were cited. Resident Council meeting conducted on October 13, 2016. Meeting minutes indicated that the old business from previous month□s concern have been discussed and addressed with the council members and council members comments have been noted. All resident have the potential to be affected by this practice. Systemic Staffs were educated on Federal citation and deficient practice. RSD will ensure that meeting minutes are noted and issues and concerns that are brought up by the council member will be distributed to the department head/manager for all departments involved. Resident Council meeting minutes are being reviewed and sign by the administrator to ensure that the old business concerns have been discussed and council member comments are	

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F 244	Continued From page 28 audits and in-service staff. * 9/8/16 - No old business. New concerns documented were more diverse activities; meals arriving late; special meal recommendations; and call light response times. The form documented plans to add a second activity in another room; record times meals were delivered; accommodate the special meal request; and arrange for the RNA to help with call lights during shift change. On 9/20/16 at 10:00 am, the Resident Group stated the facility had provided the special meal as requested, which they very much enjoyed, but they were not aware of the action plans developed by the facility to address the other concerns they had brought forward. The Resident Group stated they would like the facility to discuss the plans as part of the "old business" at each meeting, and seek input from the group as to whether the issues had been resolved. On 9/22/16 at 9:30 am, the RSM stated she collected the concerns from the Resident Council each month and wrote each concern on a form, which was then given to the appropriate department head to develop a plan to resolve the concern. The RSM stated she thought the concerns had been addressed through the "old business" discussion at each meeting, but did not have documentation this occurred.	F 244	noted. Administrator will also review meeting minutes for departmental issues or concerns brought by the resident council members and ensure that resident concerns have been address and plan of action and investigation have been conducted. Department Heads / managers was educated on addressing residents□ concerns and issues. Plan of action and investigation need to be conducted within 5 business days. RSD will ensure to notify the resident council president of the departmental plan of action and investigation the next resident council meeting. Monitoring and QA audits Resident Council minutes and Resident council departmental concerns, issues and resolution documentation will be reviewed in the monthly QAPI meeting for 12 months to ensure substantial compliance. The RSD and Administrator is responsible.	
F 248 SS=G	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial	F 248		11/1/16

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F 248	Continued From page 29 well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of Activity Department financial records, and resident, family member, and staff interview, it was determined the facility failed to ensure sufficient supplies were provided to the activities program to help residents achieve their highest physical, mental, and psychosocial well-being. This was true for 2 of 12 sampled residents (#3 and #11), 1 random resident (#13), 4 of 4 residents who attended the resident group, and had the potential to negatively impact all resident wishing to participate in the facility's activities program. Resident #3 experienced psychosocial harm when she was intimidated and threatened with involuntary seclusion when objecting to Resident #11 being deprived of supplies during an activity. This also created the potential for all residents to experience psychosocial harm due to loss of social stimulation, inability to continue life-long hobbies and enjoyed activities, and loss of interest in activities due to lack of variety. Findings include: 1. Individual Resident Interview: a. On 9/19/16 at 2:45 pm, Resident #3 reported during a facility Bingo activity in July 2016, she observed AA #1 remove a Bingo card from Resident #11 and give it to another resident while the Bingo game was in process. Resident #3 stated when she objected to Resident #11's treatment, AA #1 spoke and gestured to her in an intimidating manner, threatened to exclude her	F 248	F 248 ACTIVITIES MEET INTERESTS/NEEDS OF EACH RESIDENT This facility will ensure sufficient supplies were provided to the activities program to help residents achieve their highest physical, mental, and psychosocial well being. Affected Residents On September 23, 2016, the staff member involved was terminated from employment. On September 22, 2016 Residents #3 and #11 were observed and assessed by an LCSW to ensure the deficient practice has not caused ongoing affects to their physical and psychological well-being. Resident # 3 and # 11 have been interviewed and their current activity preferences identified and care planned. Resident #13 had been to see the garden and has spent time in the garden and participated in outings along with other residents. Such outings include a trip to the pumpkin patch, corn maze and had the chance to watch the fall color leaves at South Hills recreational area. Potential Residents All resident have the potential to be affected by this practice. Resident Council meeting conducted on October 13, 2016. Meeting minutes indicated that activities program from	

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F 248	Continued From page 30 from the remainder of the activity, and threatened her with involuntary seclusion. Resident #3 stated she reported the event to the facility, but there was no follow-up. Resident #3 stated she stopped participating in the facility's activities program for a few weeks following that event. Resident #3 stated, "I still think about it. It was not fair to [Resident #11.]" During the same interview, Resident #3 also reported an important aspect of her quality of life was to have a pleasant place to be outdoors. Resident #3 stated many of the other residents felt that way as well, as the facility was in a rural farming community. Resident #3 stated the residents had suggested in the spring that the facility allow them to plant flowers in pots on the facility patio. Resident #3 stated the former Administrator had told them such things were "not in the budget." Resident #3 stated one of her family members ended up purchasing supplies and donating her labor in order to update the facility's patio to provide a pleasant outdoor space for residents. b. On 9/19/16 at 1:55 pm, Resident #13 stated she had recently been admitted to the facility and missed her home very much. Resident #13 was tearful as she described her adjustment to the facility. Resident #13 stated one of the things at the facility that gave her comfort was her garden. Resident #13 asked if she could show the surveyor her garden, and led the surveyor out to the patio area, where there was a lawn, flowers, garden decor, and lawn furniture. Resident #13 stated, "This is the one place outside I can go by myself, where I can't get lost because there is a fence. I love my garden."	F 248	previous month have been discussed and concerns and suggestions have been noted. Residents that have not attended the resident council meeting have been interviewed of their activity preference to ensure that activities program are favorable by all. Facility now has ample activities supplies for scheduled activities programs. Systemic Staff were in serviced on Federal citation and deficient practice. Activities department staff was in serviced regarding preparing enough supplies that are in good condition for all residents to use. This facility has also subscribed annually to Activity connection, an online activities program resources to ensure or to get ideas on variety of activities program. Resident council meeting will include an activity department and program discussion and suggestions. RSD will ensure that meeting minutes are noted and issues and concerns that are brought up by the council member for the activity department will be made known to the activity director and the administrator. A reasonable budget for activities programs or department will be set for an average of $150.00 per month. And a record of spending will be recorded. Any reasonable activities request that is out of the budgetary amount should be referred to the Administrator before denying any activities request. Decision for such request will be documented for	

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F 248	Continued From page 31 2. Resident Family Interview: On 9/19/16 at 3:00 pm, Resident #3's family member stated Resident #3 had a diagnosis of bipolar disorder, with a history of both manic and depressive episodes. Resident #3's family member stated she felt Resident #3 was growing increasingly depressed as the weather turned nice in the spring, as there was nowhere at the facility to sit outside or maintain plants. Resident #3's family member stated she repeatedly requested the facility buy pots and flowers, and create a safe walking surface, in the facility's fenced-in patio area, but was told several times such expenses were not in the budget. Resident #3's family member stated, "I even told them I would do all the work. But they still said no. I ended up buying everything myself and doing all the work, just for [Resident #3's] sake. But they all love it." During the same interview, Resident #3's family member stated she was upset by the event that took place between Resident #3, Resident #11, and AA #1 during the 7/22/16 Bingo game. The family member stated, "[Resident #3] didn't go to activities for a long time after that. She was really bothered by what happened to [Resident #11]." 3. Resident Group Interview: On 9/20/16 at 10:00 am, 4 of the 4 residents in the Resident Group Interview stated: *The facility activities program lacked variety. *There were not enough activities in the evening. *They activities program was repetitive, with the	F 248	future reference. Monitoring and QA audits Resident Council minutes and Resident council activities concerns, issues, suggestions, request and resolution documentation will be reviewed in the monthly QAPI meeting for 12 months to ensure substantial compliance. RSD and Administrator are responsible.	

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F 248	Continued From page 32 same games over and over. One resident stated, "I used to like the games. But we've been playing the same ones for so long it just gets old. I asked them to get new games, but they just keep saying it's not in the budget." *There were not enough supplies for all residents who wanted to participate in activities, and the supplies available were worn or in disrepair. *When the residents made suggestions for greater variety of activities, requested updated supplies, or asked for outings or outdoor activities, but were always told, "It's not in the budget." *The residents stated someone had to donate money and time to make the facility's patio area safe and enjoyable, as the facility did not respond to their request for an outdoor area for activities. 4. Staff Interviews: a. On 9/21/16 at 10:00 am, the AD stated she was aware the residents were unhappy with the availability of supplies for activities, but her budgetary restrictions made developing and maintaining a program difficult. The AD stated, "I've been through the course and got my certification to be an activities director, and I know what I should be doing, but I just can't with the budget they've got me on." The AD stated her budget for the facility activities program was $100.00 per month, but she did not always get the money every month, nor was there a set day of the month when she received the money. The AD stated, "The money comes from [the facility's] petty cash, and I only get it when there's money there, which is not every month. Sometimes I don't get any money, and sometimes I get less than the $100." The AD stated the activities	F 248		

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F 248	Continued From page 33 budget had to cover "special" snack items requested by the residents, as the facility kitchen would only supply brownies, ice cream, or pies, and the residents "get tired of the same stuff all the time." The AD stated the Activities budget also had to cover decor for the rooms of residents who did not have family to bring in personal items, and prizes for the Bingo games. The AD stated, "I try to make it stretch as far as I can, but by the time I pay for all that other stuff, I don't have money left over for new supplies. And that's even if I get the activity budget every month, which I don't. Many times, I go to yard sales to see what I can find, and I use my own money. It's really hard to try to do everything I know I should be doing." On 9/21/16 at 11:30 am, the AD provided her Monthly Spend Down ledger for the past year. Between 9/1/15 and 9/21/16, the facility had provided a total of $900 as follows: * 10/6/15, for the month of October 2015, $100. * 12/21/15, for November and December 2015, $200. * 1/19/16, for January 2016, $100. * 2/25/16, for "partial" February 2016 budget, $60. * 3/19/16, for "rest of February" and March 2016, $140. * There was no allowance for April 2016. * 5/23/16, for May 2016, $100. * 8/19/16, for June, July, and August 2016, $200. This was 1/3 less than should have been provided, per the budget described by the AD, and there was no record of monies being received for Activities for September 2016.	F 248		

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F 248	Continued From page 34 b. On 9/21/16 at 11:00 am, AA #1 stated there were not always enough Bingo cards for every resident who wanted to play. AA #1 recalled the Bingo game from 7/22/16 with Resident #3 and Resident #11. AA #1 stated she had removed Resident #11's Bingo card because he wasn't playing the game correctly, and there were no more Bingo cards available. When another resident joined the game who could play correctly, AA #1 stated, "I needed [Resident #11's] card for another resident, so I took it." c. Administrative Interview: On 9/21/16 at 12:55 pm, the current Administrator stated he had only been working in the facility for 20 days, and had not yet had a chance to review the Activities budget. The Administrator stated he did not think $100 per month would be enough to fund the Activities program, and he would review that figure to make sure the facility Activities program had sufficient funding.	F 248		
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: Based on observation, resident, family member, and staff interview, and review of clinical records	F 250	F 250 PROVISION OF MEDICALLY RELATED	11/1/16

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F 250	Continued From page 35 and a facility video recording, it was determined the facility failed to ensure the provision of medically-related social services. This was true for 1 of 6 residents (Resident #3) sampled for social services. Resident #3 was harmed when the facility did not assess her psychosocial status following an allegation of abuse, or monitor for ongoing emotional needs after the allegation. Findings include: Resident #3 was admitted to the facility on 7/24/15, with diagnoses which included bipolar disorder. On 9/19/16 at 2:45 pm, Resident #3 stated she was upset by the way AA #1 treated Resident #11 during a Bingo game "a couple of months ago." Resident #3 stated she was sitting at a table in the dining room with Resident #11, playing Bingo, when AA #1 approached Resident #11 and took his Bingo card away from him in the middle of the game to give to another resident who had just joined the game. Resident #3 stated when she objected to the removal of the card, AA #1 stated, "It doesn't matter. He [Resident #11] doesn't know how to play anyway." Resident #3 stated when she continued to object, AA #1 became angry, began to point her finger in Resident #3's face, and told her she could either calm down or leave the activity. Resident #3 stated when she refused to leave, AA #1 came closer to her, and began to pound on the table and "she was yelling at me." Resident #3 stated she stayed in the activity for a few minutes, but was so upset she left to call a family member. Resident #3 stated, "[Resident #11] shouldn't be treated like that. And [AA #1] shouldn't have yelled at me."	F 250	SOCIAL SERVICE This facility will ensure to provide medically related social services and this facility will ensure to assess resident psychosocial status following an allegation of abuse or monitor for ongoing emotional needs after allegation. Please refer to F225. Affected Residents On September 21, 2016, the staff member involved was removed from the facility and was suspended pending investigation. On September 23, 2016, the staff member involved was terminated from employment. On September 22, 2016. Residents #3 and #11 were observed and assessed by an LCSW to ensure the deficient practice has not caused ongoing affects to their physical and psychological well-being. Potential Residents All resident have the potential to be affected by this practice. Residents that usually attend to activity programs were also observed and assessed by an LCSW to assess whether the deficient practice has caused ongoing affects to their physical and psychological well-being. Resident activities participation records have been reviewed to ensure that the deficient practice has not caused negative affects to their physical and psychological well-being. Systemic Staffs were educated on Federal citation and deficient practice.	

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F 250	Continued From page 36 On 9/19/16 at 3:00 pm, Resident #3's family member stated she remembered the day of the event, and identified the date as Friday 7/22/16. Resident #3's family member stated Resident #3 was so upset when she called that the family member immediately came to the facility, and went with Resident #3 to talk to the RSM. The family member stated the RSM assured them she would "take care of this," and that AA #1 left the building shortly after the report was made, but "she was back at work the following Monday morning, as usual, and nothing happened." There was no documentation of Resident #3's concern in her clinical record, the facility's grievance file, or incident reports. On 8/5/16 at 1:17 pm, a Resident Services (Social Services) Progress Note in Resident #3's record documented, "Monthly behavior note - [Resident #3] has had episodes of verbal aggression, nonadherence, hallucinations, and attempted trespass since the last review...getting agitated and becomes aggressive with staff...attends activities that she likes and can tolerate...refuses most group activities..." This was the only Resident Services progress note in Resident #3's record between 7/22/16 and 9/20/16. On 9/20/16 at 10:00 am, Resident #3 stated she was upset with the way the RSM had reacted to the report she made of the 7/22/16 Bingo game. Resident #3 stated, "She didn't believe me, and as much as told me so. She made me feel like I was crazy for even saying anything about it." On 9/21/16 at 1:45 pm, the RSM stated she	F 250	RSM during the time of the incident is no longer the RSM or RSD for this facility. A new RSD that is very knowledgeable with Abuse reporting process and grievance procedure was hired and started working fulltime on September 26, 2016. This facility will continue to provide ongoing and routine assessments and counseling by an LSCW or by an LCPC to all residents and a record of this assessments or counseling sessions will be recorded to the resident medical records to ensure proper monitoring of residents psychosocial well-being. Monitoring and QA audits All Abuse allegations will be reviewed and audited daily at the stand up meeting and reviewed on weekends by the supervisor to ensure proper reporting and investigative procedure was being followed and implemented. Medical director and/or system consultant will review all Grievance, complaints and any allegation of abuse to ensure proper reporting and investigative procedure was being followed and implemented. Medical director and/or system consultant will sign the log book or binder monthly. The abuse reportable log will be filled out for all allegations of abuse per occurrence and the log and investigation report will be trended and analyzed in the monthly QAPI meeting to ensure the alleged violation is verified and the appropriate corrective action has been taken and to ensure that the facility is on substantial compliance. Administrator is responsible.	

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F 250	Continued From page 37 remembered Resident #3 and her family member coming to her office to let her know of the event that took place during the 7/22/16 Bingo game. The RSM stated she told the DNS about the event, but that was the extent of her involvement. The RSM stated she did not feel the need to follow up with Resident #3 about the event. On 9/21/16 at 1:50 pm, the Administrator, DNS, Systems Consultant, and 2 surveyors viewed the video recording of a 7/22/16 Bingo game. The recording was consistent with Resident #3's description of the event. On 9/22/16 at 3:00 pm, Resident #3 was in her room, seated at the edge of her bed, fidgeting and restless. Resident #3 stated, "Did you see the video? Did it happened the way I remember? I worry that no one believes me or that I made it up, because I told them and told them about it and nothing happened." Resident #3 experienced psychosocial harm when she reported an allegation of abuse towards both herself and Resident #11, with no social services assessment, monitoring, or follow-up.	F 250		
F 253 SS=F	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was	F 253	F 253	11/1/16

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F 253	Continued From page 38 determined the facility failed to ensure sufficient maintenance services was provided to maintain residents' rooms, base boards, dining room, and lobby, in good condition. This failure had the potential to affect the quality of life of all residents in the facility. Findings include: On 9/19/16 between 3:15 pm and 3:42 pm, and on 9/20/16 around 11:45 am, the following was observed: *The carpet at the main lobby was old, faded and in need of extensive cleaning or replacement. *Shower Room door in 100 hall - the protective covering on the lower half of the door was missing *Rooms 201, 202, 203, 204, 207, 210, 211, and 212 had doors which were marred, chipped and scratched especially on the lower third of the hinge side of the doors. *Rooms 302, 304, 305, 306, 307, 310, 312, and the TV Room, had doors which were marred, chipped and scratched especially on the lower third of the hinge side of the doors. *Room 302 - a bed was against the wall near the door and the footboard was in the way when closing the door. The door would not close completely. *Door of room 307 was difficult to open when completely closed. * Therapy Room door - the protective green covering was coming off.	F 253	PROVISION OF MEDICALLY RELATED SOCIAL SERVICE This facility will ensure to provide maintenance services to maintain residents room, baseboards, dining room and lobby are in good condition. Affected residents: No specific residents were cited in this deficiency. Carpet at the main lobby have been replaced, Shower room door protective covering in 100 hall have been replaced. Rooms 201, 202, 203, 204, 207, 210, 211 and 212 doors have been repainted. Rooms 302, 304, 305, 306, 307, 310, 312 and TV room doors have been repainted. Room 302□s bed has been rearranged and bed□s footboard is not obstructing the door from closing. Room 307□s door has been serviced and can easily be opened now when completely closed. Therapy room door□s protective covering was fixed with an adhesive and is now securely in place. Baseboard of the ice machine in the dining room has been repainted. Baseboard near conference room door has been fixed and is no longer coming off. Paint on the wall in the main dining room near the socket has been repainted. Potential Residents: All resident have the potential to be affected by this practice. Environmental inspection is being done by the administrator prior to compliance.	

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F 253	Continued From page 39 *Baseboard of the ice machine in the main dining room by the sink was chipped/scrapped. *Baseboard near the conference room door was coming off. *Paint on the wall in the main dining room near the socket was peeling off. On 9/21/16 at 1:05 pm, during the environmental tour of the facility with the Maintenance Director, he was shown of the above maintenance items. The Maintenance Director said about two weeks before, the new Administrator asked him to repair the doors and baseboards, and to replace the missing protective covering on the doors of residents' rooms. He said he had bought the glass board already and would start the repairs as soon as possible. The Maintenance Director agreed that the carpet at the main entrance was old, faded and was in need of cleaning.	F 253	Systemic: Staff was educated on Federal citation and deficient practice. An annual preventative maintenance program and schedule has been implemented. Weekly maintenance inspection will be done by the maintenance director to include checking paint chips, protective door coverings and baseboards. Result from this weekly maintenance inspection will be documented and will be reviewed by the administrator. Monitoring and QA audits: Administrator will review weekly maintenance inspection result to make an action plan with maintenance director and also to ensure issues and concern will be addressed in a timely manner. Administrator or department head designee will do a random inspection monthly X 12 months to ensure compliance. Administrator and maintenance are responsible.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280		11/1/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 40 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure: * A resident's care plan was revised to reflect her liberalized fluid restrictions. This was true for 1 of 1 (#5) sampled resident on fluid restrictions. * A resident's care plan was reviewed and revised to reflect her current needs. This was true for 1 of 3 (#7) sampled residents whose care plans noted they were non-adherent to care and services. These deficient practices had the potential to cause harm if residents did not receive appropriate care and treatment due to inaccurate information on their care plans. Findings include: 1. Resident #5 was admitted to the facility on 10/20/15 with multiple diagnoses including end stage renal disease. Resident #5's recapitulated Physician's orders and MARs for August and September 2016 included an order "Fluid restriction 1700 cc/24 hours (End Stage Renal Disease) two times a	F 280	F 280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP This facility will ensure that a resident□s care plan have accurate information to reflect resident□s current status. Affected Resident # 5□s care plan have been reviewed and updated to include current physician□s order regarding fluid restriction. Resident # 7□ care plan have been reviewed and updated to include current resident□s communication status. Potential Residents All resident have the potential to be affected by this practice. All residents care plan have been reviewed by the Director of Nursing Services to ensure that all residents care plans are reflective to the current physician□s order and current resident status. Systemic Staffs were educated on Federal citation	

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F 280	Continued From page 41 day." Resident #5's care plan, dated 10/28/15, included an intervention, "Serve a Liberalized Renal, CCD diet with 1500 cc fluid restriction 24 hours..." Resident #5's physician telephone orders, dated 4/11/16, documented "Increase res[ident] fluid restriction to 1700 ml/24[hour]" On 9/22/16 at 11:05 am, CNA #5 said Resident #5's fluid restriction was 1500 cc for 24 hours. On 9/22/16 at 11:20 am, LN #3 said Resident #5's fluid restriction used to be 1500 cc but had recently been increased to 1700 cc by her dialysis physician. She said the care plan should have been updated. 2. Resident #7 was admitted to the facility on 5/3/12, with multiple diagnoses including restless leg syndrome. Resident #7 Quarterly MDS assessment, dated 7/20/16, documented she had severe cognitive impairment, with short and long term memory problems, was totally dependent on 1-2 staff with most of her ADLS, and was always incontinent of bowel and bladder. The MDS also documented Resident #7's decision making ability as severely impaired. Resident #7's Behavior Care Plan, dated 12/16/13, documented a focus "Behavior -Non-adherence: [resident] refusing to allow help from staff with cares or refusing to participate in cares, [Resident] will resist having her teeth brushed or oral care done and not want to be	F 280	and deficient practice. Our policies are to ensure all care plans address the accurate care and status of each resident. We have reviewed these policies and no changes are needed. We have enforced these policies with education of IDT and their roles in care plan development and revision and increased auditing. Comprehensive care plan will be prepared in the weekly interdisciplinary team meeting with in 7 days of the completion of the resident□s comprehensive assessment. Monitoring and QA audits Interdisciplinary team will audit and update if necessary residents care plan in the weekly IDT meeting per resident□s MDS schedule and change of condition to ensure all care plans reflect resident□s current physician orders and status. Audits will be reviewed in the monthly QAPI meeting for 12 months to ensure and actions implemented substantial compliance. The DNS is responsible.	

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F 280	Continued From page 42 changed at times." Interventions included "...2. Calmly explain to [resident] care what needs to be done prior to beginning giving simple step by step procedure...3. Discuss with [resident] the reason she does not wish to comply with request...4. Re-approach [resident] a few minutes later... 5. Give [resident] positive feedback..." Resident #7's Communication Care Plan dated 5/8/12, documented "At risk for communication deficit and memory impairments due to occasional episodes of not answering appropriately. At times will open eyes and stares when spoken to but may choose not to verbally respond." Interventions included, "Ask questions that can be answered by shaking her head...Face resident and speak clearly...At times [resident] will respond by using animal sounds..." On 9/22/16 at 1:25 pm, Resident #7 was observed in bed staring at the ceiling. She was covered with a sheet up to her chest and was moving her legs as if she was scratching the mattress. There was no response when the surveyor greeted Resident #7 and no eye contact from her. On 9/22/16, the RSM was interviewed. The RSM said when the care plan was developed Resident #7 was able to answer simple yes or no questions. The former RSM said the care plan was recently updated. The former RSM provided a copy of the updated care plan. The focus and interventions were the same as those on the previous care plan. The care plan did not reflect Resident #7's current status.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		11/1/16

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F 282	Continued From page 43 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined that the facility failed to ensure residents' care plans were implemented for 1 of 12 sample residents (#2). The practice of failing to implement the plan of care placed Resident #2 at risk for harm when care was not provided as planned. The findings include: 1. Resident #2 was admitted to the facility on 12/6/10, with multiple diagnoses including Alzheimer's disease. Resident #2's Quarterly MDS assessment, dated 7/13/16, documented she had severe cognitive impairment, required the assistance of two staff with toileting and transfer, one staff with dressing, hygiene, and bathing, and set-up only for eating. The MDS also documented Resident #2 was frequently incontinent of her bowel and bladder. Resident #2's current care plan documented an intervention, "Toilet upon rising, before meals, at HS and PRN restless during the night..." On 9/20/16 Resident #2 was observed in bed asleep at 1:05 pm and 1:45 pm. At 2:30 pm, LN #1 was observed entering Resident #2's room. The surveyor immediately followed the LN. When the surveyor entered Resident #2's room, she	F 282	F 282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN This facility will ensure that a resident□s care plan have accurate information and are implemented. Affected Resident Resident # 2□s care plan have been reviewed and updated to include to offer toilet use as resident will allow, preferably upon rising and with any behavior indication of the resident□s needs to void. Resident # 2□s care plan have been reviewed and updated to include to offer food, snack or supplement upon rising. Potential Residents All resident have the potential to be affected by this practice. All residents care plan have been reviewed by the Director of Nursing Services and or Licensed Nurse designee to ensure that all residents care plans are reflective to the current physician□s order and current resident status. Systemic Staffs were educated on Federal citation and deficient practice. It is our policy for staff to follow care plans as written or to communicate with nursing	

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F 282	Continued From page 44 was already in her wheelchair. LN #1 said she had to be quick to assist Resident #2 to her wheelchair because she was a fall risk. When asked if Resident #2 was toileted, LN #1 did not answer. On 9/20/16 at 2:35 pm, Resident #2 was wheeled to the main dining room and placed by the window. Resident then moved herself to an empty table next to the window but CNA #3 quickly moved Resident #2 back by the window. On 9/20/16 at 2:45 pm, LN #2 was asked if Resident #2 had eaten her lunch. The LN said they did not wake Resident #2 for lunch because she became combative when awakened from her sleep. LN #2 said Resident #2 had consumed about 60 cc of a nutritional supplement at 1:30 pm. LN #2 then asked a CNA to get some food for Resident #2. On 9/22/16 at 10:10 am, the DNS said Resident #2 should have been toileted upon rising and should have been offered food when she was in the dining room.	F 282	staff managers when care is not or cannot be provided as listed on the care plan. We have reinforced this policy through education and auditing. Interdisciplinary team will audit and update if necessary residents care plan in the weekly IDT meeting per resident□s MDS schedule and change of condition to ensure all care plans reflect resident□s current physician orders and status. Monitoring and QA audits Random weekly staff resident care audits are being conducted which include direct observation of care based on care plan documentation will be done by the DNS or Department Head LN to ensure staff are implementing resident plan of care. Audits will be reviewed in the monthly QAPI meeting for 12 months and actions implemented to ensure substantial compliance. DNS is responsible.	
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 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.	F 314		11/1/16

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F 314	Continued From page 45 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 pressure ulcers did not develop in the facility and interventions to promote the healing of pressure ulcers were initiated and monitored for effectiveness. This was true for 2 of 6 residents (#1 and #2) sampled for pressure ulcer prevention. Resident #1 was harmed when she developed an unstageable pressure ulcer to her left heel. Resident #2 had the potential for harm when she was not repositioned as her care plan instructed. Findings include: Resident #1 was readmitted to the facility on 1/8/16 with diagnoses of rheumatoid arthritis, anemia, protein-calorie malnutrition, diabetes mellitus, history of pressure ulcers, peripheral neuropathy, and obesity. Resident #1 had a history of bilateral leg fractures, bilateral knee replacements, and right hip replacement. Resident #1's quarterly MDS assessment, dated 7/15/16, documented Resident #1 had short term and long term memory impairment; rejected cares 1-3 days in the past 7 days; was dependent on 2 persons for bed mobility and transfers using a Hoyer Lift; and had impaired ROM to both lower extremities. The MDS identified Resident #1 as being at risk of pressure ulcers. A nursing note on 7/15/16 documented Resident #1 had no ability to move her lower extremities. Resident #1's Care Plan documented she was at	F 314	F314 This facility will ensure pressure ulcers are not developed in the facility and interventions to promote the healing of pressure ulcers are initiated and monitored for effectiveness. Affected Residents Resident 1 □ The air mattress has been checked and is operating effectively □ the settings are accurate for this resident□s weight. The care plan addresses skin care and positioning needs and staff are supervised to follow. Resident 2 - The care plan addresses skin care and positioning needs and staff is supervised to follow. Potential Residents All residents with skin at risk and / or open areas have been reviewed to ensure the care plan addresses positioning and skin care needs. Staff is being supervised to follow the care plan. Systemic We are reviewing current NPUA recommendations for wound management and will revise our policies in accordance with those recommendations, as applicable, and as approved by our Medical Director. We have reassessed all resident□s with wounds to ensure proper pressure relief, at the correct settings and a turning program. Care plans have been updated. Care giving staff have received education on the importance of following the care	

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F 314	Continued From page 46 risk for pressure ulcers related to her refusal to change positions, refusal of treatments, and refusing baths. Resident #1 had a history of pressure ulcers and other skin issues. The Care Plan goal documented Resident #1 would have no areas of skin breakdown due to her refusal of cares. Interventions in place as of 7/15/16, included complete body assessment weekly per LN, notify LN of refusals to reposition or bathe, LN to educate on risks caused by her refusal, use of a bariatric alternating low air loss bed, and the LN was to check Resident #1's weight and the air bed settings daily. Nursing notes, dated from 8/10/16 through 9/21/16, documented Resident #1 refused showers, vital signs, meals, and repositioning, at times on a daily basis. Resident #1's medical record did not document investigation of the reasons for her refusals, or what interventions were implemented to try to overcome them. On 8/31/16 Resident #1's TAR documented her skin was intact. On 9/6/16 at 3:09 pm, a nursing note documented Resident #1's skin assessment was completed as scheduled and there was a new skin issue observed to her left heel. The area was documented to have discoloration and a mushy appearance. There was no drainage at the site and the area was unopened. The physician was notified and orders to have the WOCN evaluate Resident #1 were received. The Wound or Pressure Sore Identification and Progress Record dated 9/6/16 documented an unstageable wound to Resident #1's left heel.	F 314	plan and offering and/or providing repositioning as documented on the care plan. Monitoring and QA Audits Currently we are observing and auditing turning schedules daily X 2 weeks to ensure ongoing compliance. DNS or Department Head LN will do a random weekly staff resident care audit for 8 weeks, then monthly for 10 Months to include air mattress check, positioning, turning schedules and skin care needs to ensure staff are implementing resident plan of care. Residents will be chosen from the Casper report monthly for review to ensure our wound policies are followed and care is being provided in accordance with the care plan. Audits will be reviewed in the monthly QAPI meeting for 12 months to ensure substantial compliance. The DNS is responsible.	

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F 314	Continued From page 47 On 9/6/16, Resident #1's TAR documented orders to treat the wound with Skin Prep and to ensure Resident #1's heels were not touching the bed or pillows. The TAR provided space twice daily for the LN to document the number of times Resident #1 refused these measures. For 28 opportunities 9/6/16-9/20/16, there were 4 blank boxes. The remaining 24 boxes documented a check mark and initials. It could not be determined from the documentation how often Resident #1 refused these measures, for what duration, what was done to attempt to overcome her objections, or whether she was more agreeable to the treatment after her objections were addressed. On 9/6/16, Resident #1's Care Plan was updated to include skin breakdown to her left heel, with a goal to resolve it in a timely manner and for her to have no signs or symptoms of infection at the site. The interventions added included the application of Skin Prep to both heels twice daily, treatment from a WOCN, and weekly measurements of the area. The care plan did not include direction for staff to float the Resident #1's heels as ordered on 9/6/16. On 9/8/16, a Nutrition Risk Progress Note documented the recommendation to increase Resident #1's nutritional supplement to one can three times a day. Documentation showed the recommendation was implemented 9/22/16 at 10:46 am, 2 weeks after the recommendation was made. On 9/12/16, the WOCN documented, "new heel breakdown discovered 9/6/16 by skin LPN	F 314		

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F 314	Continued From page 48 measured 2 x 1.5, black, boggy without any open skin... Is on alternating low air loss bed. Eats poorly and very resistant to repositioning of any type. Does not get out of bed for meals. Does not allow staff to weigh her. Has been floating heels 80% of time. Will not wear any type of heel protection. Wound area measures 0.8 x 1.4 cm, purple area is hard but with no drainage. Has scaling at medial edge-probable SDTI-improving. Continue to float heel as much as possible, continue Skin Prep. Encourage turning side to side." Whether Resident #1 was experiencing pain related her rheumatoid arthritis, or other medical conditions was not addressed as one of the potential reasons for her reluctance to reposition. The WOCN's assessment and those of LNs did not addressed how the mattress settings were to be determined, in light of Resident #1's preference not to be weighed. The WOCN's assessment did not document whether Resident #1 was made aware of the correlation between her weight and the determination of an effective setting for the mattress. On 9/14/16, the LN completed a weekly skin assessment with no change in physician orders or interventions. On 9/17/16, the LN completed a weekly skin assessment with no change in physician orders or interventions. On 9/19/16 at 10:15 am, Resident #1 was observed in bed with her eyes closed. Both of her heels rested directly on the bed.	F 314		

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F 314	Continued From page 49 On 9/19/16 at 1:50 pm, Resident #1 was lying on her back in bed with a pillow under her head and one to her left side. She was awake and watching television. Resident #1 was lying on an alternating pressure/low air loss bed. Resident #1 stated the bed was "hard as a rock." The mattress was firm to solid when touched. There was no visible movement or alternation on the surface of the mattress. Her left heel was directly on the mattress and her right foot was turned so the outer aspect of her foot was directly on the mattress. There were no pillows on the bed near Resident #1's legs or feet, and no pillows on the floor near the bed. Resident #1 stated she often experienced arthritic pain, which made it difficult for her to find a comfortable position. Resident #1's September 2016 MAR documented the use of routine Neurontin, OxyContin ER, and Cymbalta. The MAR also documented Resident #1 could have Oxycodone 5 mg every 6 hours, as needed. Resident #1 received the "as needed" medication on 3 occasions during the month of September. Documentation of Resident #1's pain level or of staff offering her pain medication prior to position changes or wound care was not found in the MAR or elsewhere in Resident #1's record. On 9/19/16 at 4:00 pm, Resident #1 was lying in bed on her back with her left heel directly on the mattress. Pillows were not on the bed near Resident #1's legs or feet, nor on the floor near her bed. She stated she had not been repositioned that afternoon. On 9/20/16 at 9:00 am, Resident #1 was in bed, lying on her back with her eyes closed. Both feet	F 314		

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F 314	Continued From page 50 were directly on the mattress. Pillows were not observed on the bed near Resident #1's legs or feet or on the floor near her bed. On 9/20/16 at 1:10 pm, Resident #1 was in bed, lying on her back. Both of her feet showed 3+ edema. Resident #1's left heel was in direct contact with the mattress. Resident #1 stated her feet were painful to touch. Resident #1 stated the pressure ulcer to her heel was "almost gone", and that staff wanted her to elevate her heels off the surface of the bed to keep her legs from falling asleep. On 9/20/16, the LN completed a weekly skin assessment with no change in physician orders or interventions. On 9/21/16 at 4:06 pm, CNA #1 and CNA #4 provided cares to Resident #1. Resident #1 was positioned on her back with her heels directly on the mattress before cares began. When cares were completed, she was lying on her back in bed, with her heels positioned directly on the mattress. When the CNAs exited the room Resident #1 was in the same position. They did not offer or attempt to position Resident #1 so her heals did not touch the mattress. On 9/22/16 at 8:00 am, Resident #1 was observed in her room lying on her back with her left heel directly on the mattress. She was in the same position at 9:00 am. On 9/22/16 at 10:30 am, the treatment nurse stated Resident #1's "as needed" pain medication should be used to try to minimize her pain prior to care. The treatment nurse also	F 314		

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F 314	Continued From page 51 stated the facility did not know what the manufacturer's recommendation was for the correct inflation of an alternating low air los bed for Resident #1. The treatment nurse indicated she was not sure how the settings on Resident #1's air mattress were being adjusted in light of her refusals to be weighed. The treatment nurse was not aware of Resident #1's complaints of the mattress being too hard and uncomfortable. She stated she checked 3 to 4 times daily to ensure pillows were placed under Resident #1's legs to keep her heels from lying directly on the mattress. The treatment nurse stated, at times, she would find the pillow on or near the bed, removed from under Resident #1's legs, and stated this was because Resident #1 removed it. On 9/22/16, the WOCN documented Resident #1's left heel wound was worsening, with Resident #1 frequently refusing to be repositioned. The left heel wound was documented as 2.1 X 1.4 cm, deep purple, with no drainage. The wound was documented as not open. The WOCN documented Resident #1 had refused pressure-relieving boots and all treatment except Skin Prep. The note documented Resident #1 complained her bed was hard and uncomfortable. The note directed staff to continue to offer boots and try different approaches for Resident #1 to keep her heels elevated. The note did not address pain as a potential factor in Resident #1's refusal of interventions, or direct staff as to what different approaches might be effective to overcome Resident #1's objections. Resident #1 was harmed when the facility failed to implement pressure ulcer prevention	F 314		

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F 314	Continued From page 52 interventions, assess the effectiveness of those interventions, and revise interventions as needed. 2. Resident #2 was admitted to the facility on 12/6/10, with multiple diagnoses including Alzheimer's disease. Resident #2's Quarterly MDS assessment, dated 7/13/16, documented she had severe cognitive impairment, required the assistance of two staff with toileting and transfer, one staff with dressing, hygiene and bathing, and set-up only for eating. The MDS also documented Resident #2 was frequently incontinent of bowel and bladder and at risk of pressure ulcer development. Resident #2's care plan, dated 1/24/12, documented an intervention "Turn at least q 2 hr and prn for restlessness when in bed and reposition when up in w/c..." On 9/20/16, between 10:10 am and 2:05 pm, the following observation were made: * At 10:10 am, two CNAs were observed assisting Resident #2 to bed. Resident #2 was lying on her back. * At 1:05 pm, Resident #2 was observed sleeping, lying on her back. The CNA who was providing 1:1 care to her roommate said Resident #2 was in bed since 10:00 am. * At 1:45 pm, Resident #2 was observed in bed sleeping, lying on her back. * At 2:05 pm, Resident #2 was observed in bed	F 314		

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F 314	Continued From page 53 sleeping, lying on her back. On 9/22/16 at 10:10 am, the DON said Resident #2 had a tendency to be combative when awakened from sleep, but CNAs should try to repositioned her at least every 2 hours to prevent pressure ulcer development.	F 314		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. 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 provide necessary assistance for a resident to maintain his nutritional needs. This was true for 1 of 6 residents (Resident #4) sampled for appropriate assistance. The deficient practice had the potential for harm should Resident #4 experience weight loss due to a lack of assistance. Findings include: Resident #4 was admitted to the facility on 6/16/15, with diagnoses which included Traumatic Brain Injury.	F 325	F 325 MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE This facility will ensure to provide necessary assistance for a resident to maintain resident□s nutritional needs. Affected Resident Resident #4's care plan have been reviewed and updated to include to offer meal to resident when awake and not in the dining room during meal time. Potential Residents All resident have the potential to be	11/1/16

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F 325	Continued From page 54 Resident #4's Annual MDS Assessment, dated 6/17/16, documented his cognition was moderately impaired, he experienced delusions, required extensive assistance of one person to transfer in and out of bed, and needed limited assistance to eat meals. Resident #4's care plan documented a focus area of assistance for ADL's, including supervision and set-up for meals. The interventions included offering the resident a small meal if he slept in. Resident #4's care plan for memory loss included interventions to ensure his full attention when speaking to him, allow time to process the information, and offer simple choices. Resident #4's care plan for dysphagia documented an intervention of dining in the restorative dining room. a. On 9/20/16 at 5:25 pm, CNA #8 brought Resident #4's dinner meal tray to the 300 hall dining room, and stated she was looking for Resident #4. LN #5 stated, "He [Resident #4] stated he didn't want it." CNA #8 stated, "Oh," placed the meal tray in the dining cart, and left the dining room. CNA #8 and LN #5 did not inform Resident #4 that his dinner tray had arrived, encourage him to come to the dining room, or offered him his meal tray in his room. On 9/20/16 at 6:00 pm, Resident #4 was lying in bed awake. Resident #4 stated, "I didn't eat dinner. I went to bed." Resident #4 stated he was hungry and was waiting for someone to let him know when his dinner was ready. On 9/20/16 at 6:08 pm, LN #6 stated she was	F 325	affected by this practice. Please see our plan of correction below. Systemic All Staff were educated on Federal citation and deficient practice. It is our policy to ensure all residents are offered their meals in accordance with their preferences. No changes are needed to these policies. Nursing staffs were educated to offer meals to all residents, to awaken them per their preferences, and to provide them assistance/cueing as needed while eating. Monitoring and QA audits A random weekly room audit will be done by a department head assigned to ensure that residents are offered of their meal and adequate assistance are provided to residents. Department heads will sign the completed audit sheet and turn in to the D.N.S. for review. All Audits will be reviewed at the Monthly QAPI meeting and actions implemented to ensure substantial compliance. The DNS is responsible.	

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F 325	Continued From page 55 Resident #4's LN for that shift. LN #4 stated it was "normal" for Resident #4 to refuse his dinner. When informed staff had not approached Resident #4 to let him know his dinner was ready, LN #6 stated staff would retrieve the meal tray from the cart and reheat it for him when he was "ready." When informed Resident #4 had stated he was hungry and waiting for someone to tell him when his dinner was ready, LN #6 shrugged and stated, "It's OK. It's care planned." The facility's Systems Consultant was informed of Resident #4's status, and stated she would have someone assist Resident #4 to the dining room for dinner. On 9/20/16 at 6:26 pm, Resident #4 was alert and awake, seated at a table in the 300 hall dining room, feeding himself with a spoon in each hand. b. On 9/22/16 at 7:47 am, Resident #4 was sitting in his wheelchair at a table in the 300 hall dining room. Resident #4 had his head down, chin on his chest, and his eyes closed. His breakfast meal was on the table in front of him. No staff approached Resident #4 for the next 10 minutes. On 9/22/16 at 7:57 am LN #2 stopped at Resident #4's table, roused him briefly, and encouraged him to wake up and eat his breakfast. Resident #4 opened his eyes, lifted his head, and responded. LN #2 then walked away from the table. Resident #4 then dropped his head so his chin was on his chest and closed his eyes. He did not attend to his meal or initiate feeding himself. On 9/22/16 at 8:05 am, CNA #2 sat on a stool at	F 325		

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F 325	Continued From page 56 Resident #4's table, roused him, and began to feed him. Resident #4 sat up, and allowed CNA #2 to feed him a few bites. On 9/22/16 at 8:07 am, Resident #4 took the spoon from CNA #2 and began to feed himself. He continued to feed himself until his meal was consumed. On 9/22/16 at 3:30 pm, the DNS stated Resident #4 was a night shift worker for the majority of his career, and his sleep patterns tended to mimic a night shift worker. The DNS stated the facility did ensure a dinner tray was saved for Resident #4 every night, as he was usually hungry when he awoke in the night. The DNS stated the staff should approach him when the regular dinner meal is served and offer him the opportunity to eat at that time, with the other meal available upon Resident #4's request. The DNS stated Resident #4 was now able to feed himself, and no longer required restorative dining, but staff should attempt to arouse him and engage him in his meal if he is asleep in the dining room.	F 325		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		11/1/16

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F 431	Continued From page 57 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure ophthalmic medications were dated when opened, and expired medications and vaccines were removed from the medication cart and medication room. This was true for 2 of 2 medication carts and 1 of 1 medication room checked for expired medications. This failed practice created the potential for residents to receive expired medications with decreased efficacy. Findings include: 1. On 9/22/16 at 10:00 am, during inspection of	F 431	F 431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS This facility will ensure that ophthalmic medications were dated when opened and expired medications and vaccines were removed from medication cart and medication room. Potential Residents All resident have the potential to be affected by this practice. All vials of ophthalmic medication with lack of date when it was first opened were	

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F 431	Continued From page 58 100 Hall Medication Cart with DNS present, 6 vials of ophthalmic medications lacked the date of when they were first opened. LN #3 stated "We are supposed to date it when they are first opened." The DNS stated the manufacturer's recommendations were followed. One insert was found and reviewed but information for this was not found. The DNS provided the Recommended Minimum Medication Storage Parameters for ophthalmic medications from the pharmacy. Depending on the medication, the discard recommendation was from 14 days to 3 months. On 9/22/16 at 10:15 am, during inspection of the facility's medication room with the ICN present, a box with a tuberculin vial inside, with an open date of 8/20/16, was found in the refrigerator. Directions on the box stated to dispose of it 30 days after opened. On 9/22/16 at 1:00 pm, an inspection of 300 Hall Medication Cart was completed with LN # 4. Expired medication found included a multi-use bottle of folic acid with a manufacturer's expiration date of 5/2016, and a bottle of mineral oil with the expiration date of 9/2016. LN #4 said the mineral oil should be good through the last day of September. The ICN said it would be disposed on the first day of September. A box of Ipratopium Bromide and Albuterol inhalers was found with the foil pouch open. There was no date indicating when the pouch was first opened. The direction on the box was to dispose of the remaining vials 4 weeks after the foil pouch was opened. On 9/22/16 at 10:15 am, during inspection of the facility's medication room with the ICN present, a	F 431	removed from medication cart. The expired tuberculin vial inside the refrigerator was removed and discarded. Medication cart and refrigerator audit for medication expiration and open date was done by a Registered Nurse Consultant. All vials are now labeled with open date and expiration date. Systemic Staffs were educated on Federal citation and deficient practice. It is our policy to ensure outdated medications are discarded and standards related to opened medications followed. No changes are required to this policy, however we will reinforce with education and auditing. Licensed staff was educated to use the sticker label when opening a new medication. Label to include medication date open, expiration date and the initial of the Licensed Nurse that opened the medication. Monitoring and QA audits A random cart and refrigerator audit will be done at least weekly by the director of nursing services and/or licensed nurse designee to ensure that all medication are dated to when it was opened and no expired medication are in the medication cart and refrigerator. In addition, our pharmacy consultant will continue to perform monthly reviews. Result of this audit will be reviewed at the Monthly QAPI meeting X 12 to ensure substantial compliance and action plans implemented. The DNS is responsible.	

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F 431	Continued From page 59 box with a tuberculin vial inside, with an open date of 8/20/16, was found in the refrigerator. Directions on the box stated to dispose of it 30 days after opened.	F 431		
F 441 SS=F	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 (3) Maintains a record of incidents and corrective actions related to infections. (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. (c) Linens	F 441		11/1/16

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F 441	Continued From page 60 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined the facility failed to ensure the glucometer was disinfected after each use to prevent the spread of blood borne organism, and soiled linens were not transported and washed in a local laundromat, were hygienically clean and handled to prevent recontamination after the facility's commercial washer broke down. This failed practice created the potential for infection to develop and affect all the residents in the facility. Findings included: On 9/20/16 at 4:00 pm, LN #1 was observed as she performed a BG check for Resident #5. After the BG check, LN #1 closed the pouch of the glucometer, removed her gloves, and walked down the hallway towards the medication cart which was by the 100 Hall nurse's station. She then took an alcohol swab and cleaned the outside of the glucometer pouch. LN #1 was not observed to disinfect the glucometer. On 9/20/16 at 4:25 pm, LN #1 said the glucometer she used could be used for multiple residents but Resident #5 was the only resident using it. LN #1 said each of the other residents in the facility who required BG checks had their own glucometer. The LN said sometimes she used saniwipes to clean the glucometer but most of the time she used an alcohol swab.	F 441	F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS This facility will ensure the glucometers are disinfected after each use to prevent the spread of blood borne organisms, and soiled linens were not transported and washed in a local Laundromat, were hygienically clean and handled to prevent recontamination after the facility□s commercial washer broke down. Affected Resident Resident #5 glucometer is now being disinfected using a disinfectant wipe after every use. Potential Residents All residents have the potential to be affected by this practice. 1. Facility has provided an individual glucometer to all residents that needed their BG check. Staff are now sanitizing individual glucometer using a disinfectant wipe after every use. 2. The commercial machine is now in full operational capacity. Systemic Staffs were educated on Federal citation and deficient practice. 1. Licensed staff were educated on the	

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F 441	Continued From page 61 On 9/21/16 at 2:40 pm, the ICN said the glucometer should be cleaned and disinfected in between uses with a saniwipe. 2. On 9/21/16 at 2:20 pm, during the environmental tour, the laundry room was inspected. The laundry room had one commercial washer and two small regular washing machines. The Laundry Manager said the small washing machines were used for residents' personal clothing. She said one of the regular washing machines arrived three days after the new administrator started in the facility. When asked why there was a need for a new washing machine, the Laundry Manager said the big commercial washer broke down the preceding month and it was repaired on the same day she reported it. She said, the commercial washer worked for about a week but it broke down again. The Laundry Manager said she reported it again to the Maintenance Department but could not remember the exact date the commercial machine broke down the second time and the date she reported it. The Laundry Manager said when the new administrator was making his rounds, she mentioned the broken commercial washer and that she was staying late in the facility to wash the soiled materials. When asked if the soiled linens were washed in the small washing machine, the Laundry Manager said they were not. She said the soiled linens and blankets were washed at the local laundromat. She said soiled linens and blankets were double bagged and then the bags, along with the facility's detergents and bleaching solution, were transported to the local laundromat using the	F 441	proper procedure of disinfecting glucometer machine. 2. Infection control nurse and medical director will be made aware in the future if the commercial machine breaks down and a plan of action will be made with Interdisciplinary team, Infection control nurse and medical director. An agreement with a professional laundry company will be initiated in the event the facility commercial machine is not working. Monitoring and QA audits 1. DNS and or Licensed Nurse department head will do a random audit weekly and observe charge nurse to ensure the infection control practice in disinfecting glocumeter machine have been done according to Policies and procedures. 2. Maintenance director will do a weekly commercial washer inspection to ensure that the machine is working properly. Audits and inspection report will be reviewed in the monthly QAPI meeting.	

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F 441	Continued From page 62 facility's van. She said they disinfected the washing machine and dryer in the laundromat using a sani wipe before and after use, and the same was done for the table they folded the clean linens and blankets on. The Laundry Manager said the clean linens were double bagged and transported back to the facility in the facility van. On 9/21/16 at 4:30 pm, the Maintenance Director said the commercial washer was not in use for about two weeks and said the part of the washer that was replaced was the variable frequency drive. The Maintenance Director could not give the exact date when the commercial washer failure was reported to him and when it was repaired. The Maintenance Director was not able to provide a log book of work orders requests. On 9/21/16 at 4:45 pm, the ADM was asked the break down of the commercial washer and processes used while it was not functioning. On 9/22/16 at 8:00 am, the ADM provided the following narrative statement: *The commercial washer first broke down on 8/25/16 and was checked on the same day. The facility was told the Solenoid assembly needed to be change. It was ordered on 8/26/16 and was installed on 8/30/16. "but the solenoid replacement did not fix the problem." *On 9/1/16 at 9:00 am, the new ADM was introduced to the staff by the previous ADM. At approximately 5:00 pm, the new ADM found out that the commercial washer had broke down and asked the Maintenance Director to call a laundry	F 441		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 63 technician and approved a work order for the commercial washer. The new ADM then instructed the Laundry Manager to prepare all the soiled linens to be transported to the local laundromat the following day. *On 9/2/16, the laundry staff wore gloves, loaded all double bagged soiled linens in the utility cart and then to the vehicle with a wipeable fiberglass cargo lining. The report said the laundry staff brought the facility's laundry supplies with them "Royal Brite Enzyme detergent with Oxygen bleach, Bleach-Laundry destainer concentrated chlorinated bleach, Sani-cloth plus germicidal disposable cloths, laundry apron/gown, 2 boxes of large gloves and a few rolls of heavy duty bags." ..."I helped unload all linens with gloves on and instructed the [Laundry Manager] and staff to follow infection control procedure...just like when we are doing the laundry in the facility...And instructed to make sure to use hot wash and use facility sanitizing detergent and add bleach in each load." *On 9/2/16 at approx 12;00 noon, the Laundry Technician checked the commercial washer. *On 9/5/16, "...I have told the Maintenance Director to go ahead and order, But [name of technician] was going to call the vendor again to make sure that a stock is available." *On 9/6/16, overnight shipping of the part was approved by the ADM. *On 9/816 at approximately mid morning, the Laundry Technician installed the part and the commercial washer was fixed.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135084		09/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK REHABILITATION CENTER OF KIMBERLY	500 POLK STREET EAST KIMBERLY, ID 83341

(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 441	Continued From page 64 The [Laundry Manager] Procedural Report documented the following: 1. Double bagged all linens for transport... 2. Wear protective equipment. 3. Used Sani-cloth wipe to sanitized washer before loading and before removing ... 4....all soiled linens went directly to the washing machine... 10. Two vehicle transport was used. One to transport double bagged soiled linens...And the 2nd vehicle, the facility van was used to transport double bagged clean linen... On 9/22/16 at 9:53 am, the ICN said she did not know soiled linens were transported to, washed, and dried, at the local laundromat. She said had she known she would not have allowed it to happen. The ICN said she would have called a professional laundry to transport and wash the soiled linens and transport the clean dry linens back to the facility. The facility's policy and procedure on linen handling documented "...If linen is sent off to a professional laundry, the facility should obtain an initial agreement between the laundry service and facility that stipulates the laundry will be hygienically clean and handled to prevent recontamination from dust and dirt during loading and transport."	F 441		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MDS001530		**09/23/2016**

NAME OF PROVIDER OR SUPPLIER
OAK CREEK REHABILITATION CENTER OF KI

STREET ADDRESS, CITY, STATE, ZIP CODE
500 POLK STREET EAST
KIMBERLY, ID 83341

(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) COMPLETE DATE
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a representative from each department was included and signed in at the Infection Control Meetings. This failure had the potential to affect all residents, staff and visitors to the facility. Findings include: On 9/22/16 at 9:53 am, the ICN said the facility held their Quality Assurance Performance Improvement meetings on a monthly basis in which infection control was a component. Review of the sign-in sheets for the last 7 months, from January 2016 to August 2016, covered the last 2 quarterly meetings, revealed the Pharmacist, Maintenance Director and the Housekeeping/Laundry Manager had not attended any of the monthly meetings. The ICN did not offer any explanation why the Pharmacist, Maintenance Director and Housekeeping/Laundry Manager did not attend the meetings.	C 664	02.150,02,a Required Members of Committee The Administrator will ensure that all members of the committee will be in attendance for the infection control part of monthly QAPI meetings. Administrator is responsible.	11/1/16

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/28/16

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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January 6, 2017

Darwin Royeca, Administrator
Oak Creek Rehabilitation Center Of Kimberly
500 Polk Street East,
Kimberly, ID 83341-1618

Provider #: 135084

Dear Mr. Royeca:

On **September 23, 2016**, an unannounced on-site complaint survey was conducted at Oak Creek Rehabilitation Center Of Kimberly. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007358

The investigation was conducted in conjunction with the facility's recertification survey between September 19, 2016 and September 23, 2016.

During the survey, clinical records for 13 residents were reviewed, including the identified residents. Staff were interviewed regarding the identified incidents. Nursing, activities, and housekeeping staff were asked about their training and knowledge of abuse prevention, recognition, reporting, and resident protection. The files of five facility employees were reviewed for appropriate screening for abuse history. Observations were made of staff interactions with residents, including interactions during activities. Four individual residents were interviewed and two resident families were interviewed. A resident group interview was conducted. A video recording of the identified event was reviewed. Medication pass observations were conducted.

Allegation #1: Supplies were removed from one resident during a facility activity and given to another resident. When a third resident objected to the treatment of the first resident, the staff member became angry and verbally abusive with the third resident.

Findings #1: The allegation was substantiated and the facility cited at F 225, F 226, F 248, and F 250.

Conclusion #1: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #2: An identified resident routinely received medications late, causing lethargy.

Findings #2: The identified resident's Medication Administration Record documented the times medications were administered. The standard of practice for medication administration called for medications to be given up to an hour before or an hour after the scheduled time. There were occasions where the identified resident received one dose of her medication towards the end of this two-hour window allowance, and the next dose towards the beginning of the next two-hour allowance. On occasions where the medication was either not given due to nursing judgement or resident refusal, the physician was notified.

The record of the identified resident documented times the resident was lethargic. On those occasions, the physician assessed the resident to have other medical issues contributing to the lethargy, which were treated and the resident's lethargy improved.

There was insufficient information to substantiate this allegation, and no deficiencies were cited.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt