



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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December 14, 2016

George Wiemerslage, Administrator
Lacrosse Health & Rehabilitation Center
210 West Lacrosse Avenue
Coeur d'Alene, ID 83814-2403

Provider #: 135042

Dear Mr. Wiemerslage:

On **November 7, 2016**, a survey was conducted at Lacrosse Health & Rehabilitation Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. This survey found the most serious deficiencies in your facility to be **ISOLATED** and to constitute immediate jeopardy to residents' health and safety **as documented on the enclosed CMS-2567, whereby significant corrections are required.** You were informed of the immediate jeopardy situation(s) in writing on **November 3, 2016 and November 4, 2016.**

On **November 14, 2016**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, and an onsite visit November 17, 2016 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.

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.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 27, 2016**. Failure to submit an acceptable PoC by **December 27, 2016**, may result in the imposition of additional civil monetary penalties by **January 13, 2017**.

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 -- Investigate/report Allegations/individuals
F0323--Free Of Accident Hazards/supervision/devices
F0226 -- 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 Monetary Penalty**
- **Denial of payment for new admissions**

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

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

Your facility's noncompliance with the following:

- F0225--483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals**
- F0323-- 483.25(h) -- Free Of Accident Hazards/supervision/devices;**
- F0226-- 483.13(c) -- Develop/implment 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, #14, #20 and #23** 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, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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,

George Wiemerslage, Administrator
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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:

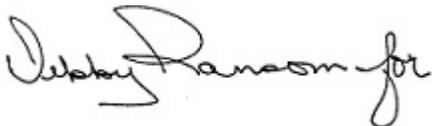
- BFS Letters (06/30/11)

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

This request must be received by **December 27, 2016** . If your request for informal dispute resolution is received after **December 27, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nina Sanderson, LSW, Supervisor
Long Term Care

NS/lj
Enclosures

cc: Chairman, Board of Examiners - Nursing Home Administrators

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2016
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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint investigation survey conducted October 31, 2016 to November 7, 2016.</p> <p>The surveyors conducting the survey were:</p> <p>David Scott, RN, Team Coordinator Amy Barkley, RN, Jenny Walker, RN Marci Clare, RN Linda Close, RN Marcia Mital, RN Sherrie McElwain, RN Linda Kelly, RN</p> <p>ABBREVIATIONS:</p> <p>ADL = Activities of Daily Living am = Time from 12:00 midnight to 12:00 noon AST = Aspartate aminotransferase BID = Twice a Day BIMS = Brief Interview for Mental Status BLE = Bilateral Lower Extremities Braden score = (used to determine a person's risk to develop pressure ulcers) BUE = Bilateral Upper Extremities BUN = lab test done to assess kidney function CAA = Care Area Assessment CBC = Complete Blood Count (lab test) CM = Centimeters CNA = Certified Nursing Assistant CO2 = Carbon Dioxide DC'D = Discontinued DON = Director of Nursing GDR = Gradual Dose Reduction HOB = Head of bed</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 12/27/2016
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 IV = Intravenous LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set NC = Nasal cannula OOB = Out of bed OT = Occupational Therapy O2 = Oxygen PHQ-9 = Patient Health Questionnaire PICC = Peripherally Inserted Central Catheter pkt = Packet pm = Time from 12:00 noon to 12:00 midnight PN = Progress Notes PO = Orally (by mouth) P&P = Policy and Procedure(s) PROM = Passive Range of Motion PT = Physical Therapy PTSD = Post-Traumatic Stress Disorder PU = Pressure Ulcer RCM = Resident Care Manager RN = Registered Nurse RNA = Restorative Nursing Assistant ROM = Range of Motion RNP = Restorative Nursing Program ST = Skin Tear	F 000			
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on review of grievances, policies, and	F 166	This Plan of correction constitutes this	1/23/17	

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F 166	<p>Continued From page 2</p> <p>clinical records, and staff, resident, and family member interview, it was determined the facility failed to ensure that resident and family grievances were promptly investigated and resolved, and residents and family members were appropriately apprised of the progress toward resolution of their grievances. This was true for 1 of 19 sampled residents (#3) and 4 random residents (#26, #27, #28, #29) and had the potential to impact all residents in the facility. The deficient practice created the potential for residents and family members to experience frustration and/or psychosocial harm when their concerns, including those of mistreatment, were not investigated and resolved. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 5/9/16, with diagnoses that included Guillain-Barre Syndrome, respiratory failure, depression, quadriplegia, and atrial fibrillation.</p> <p>Resident #3's admission MDS assessment, completed on 5/16/16, documented he had no cognitive impairment, required total assistance with all activities of daily living due to the paralysis of all four limbs and below the neck, caused by the sudden onset of Guillain-Barre Syndrome [A rare but serious autoimmune disorder in which the immune system attacks healthy nerve cells in the peripheral nervous system leading to paralysis]. The MDS documented Resident #3 was totally dependent on staff and required the physical assistance of two people.</p> <p>On 11/2/16 at 4:00 pm, a family member of Resident #3 stated that soon after admission to the facility an incident occurred with CNA #6. The</p>	F 166	<p>facility's written allegation of compliance for deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report</p> <p>Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Resident #3 is no longer at the facility. Residents #26, #27, #28 and #29 have had concerns/grievances investigated. The residents listed and/or their family members have been apprised of the resolution. Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility who have concerns/grievances could be affected by this deficient practice. Resident concerns/grievances have been reviewed for the last 30 days and have been resolved. Resident and/or family members are apprised appropriately of the resolution of identified grievances and resolution. Measures in place and systemic changes made to ensure that the deficient practice does not recur; Staff employed at the facility has been inserviced on the concern/grievance policy and procedure. Concerns/Grievances will be reviewed during the morning management meeting for investigation and resolution.</p>		

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F 166	<p>Continued From page 3</p> <p>family member stated, "Right after we got here we had a problem. A night shift CNA was rough with him. She let his arms and legs hang over the sides of the bed. She tried to turn him by herself and when she left the room his head was hanging off of the bed. He uses his head to press against the call light and he was unable to use his call light. He told me that he was left in that position for several hours and unable to ask for help. It happened sometime in May, I wasn't writing in my journal then. He told me about it the next morning when I got here. I am here every day from 8:30 in the morning until about 9:00 at night. He told me a nurse came into the room several hours later and with the help of another CNA repositioned him correctly. I wrote a note about it and gave it to the Unit Manager who said she would write it up. I didn't know her name but when I described her to the Unit Manager she said it was CNA #6. I never heard what happened but she didn't come back to care for him again."</p> <p>During the conversation with the family member on 11/2/16 at 4:00 pm, the family member provided a copy of the journal where she had recorded what Resident #3 reported to her. The journal entry documented the following, "10/2/16 Arrive 8:35 leave 9:45 couldn't get changed during night-called for help-because other aide was one Resident #3 had problems with. She refused to come in, he wouldn't have her." The family member stated, "I told (the Director of Nurses) (DON) and he said, "We have trouble finding CNAs that are comfortable with vent patients." The family member stated that the DON never came back to tell her what he found out regarding her concerns of the night of</p>	F 166	<p>A concern/grievance log will be maintained by the administrator and reviewed during the morning management meeting for investigation and apprising family/resident of progress made timely towards resolution. Concerns/grievances generated from resident council will be documented on the concern/grievance form and reviewed for investigation, notification and resolution by the Executive Director. Monitor performance to ensure the corrective actions are effective and compliance is sustained; The concern/grievance log will be reviewed daily Monday-Friday by the administrator/designee. Investigation, notification, and resolution will be monitored weekly X 12 by the Regional Director of Services/ Regional Director of Operations to ensure completion. Findings will be corrected as identified and presented at QAPI (quality assurance performance improvement) meeting monthly X 3 for further educational opportunities. Date corrective action will be complete and who is responsible to maintain compliance;</p> <p>_____ Administrator</p>		

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F 166	<p>Continued From page 4 10/1/16.</p> <p>On 11/3/16 at 9:15 am, the DON stated he did not recall any complaint by the family member regarding anyone on the night shift. He stated he did not have anything in writing and there were always two CNAs on duty on the 600 hall.</p> <p>On 11/3/16 at 9:30 am, an interview with UM #1 was completed. She stated "I vaguely recall. I don't remember all the circumstances, I need to talk to (the DON). I remember a conversation I had with them, (Resident #3 and the family member), and I took it to (the DON). I don't know if they investigated it or not. I don't remember if they said rough handling but more of a repositioning problem. When I talked to them they said his legs and head were off the bed. They said they did not want CNA #6 to go back into the room. I talked to therapy about it and to the educator. I don't recall getting any written note from the family member. I might have been the one who requested that CNA #6 not go back into the room, I just can't recall and I don't have anything in writing."</p> <p>On 11/3/16 at 12:40 pm, the family member for Resident #3 stated, "On 10/10/16 I told them I wanted to have a conference with the DON and the Administrator. We met in the Administrator's office and the DON was there. I told him again that I didn't want her [CNA #6] in his room. The family member stated that she asked the DON, "Why do we still have her on this wing?" The family member provided a blank Resident Concern Report form. The family member stated, "Someone handed me this blank form to fill out during the meeting. I thought the facility was</p>	F 166			

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F 166	<p>Continued From page 5 supposed to do that."</p> <p>On 11/3/16 at 1:00 pm, during an interview, the Administrator stated he recalled the meeting with the family member on 10/10/16, however, was not aware of an allegation of mistreatment of Resident #3 by CNA #6. He said notes were not taken during the meeting and the issue was not handled as a formal grievance.</p> <p>The facility's "PROCEDURE Concern-Resident/Family" process included the following, "The center provides residents and their family members with an uninhibited resident/family concern procedure. The procedure is such that each and every resident and/or family has the right to express their grievance or concerns directly to the center's administration either verbally or in writing. Assure the resident and/or family that they can voice their concern without fear of discrimination or reprisal. Any employee may receive a concern. All employees that receive a concern should attempt to resolve the concern. All employees will complete the Resident Concern Report for any and all concerns. The Executive Director is responsible for the process in the center."</p> <p>2. The facility's Resident Concern Report file for April through October 2016 included 13 reports for which the facility failed to address residents' grievances. The Resident Concern Reports included:</p> <p>* Resident Council Meeting minutes, dated 6/2/16, documented, "Has it been checked on yet regarding a handicap access to allow residents to use the patio?" On 11/1/16 at 10:30 am, Resident</p>	F 166			

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F 166	<p>Continued From page 6</p> <p>Council members told surveyors an access to the patio for residents who were non-ambulatory had still not been addressed by the facility. On 11/2/16 at 1:42 pm, while conducting a general tour of the facility, the Maintenance Supervisor stated he had not been informed non-ambulatory residents were experiencing difficulty accessing the patio.</p> <p>* Random Resident #26 reported on 7/13/16 that he was missing an expensive maroon cell phone. The section of the report titled "Resolution and Disposition" was blank. The "Follow-up" section documented, "Resident stated that he does not remember this incident." The facility did not provide documentation its investigation attempted to confirm the resident owned such a phone through interviews with interested parties, other cognitively intact residents, or staff.</p> <p>* Random Resident #27 reported on 7/25/16 that a pair of deerskin gloves costing \$70 was missing. The unsigned "Follow-up" section of the report documented the facility would reimburse the resident for the purchase of new gloves upon presentation of a receipt. Random Resident #27 stated on 11/4/16 at approximately 2:00 pm that this was the second pair of identical gloves that had been removed without his permission from his room. The resident stated the facility reimbursed him for the first pair that went missing, but required him to purchase a new pair of gloves before the cost of the second pair would be reimbursed.</p> <p>* Random Resident #27 reported on 8/4/16 that another resident was removing snacks and soda from his room "whenever she wants, even in the</p>	F 166			

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F 166	<p>Continued From page 7</p> <p>middle of the night." The intrusive resident was known to facility staff and had been observed with Random Resident #27's soda in a hallway. The report documented Random Resident #27 stated he "wants something done," and that he "shouldn't have to close his door to keep her out." The report's outcome documented, "[Random Resident #27] will not keep soda in his room ... no further issues." The facility required Random Resident #27 to forego his own preferences rather than address the disruptive behavior of another resident in the facility.</p> <p>* A Resident Concern Report, dated 8/4/16, documented Random Resident #28 stated CNAs were not answering call lights or assisting him; 3 residents stated nurses documented they had administered medications the residents did not receive; Random Resident #29 stated nurses had attempted to administer another resident's medication to her and that she "would like nurses to know who they [residents] are"; and an unspecified number of residents stated they would like to be bathed the day prior to physician appointments or hospital procedures. The sections of the report entitled "Investigation Report," "Disposition," and "Follow-up" were blank.</p> <p>* On 11/1/16 at 10:30 am, 10 residents attending a meeting with surveyors stated Resident Council concerns were brought to the attention of the facility's Administrator or Director of Nursing. When asked if their concerns were addressed in a timely manner, one of the residents who asked for anonymity stated, "We usually have to wait a couple weeks." When asked how the Resident Council addresses concerns to the facility that</p>	F 166			

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F 166	Continued From page 8 have not been resolved within "a couple of weeks," the resident stated, "We wait a couple more [weeks]."	F 166			
F 225 SS=J	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 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	F 225		1/23/17	

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F 225	<p>Continued From page 9 survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff, resident, and family member interview, policy review, and review of staffing schedules and in-service training records, it was determined the facility failed to ensure allegations of mistreatment, sexual assault, elopement, and injury of unknown origin were investigated and/or reported for 4 of 24 sampled residents (#3, #14, #20, and #23). This deficient practice placed Resident #3 in Immediate Jeopardy (IJ) for serious harm, impairment, or death.</p> <p>Specifically, Resident #3 alleged he was mistreated by a CNA who was allowed to provide cares for his roommate for 5 months following the allegation, which was neither reported nor investigated by the facility. Resident #3 was in Immediate Jeopardy for repeat instances of mistreatment and continued to experience anxiety when the alleged perpetrator was allowed to continue assisting with cares for his roommate over a 5-month period.</p> <p>Resident #23 was also harmed when she was sexually assaulted by Resident #24, whose care plan stated he was to receive 1:1 supervision. A thorough investigation of the incident was not completed.</p>	F 225	<p>Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Resident #3 is no longer at the facility. Resident #14 has had any identified bruising investigated for abuse and neglect. Measures are in place to protect the resident. Resident #23 -the perpetrator was discharged from the facility at the time of the incident. Resident #23 has had follow-up psychosocial evaluation and intervention related to the event. Resident #20 is no longer at the facility. Other residents who have the potential to be affected by the same deficient practice and what measures will be taken; Residents residing at the facility have the potential to be affected by this deficient practice. Residents residing at the facility have been interviewed and assessed for abuse/neglect potential. There are no additional residents identified. All other missing persons have been reported and investigated. Measures in place and systemic changes made to ensure that the deficient practice</p>		

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F 225	<p>Continued From page 10</p> <p>Additionally, Resident #14 presented with significant bruising of unknown origin that was neither reported nor investigated in a timely manner by the facility. This deficient practice placed Resident #14 at risk of potential abuse as the source of her injuries had not been investigated.</p> <p>The facility failed to investigate a missing resident (Resident #20) who was not located until he was admitted to a hospital approximately 36 hours later with diagnoses that included hypothermia, catatonia, and dehydration. The facility failed to investigate this elopement as a possible case of neglect or address supervision concerns for other residents in the facility who were also at risk of elopement.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident #3 was admitted to the facility on 5/9/16 with diagnoses that included Guillain-Barre Syndrome and quadriplegia. <p>The admission MDS assessment, dated 5/16/16, documented Resident #3 was cognitively intact, and totally dependent on at least two staff for all activities of daily living due to paralysis below the neck from a sudden onset of Guillain-Barre Syndrome, a rare autoimmune disorder in which the immune system attacks healthy nerve cells in the peripheral nervous system leading to paralysis.</p> <p>On 11/2/16 at 4:00 pm, Resident #3's family member stated, "Right after we got here we had a problem. A night shift CNA [#6] was rough with him. She tried to turn him by herself and when</p>	F 225	<p>does not recur;</p> <p>Field Director of Education and Training has educated all staff on abuse and neglect policies and procedures to include but not limited to immediate suspension of alleged perpetrator, assessing safety of the resident and initiation of investigation and reporting requirements.</p> <p>Executive Director of Clinical Services has educated department head managers on abuse and neglect recognition, identification and the investigative process.</p> <p>Executive director of Clinical Services has educated department head managers on abuse and neglect recognitions, identification and the investigative process.</p> <p>Executive Director of Clinical Services has educated department managers on the facility's grievance process to include reviewing grievances within the facility's meeting structure to assure that any potential allegation is thoroughly investigated. This will also provide educational opportunities to assure Department Heads fully comprehend abuse and neglect policy.</p> <p>Random interviews will e completed by manager of the day and Caring Partners daily of staff to assure understanding of education provided.</p> <p>Director of Clinical Services and Director of Operations will complete random interviews during facility visits.</p> <p>DON will write a comprehensive investigation for every allegation of abuse and neglect before investigation will be</p>		

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F 225	<p>Continued From page 11</p> <p>she left the room his head, arms, and legs [were] hanging off of the bed. He uses his head to press against the call light and he was unable to use his call light. He told me that he was left in that position for several hours and unable to ask for help. He told me a nurse came into the room several hours later and with the help of another CNA repositioned him correctly. I wrote a note about it and gave it to the Unit Manager who said she would write it up. I never heard what happened, but she [CNA #6] didn't come back to care for him again."</p> <p>On 11/2/16 at 4:00 pm, Resident #3, when asked if he felt CNA #6 was "rough" with him, nodded his head, "Yes." The family member stated, "The Unit Manager asked him if it would be alright if she brought [CNA #6] into the room to teach her how to reposition him. He told her, 'No,' by moving his head from side to side. She is the only one [staff] he has a problem with and he insisted that she not come back into the room."</p> <p>During this conversation with the family member on 11/2/16 at 4:00 pm, Resident #3, who was unable to speak due to a tracheostomy tube providing oxygen via ventilator, motioned for a communication board. The resident then nodded his head back and forth or side-to-side as his family member pointed out letters that eventually spelled, "Tell her what happened." The family member stated, "On 10/2/16 he told me something that happened the night before on the night shift. He said there were only two people on the shift and one of them was [CNA #6]. He said a nurse came into the room and told him she couldn't reposition him by herself and the other CNA on duty was [CNA #6], who was not allowed</p>	F 225	<p>finalized and will review with the Director of Operations or the Director of Clinical Services.</p> <p>Director of Clinical Services or Executive Director of Clinical Services will review all allegations of abuse and neglect for the next 30 days and monthly thereafter for monitoring of the abuse and neglect investigation process.</p> <p>Residents will be interviewed weekly on resident treatment by Caring Partners and findings forwarded to Executive Director. Any negative responses will be investigated immediately within the policies and procedures related to abuse and</p> <p>Facility's Executive of Clinical Services was on site on 11-9-16 to 11-11-16 to review systems and implementation.</p> <p>Facility's Director of Education and Training was on site 11-4-16 to 11-11-16 to provide in-service training to staff.</p> <p>Facility's Field Director of Education and Training was on site 11-4-16 to 11-11-16 to provide in-service training to staff.</p> <p>Executive Director with oversight by the Executive Director of Clinical Service and or Director of Clinical Service will continue monitoring implementation of the facility's abuse and neglect policies and procedures.</p> <p>Monitor performance to ensure the corrective actions are effective and compliance is sustained;</p> <p>Random interviews of the staff were completed for 30 days to ensure understanding of the identification and resident protection related to abuse and</p>		

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F 225	<p>Continued From page 12</p> <p>in the room. He wasn't repositioned or changed [when incontinent] all night."</p> <p>The family member, who kept a journal in which she documented what Resident #3 reported to her, contained the following entry: "10/2/16 - Arrive 8:35 leave 9:45 couldn't get changed during night-called for help-because other aide was one he had problems with. She refused to come in, he wouldn't have her." The family member stated, "I told (the DON) and he said, "We have trouble finding CNAs that are comfortable with vent patients."</p> <p>On 11/3/16 at 9:30 am, UM #1 stated, "I remember a conversation I had with [Resident #3 and his family member] and I took it to [the DON]; I don't know if they investigated it or not. [Resident #3 and his family member] said they did not want [CNA #6] to go back into the room. I don't recall getting any written note from the family member. I might have been the one who requested that [CNA #6] not go back into the room, I just can't recall and I don't have anything in writing."</p> <p>On 11/3/16 at 11:00 am, the DON said he was aware CNA #6 was not allowed into Resident #3's room to provide care, but did not know the reason. The DON stated he scheduled CNA care assignments and that he assigned CNA #6 to an area of the facility where she would not come into contact with Resident #3 or his family member.</p> <p>On 11/3/16 at 12:20 pm, UM #1 stated she did not initiate an investigation when Resident #3's family member spoke to her several months previous. UM #1 stated, "The only nurse aide that</p>	F 225	<p>neglect.</p> <p>Elopement risk changes for residents residing at the facility will be review through the Comprehensive Care Plan Review meeting in accordance with the MDS schedule.</p> <p>The regional support Director will monitor incidence of potential abuse/neglect to ensure the investigative and required interventions are in place as per policy and procedure X 3 months for further corrective actions. Findings will be corrected upon identification and presented to QAPI for further corrective opportunities.</p> <p>Date corrective action will be complete and who is responsible to maintain compliance;</p> <p>_____ Administrator</p>		

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F 225	<p>Continued From page 13</p> <p>[Resident #3] and his family member had a problem with was [CNA #6]. I counseled [CNA #6], but I didn't write anything up. I talked to the DON and we tried to brainstorm ..."</p> <p>On 11/3/16 at 12:30 pm, LN #2 said she worked the night shift and knew CNA #6 was not allowed to provide care to Resident #3. LN #2 stated, "When [CNA #6] works ... we have to watch her call lights because she is not allowed to care for [Resident #3]. [CNA #6] trades with someone else on duty when it comes to [Resident #3's] care; everyone knows she can't go in there."</p> <p>On 11/3/16 at 12:40 pm, Resident #3's family member stated she met with the Administrator and DON on 10/10/16, at which time she stated she did not want CNA #6 in the resident's room. At the time of this interview, Resident #3 stated his participation in Speech Therapy enabled him to now speak. Resident #3 stated, "She's the only one I had trouble with. At that time I had no strength in my neck and I couldn't position my head. She left me on my bed sore for hours and I couldn't use my call button. I couldn't explain to them then what I needed and they didn't have time to use the communication sheet." When asked if he felt he had been mistreated by CNA #6, Resident #3 said, "Yes."</p> <p>On 11/3/16 at 12:45 pm, CNA #4 said she knew CNA #6 was not allowed in Resident #3's room and stated, "I heard [CNA #6] was being too rough when changing him. A couple of days ago [CNA #6] worked that night and the resident and his [family member] said he wasn't changed or touched all night because [CNA #6] could not go in there and they were short [staffed] that night."</p>	F 225			

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F 225	<p>Continued From page 14</p> <p>On 11/3/16 at 1:00 pm, the Administrator stated he recalled the meeting with Resident #3's family member on 10/10/16, however, he said he was not aware of an allegation of mistreatment involving CNA #6. He said notes were not taken during the meeting and the issue was not processed as a formal grievance.</p> <p>Daily Nursing Schedules for 5/1/16 through 11/4/16 documented CNA #6 was assigned to provide cares to Resident #3, who resided on the 600 Hall, until 5/23/16, when she was assigned to another hall for the rest of that month. The daily nursing schedule, dated 6/1/16, documented CNA #6 was again assigned to the 600 Hall. The daily nursing schedules documented CNA #6 was again assigned to Resident #3 from that time forward, including the night shift of 10/1/16.</p> <p>An In-service Training Record, dated 5/16/16, documented 10 staff were re-educated on providing care to Resident #3. The in-service record documented, "[Resident #3] - ensure head is properly positioned and ears are not kinked. Have [Respiratory Therapy] check him after every reposition. Be mindful of head and leg position when repositioning."</p> <p>A 6/6/16 In-service Training Record documented, "[Resident #3] - Must be offered to turn and reposition and change brief every 2 hours."</p> <p>The daily nursing schedule for 10/1/16 night shift documented CNA #6 was reassigned from another area of the facility to the 600 Hall when two staff called in sick. The staffing schedule</p>	F 225			

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F 225	<p>Continued From page 15</p> <p>documented CNA #6 was the only night shift CNA assigned to the 600 hall on 10/1/16.</p> <p>The facility's Prevention and Reporting Mistreatment, Neglect, Abuse policy documented, "The [facility] is required to report these alleged violations to the Executive Director and DON/designee immediately. 'Immediately' means as soon as possible, but not to exceed 24 hours after discovery of incident...Provide training for all staff who provide care...Training will include...verbal, sexual, physical, and mental abuse, neglect, mistreatment, injuries of unknown source, and misappropriation of property. Suspend identified employee(s) immediately pending outcome of investigation. Additional steps to prevent further potential abuse include...protection from retaliation, staffing changes, follow-up counseling for the resident. Review and investigate...enter details of the investigation into the electronic accident/incident report...report the results to other officials in accordance with State law within 5 working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken. In the case of an employee being investigated for abusing, neglecting, or mistreating a resident, the Executive Director must relieve the individual of their duties without pay until the investigation is complete."</p> <p>NOTIFICATION AND REMOVAL OF IMMEDIATE JEOPARDY: F225 and F226</p> <p>On 11/3/16 at 6:45 pm, the Interim Administrator and DON were informed these systemic failures placed Resident #3 in Immediate Jeopardy (IJ) of serious harm, impairment, or death based on the</p>	F 225			

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F 225	<p>Continued From page 16 facility's failure to identify, investigate, and report the allegation of mistreatment.</p> <p>On 11/14/16, the facility provided an acceptable plan to remove the immediate jeopardy at CFR 483.13 (c) [F225] and CFR 483.13(c)(3) [F226] and alleged removal of the immediacy as of 11/16/16.</p> <p>The systems, procedures, and protocols implemented by the facility to assure removal of the IJ for F225 and F226 were:</p> <ul style="list-style-type: none"> * Field Director of Education and Training has educated all staff on abuse and neglect policies and procedures to include measures to be taken if abuse/neglect is suspected to include but not limited to immediate suspension of alleged perpetrator, assessing safety of the resident and initiation of investigation and reporting requirements. * Executive Director of Clinical services has educated department head managers on abuse and neglect recognition, identification and the investigative process. * Executive Director of Clinical services has educated department managers on the facility's grievance process to include reviewing grievances within the facility's meeting structure to assure that any potential allegation is thoroughly investigated. This will also provide educational opportunities to assure Department Heads fully comprehend abuse and neglect policy. * Random interviews will be completed by manager of the day and Caring Partners daily of staff to assure understanding of education provided. 	F 225			

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F 225	<p>Continued From page 17</p> <ul style="list-style-type: none"> * Director of Clinical Services and Director of Operations will complete random interviews of staff during facility visits. * DON will write a comprehensive investigation for every allegation of abuse and neglect before investigation will be finalized and will review with the EDCS or the DS. * DCS or EDC? will review all allegations of abuse and neglect for the next 30 days and monthly thereafter for monitoring of the abuse and neglect investigation process, * Residents will be interviewed weekly on resident treatment by Caring Partners and findings forwarded to Executive Director, Any negative responses will be investigated immediately within the policies and procedures related to abuse and neglect. * Facility's Executive Director of Clinical services was on site on 11/9/16 to 11/11/16 to review systems and implementation. * Facility's Director of Clinical S?rvices was on site on 11/4/16 to 11/10/16 to review systems and implementation, * Facility's Field Director of Education and Training was on site l 1/4/16 to 11/11/16 to provide in-service training to staff * Executive Director with oversight by the EDCS and/or DCS will continue monitoring implementation of the facility's abuse and neglect policies and procedures. <p>On 11/17/16, an on-site revisit was conducted to confirm the immediate jeopardy had been removed. The on-site team confirmed the facility had removed the immediacy as of 11/16/16.</p> <p>2. Resident #23 was admitted to the facility on 3/13/15, with multiple diagnoses, which included</p>	F 225			

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F 225	<p>Continued From page 18 anxiety and depression.</p> <p>A Social Service Progress Note, dated 5/5/16, documented Resident #23 was cognitively intact.</p> <p>The quarterly MDS assessment, dated 7/13/16, documented Resident #23 was able to make herself understood, could understand others, and was cognitively intact.</p> <p>An Incident Summary, dated 7/22/16, documented that a male resident, whose care plan stated he was to have 1:1 supervision, touched Resident #23's face, and then slid his hand down to her chest before staff could intervene. Resident #23 was upset from the incident and denied physical injury but was emotionally upset from the incident.</p> <p>A Reporter Statement, dated 7/22/16 at 8:50 am, documented Resident #23 called for RN #1 to come in to her room. When she entered the room Resident #23 burst into tears and stated, "I was just molested. Resident #24 across the hall came into my room and touched me inappropriately. He patted my head then moved his hands down to my breasts. I tried to stop him and [Hospitality Aide #1-Resident #24's 1:1] tried to get him out of my room."</p> <p>Nurses' Notes, dated 7/22/16 at 8:50 am, documented that Resident #23 reported to staff that a male resident pushed her wheelchair to her room, ran his hands over her head, down her shoulders, and to her breast. She stated that this brought up very bad memories from years ago. Resident #23 was in bed hugging her stuffed animal, as she spoke she began to cry.</p>	F 225			

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F 225	<p>Continued From page 19</p> <p>A Psychologist note, dated 7/22/16 at 3:35 pm, documented that Resident #23 was upset because one of the male residents took liberties with her that morning and it brought up memories of a past sexual abuse.</p> <p>Nurses' Notes, dated 7/22/16 at night, documented that Resident #23 had a resident-to-resident altercation initiated by a male resident, she had complaints of PTSD [post-traumatic stress disorder] from a past experience, that the staff would continue to monitor, and that there were no signs or symptoms of physical injury.</p> <p>Nurses' Notes, dated 7/24/16 at night, documented that Resident #23 had been talking about the assault and how no one seemed concerned.</p> <p>Nurses' Notes, dated 7/25/16 at 3:30 am, documented that Resident #23 was in bed throughout most of the shift except to smoke, and there were no signs or symptoms of physical injury related to the altercation.</p> <p>Nurses' Notes, dated 7/26-7/28/16, had no documentation of the sexual assault by a male resident.</p> <p>Social Services Progress Notes had no documentation of the sexual assault, or how Resident #23 was coping with the issue.</p> <p>The facility's procedure for incident investigation, 1.2.10 Section A, effective July 2015, documented that the following would be included</p>	F 225			

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F 225	<p>Continued From page 20 in an investigation:</p> <ul style="list-style-type: none"> * Document after an accident for a minimum of 72 hours in the resident medical record. * Interviewing alleged victim and witness(es). * Interviewing accused individual. * Interviewing other residents to determine if they have been abused or mistreated. <p>An Incident Summary, dated 7/22/16, documented there was a resident statement of what happened written by Resident #24, and a witness statement by Hospitality Aid #1 [Resident #24's 1:1], neither of these statements were included in the Incident Report. There were also no statements or interviews from other staff members or other residents.</p> <p>On 11/1/16 at 10:30 am, in Resident Council meeting, Resident #23 stated she would like to talk to surveyors about a sexual assault that happened to her.</p> <p>On 11/3/16 at 8:30 am, Resident #23 stated that in early summer there was a male resident across the hall, who was to be on 1:1 supervision, who pushed her wheelchair, with her in it, into her room. He then touched her head, shoulders, and continued down to grab her breast. She called out for help and [Resident #24's 1:1] tried to get him out of her room. She started crying and thought that was why the Resident #24 left her room. She stated she was still upset because it brought up memories of a previous sexual assault that happened years prior. She called in a nurse who took her down to the administrator's office. She stated she believed they transported the accused out of the</p>	F 225			

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F 225	<p>Continued From page 21 facility within 24 hours.</p> <p>On 11/3/16 at 2:45 pm, the investigation report was requested from the DON as it was not available in the monthly incident reports. The DON stated he would print it out. At 4:35 pm the report was again requested. The DON provided the incident report. While the report included a statement from Resident #23, it did not contain information from the Resident #23 related to where Resident #24's 1:1 staff was at the time of the incident, statements from other residents and staff who may have been in the area, or a statement from the staff member providing 1:1 supervision.</p> <p>3. Resident #14 was admitted to the facility in May 2014 and readmitted in June 2015 with multiple diagnoses, including rheumatoid arthritis.</p> <p>The quarterly MDS assessment, dated 9/18/16, documented Resident #14 understood- and was understood by others; had adequate hearing and vision; had moderate cognitive impairment; needed extensive 2-staff assistance for bed mobility/dressing/toileting/hygiene; required the total assistance of at least 2 staff for transfers/bathing; had limited ROM in both upper and both lower extremities; and had skin tears [ST].</p> <p>Resident #14's Skin Integrity Assessment: Prevention and Treatment Care Plan documented a ST to the right upper arm on 9/8/16, and a bath blanket between the sling and Resident #14, was added as an intervention. Another care planned intervention, undated, was a sheet between Resident #14 and the Hoyer</p>	F 225			

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F 225	<p>Continued From page 22 mechanical lift sling.</p> <p>On 11/4/16 at 9:30 am, Resident #14 was observed in bed and a large dark bluish purple and red bruise was noted on her right arm/elbow. The bruised area was covered with a transparent dressing and extended about 3 inches above the elbow and 2-to-3 inches below the elbow, and 2-to-3 inches in front of the elbow. The back of the elbow was not visualized as Resident #14 said it was "too painful" to move it. With Resident #14's permission, another resident, who asked to remain anonymous, joined the conversation and said every time staff used the Hoyer lift to get Resident #14 up the resident "gets an injury." The anonymous resident said Resident #14's right arm/elbow injury occurred "about 2 weeks ago" when 2 CNAs got her up for a shower. The anonymous resident said Resident #14 "refuses" to get up with the Hoyer now, to which Resident #14 added, "It hurts." The anonymous resident said Resident #14 used to get out of bed for showers twice a week and doctor appointments, but now she gets a bed bath. A Hoyer lift sling was observed on a chair near Resident #14's bed.</p> <p>A 9/7/16 Occurrence Report documented Resident #14 sustained a 3.5 cm by 4.5 cm ST to the right elbow when staff removed a Hoyer sling from under her in bed after a shower. The upper edge of the ST was "reapproximated" but the lower aspect could not be "reapproximated" and a transparent dressing was applied. A 9/12/16 Follow up Report to the 9/7/16 Occurrence Report documented the care plan was revised and staff were educated to place a bath blanket between Resident #14 and the shower sling.</p>	F 225			

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F 225	<p>Continued From page 23</p> <p>No other Occurrence Reports for September, October or November 2016 were found for Resident #14.</p> <p>Resident #14's PNs, dated 8/3/16 to 11/4/16, included documentation of the right elbow ST on 9/7/16 and resolution of the ST on 10/19/16. The 10/19/16 entry did not include bruising at the right elbow and there were no other entries about bruises or injuries.</p> <p>On 11/4/16 at 4:10 pm, RN #2, an RCM, said Resident #14's skin was "very fragile" and that a right elbow skin tear had resolved on 10/19/16. RN #2 said she was not aware of current bruising to Resident #14's right arm/elbow.</p> <p>On 11/4/16 at 4:15 pm, RN #2 accompanied the surveyor to Resident #14's room, where she was observed in bed with her spouse and a female visitor in the room and the Hoyer sling still on the chair. As RN #2 looked at the resident's right arm/elbow, the spouse stated, "Every time they get her out of bed that sling causes an injury."</p> <p>Immediately afterward, RN #2 reviewed Resident #14's September and October 2016 MARs and TARs and said that bruising was not monitored after the right elbow ST healed, but if there had been bruising it was "not like that." The RN said the transparent dressing over the right arm/elbow bruise was a treatment, but there was no documentation of the treatment. RN #2 said Resident #14 arose from bed only for showers and doctor appointments and her last doctor's appointment was 10/26/16. RN #2 also reviewed Bath Type Detail Reports, which documented</p>	F 225			

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F 225	<p>Continued From page 24</p> <p>Resident #14 was showered on 10/1/16, 10/4/16, 10/11/16, 10/15/16, 10/18/16 and 10/29/16 and received bed baths on 10/22/16 and 11/1/16. RN #2 said no new injuries had been reported to her, but that she would begin an investigation.</p> <p>Resident #14's September, October and November 2016 TARs included areas to document Weekly Skin Assessments with "-" to indicate no new areas and a "+" to indicate new area observed. A staff person's initials and "-" were documented weekly in September and on 10/5/16, 10/12/16, 10/19/16 and 11/2/16. However, on 10/26/16 the initials only were documented and the space to document "-" or "+" was blank.</p> <p>There was no documented evidence when Resident #14's right arm/elbow injury occurred, that staff were aware of the bruise, or that the injury of uncertain origin had been investigated to rule out potential abuse.</p> <p>4. Resident #20's 4/22/16 MDS assessment documented he was feeling down, depressed, or hopeless; had difficulty falling or staying asleep, or slept too much; experienced a poor appetite or overate; felt bad about himself or that he was a failure or had let himself or family down; and had trouble concentrating on things, such as reading the newspaper or watching television. Resident #20 was assessed with moderate cognitive impairment.</p> <p>On 11/3/16 at 4:25 pm, the DON provided a sign-out sheet for Resident #20 dated for 4/24/16 through 8/6/16; the sign-out sheet did not include the resident's signature that he had signed-out of</p>	F 225			

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F 225	<p>Continued From page 25 the facility during that period.</p> <p>An undated and unsigned document titled "Missing Person Summary" documented, "[Resident #20] an alert and oriented resident with...an active order to leave the facility left the facility on 10/25/16. He was last seen at approximately [8:30 pm] and noted to not return at [9:00 pm]. The resident was noted to not use the proper procedure to sign out in the resident sign out log. A missing person action plan was initiated at [9:00 pm]."</p> <p>An EDM [Emergency Department Medical] Record from the local hospital, dated 10/27/16, documented Resident #20 arrived in the emergency department at 9:31 am with "multiple complaints." The report documented, "[Resident #20 was] a missing person since [10/25/16]. [Resident #20] found this [morning] wet and shivering not too far from [facility name]." The report stated Resident #20 received intravenous fluids and described the resident as "in wet clothes and shaking [and] non verbal to staff." The report documented Resident #20 had been assessed with acute altered mental status, acute catatonia, acute dehydration, acute exposure to environmental cold, acute hyponatremia, acute confusion, acute dehydration, acute depression, acute paranoia, and acute vomiting.</p> <p>The facility's Missing Person Policy documented, "The Executive Director is responsible for follow-up of the incident, including any further reporting to state agencies...and completing and submitting of a detailed incident report."</p> <p>There was no evidence provided by the facility,</p>	F 225			

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F 225	Continued From page 26	F 225			
F 226 SS=J	<p>nor found in the state agency office, that the incident was reported or fully investigated.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review, observation, and resident, family member, and staff interview, it was determined the facility failed to follow its own abuse prevention policies and procedures to ensure allegations of mistreatment, elopement, and injury of unknown origin were identified, investigated, and/or reported for 4 of 24 sampled residents (#3, #14, #20, and #23). This deficient practice placed Resident #3 in Immediate Jeopardy (IJ) for serious harm, impairment, or death.</p> <p>Specifically, Resident #3 alleged he was mistreated by CNA #6 who was allowed to provide cares for his roommate for 5 months following the allegation, which was neither reported nor investigated by the facility. Resident #3 was in Immediate Jeopardy for repeat instances of mistreatment and continued to experience anxiety when the alleged perpetrator was allowed to continue assisting with cares for his roommate.</p> <p>Resident #23 was also harmed when she was</p>	F 226	<p>Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Resident #3 is no longer at the facility. Resident #14 has had any identified bruising investigated for abuse and neglect. Measures are in place to protect the resident. Resident #23 -the perpetrator was discharged from the facility at the time of the incident. Resident #23 has had follow-up psychosocial evaluation and intervention related to the event. Resident #20 is no longer at the facility. Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility have the potential to be affected by this deficient practice. Residents residing at the facility have been interviewed and assessed for abuse/neglect potential. There are no</p>	1/23/17	

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F 226	<p>Continued From page 27</p> <p>sexually assaulted by Resident #24, whose care plan stated he was to receive 1:1 supervision. A thorough investigation of the incident was not completed.</p> <p>Additionally, Resident #14 presented with significant bruising of unknown origin that was neither reported nor investigated in a timely manner by the facility. This deficient practice placed Resident #14 at risk of potential abuse as the source of her injuries had not been investigated.</p> <p>The facility failed to investigate a missing resident (Resident #20), who was not located until he was admitted to a hospital approximately 36 hours later with diagnoses that included hypothermia, catatonia, and dehydration. The facility failed to investigate this elopement as a possible case of neglect or address supervision concerns for other residents in the facility who were also at risk of elopement.</p> <p>Findings include:</p> <p>The facility's Prevention and Reporting: Resident Mistreatment, Neglect, Abuse Policy and Procedure, dated October 2016, documented, "The [facility] prohibits the mistreatment, neglect, and abuse of residents...by anyone including staff, family, friends, et. The [facility] has designed and implemented processes, which strive to ensure the prevention and reporting of resident abuse, neglect, mistreatment...All allegations that meet the definition of abuse and substantiated violations will be reported to state agencies and to all other agencies including the local law enforcement, elder abuse agencies,</p>	F 226	<p>additional residents identified.</p> <p>All elopements residents have been reported and investigated.</p> <p>Measures in place and systemic changes made to ensure that the deficient practice does not recur;</p> <p>Field director of Education and Training has educated all staff on abuse and neglect policies and procedures to include measures to be taken if abuse/neglect is suspected to include but not limited to immediate suspension of alleged perpetrator, assising safety of the resident and initiation of investigation and reporting requirements.</p> <p>Executive Director of Clinical Services has educated department head managers on abuse and neglect recognition, identification and the investigative process.</p> <p>Executive Director of Clinical Services has educated department managers on the facility's grievance process to include reviewing grievances within the facility's meeting structure to assure that any potential allegation is thoroughly investigated. This will also provide educational opportunities to assure Department Heads fully comprehend abuse and neglect</p> <p>Random interviews will e completed by manager of the day and Caring Partners daily of staff to assure understanding of education provided.</p> <p>Director of Clinical Services and Director of Operations will complete random interviews during facility visits.</p> <p>DON will write a comprehensive</p>		

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F 226	<p>Continued From page 28 and Adult Protective Services, as required. The [facility] takes all necessary corrective actions depending on the result of the investigation." This policy was not followed. Examples include:</p> <p>1. Resident #3 was admitted to the facility on 5/9/16 with diagnoses that included Guillain-Barre Syndrome and quadriplegia.</p> <p>The admission MDS assessment, dated 5/16/16, documented Resident #3 was cognitively intact, and totally dependent on at least two staff for all activities of daily living due to paralysis below the neck from a sudden onset of Guillain-Barre Syndrome, a rare autoimmune disorder in which the immune system attacks healthy nerve cells in the peripheral nervous system leading to paralysis.</p> <p>On 11/2/16 at 4:00 pm, Resident #3's family member stated, "Right after we got here we had a problem. A night shift CNA [#6] was rough with him. She tried to turn him by herself and when she left the room his head, arms, and legs [were] hanging off of the bed. He uses his head to press against the call light and he was unable to use his call light. He told me that he was left in that position for several hours and unable to ask for help. He told me a nurse came into the room several hours later and with the help of another CNA repositioned him correctly. I wrote a note about it and gave it to the Unit Manager who said she would write it up. I never heard what happened, but she [CNA #6] didn't come back to care for him again."</p> <p>On 11/2/16 at 4:00 pm, Resident #3, when asked if he felt CNA #6 was "rough" with him, nodded</p>	F 226	<p>investigation for every allegation of abuse and neglect before investigation will be finalized and will review with the Director of Operations or the Director of Clinical Services.</p> <p>Director of Clinical Services or Executive Director of Clinical Services will review all allegations of abuse and neglect for the next 30 days and monthly thereafter for monitoring of the abuse and neglect investigation process.</p> <p>Residents will be interviewed weekly on resident treatment by Caring Partners and findings forwarded to Executive Director. Any negative responses will be investigated immediately within the policies and procedures related to abuse and</p> <p>Facility's Executive of Clinical Services was on site on 11-9-16 to 11-11-16 to review systems and implementation. Facility's Director of Education and Training was on site 11-4-16 to 11-11-16 to provide in-service training to staff. Facility's Field Director of Education and Training was on site 11-4-16 to 11-11-16 to provide in-service training to staff. Executive Director with oversight by the Executive Director of Clinical Service and or Director of Clinical Service will continue monitoring implementation of the facility's abuse and neglect policies and procedures.</p> <p>Monitor performance to ensure the corrective actions are effective and compliance is sustained; Random interviews of the staff were completed for 30 days to ensure</p>		

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F 226	<p>Continued From page 29</p> <p>his head, "Yes." The family member stated, "The Unit Manager asked him if it would be alright if she brought [CNA #6] into the room to teach her how to reposition him. He told her, 'No,' by moving his head from side to side. She is the only one [staff] he has a problem with and he insisted that she not come back into the room."</p> <p>During this conversation with the family member on 11/2/16 at 4:00 pm, Resident #3, who was unable to speak due to a tracheostomy tube providing oxygen via ventilator, motioned for a communication board. The resident then nodded his head back and forth or side-to-side as his family member pointed out letters that eventually spelled, "Tell her what happened." The family member stated, "On 10/2/16 he told me something that happened the night before on the night shift. He said there were only two people on the shift and one of them was [CNA #6]. He said a nurse came into the room and told him she couldn't reposition him by herself and the other CNA on duty was [CNA #6], who was not allowed in the room. He wasn't repositioned or changed [when incontinent] all night."</p> <p>The family member, who kept a journal in which she documented what Resident #3 reported to her, contained the following entry: "10/2/16 - Arrive 8:35 leave 9:45 couldn't get changed during night-called for help-because other aide was one he had problems with. She refused to come in, he wouldn't have her." The family member stated, "I told (the DON) and he said, "We have trouble finding CNAs that are comfortable with vent patients."</p> <p>On 11/3/16 at 9:30 am, UM #1 stated, "I</p>	F 226	<p>understanding of the identification and resident protection related to abuse and neglect.</p> <p>Elopement risk changes for residents residing at the facility will be review through the Comprehensive Care Plan Review meeting in accordance with the MDS schedule with interventions implemented as indicated.</p> <p>The Regional Director of Clinical Services and/or the Executive Director of Business Administration will monitor incidence of potential abuse/neglect to ensure the investigative and required interventions are in place as per policy and procedure X 3 months for further corrective actions. Findings will be corrected upon identification and presented to QAPI for further corrective opportunities.</p> <p>_____ Administrator</p>		

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F 226	<p>Continued From page 30</p> <p>remember a conversation I had with [Resident #3 and his family member] and I took it to [the DON]; I don't know if they investigated it or not. [Resident #3 and his family member] said they did not want [CNA #6] to go back into the room. I don't recall getting any written note from the family member. I might have been the one who requested that [CNA #6] not go back into the room, I just can't recall and I don't have anything in writing."</p> <p>On 11/3/16 at 11:00 am, the DON said he was aware CNA #6 was not allowed into Resident #3's room to provide care, but did not know the reason. The DON stated he scheduled CNA care assignments and that he assigned CNA #6 to an area of the facility where she would not come into contact with Resident #3 or his family member.</p> <p>On 11/3/16 at 12:20 pm, UM #1 stated she did not initiate an investigation when Resident #3's family member spoke to her several months previous. UM #1 stated, "The only nurse aide that [Resident #3] and his family member had a problem with was [CNA #6]. I counseled [CNA #6], but I didn't write anything up. I talked to the DON and we tried to brainstorm..."</p> <p>On 11/3/16 at 12:30 pm, LN #2 said she worked the night shift and knew CNA #6 was not allowed to provide care to Resident #3. LN #2 stated, "When [CNA #6] works...we have to watch her call lights because she is not allowed to care for [Resident #3]. [CNA #6] trades with someone else on duty when it comes to [Resident #3's] care; everyone knows she can't go in there."</p> <p>On 11/3/16 at 12:40 pm, Resident #3's family</p>	F 226			

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F 226	<p>Continued From page 31</p> <p>member stated she met with the Administrator and DON on 10/10/16, at which time she stated she did not want CNA #6 in the resident's room. At the time of this interview, Resident #3 stated his participation in Speech Therapy enabled him to now speak. Resident #3 stated, "She's the only one I had trouble with. At that time I had no strength in my neck and I couldn't position my head. She left me on my bed sore for hours and I couldn't use my call button. I couldn't explain to them then what I needed and they didn't have time to use the communication sheet." When asked if he felt he had been mistreated by CNA #6, Resident #3 said, "Yes."</p> <p>On 11/3/16 at 12:45 pm, CNA #4 said she knew CNA #6 was not allowed in Resident #3's room and stated, "I heard [CNA #6] was being too rough when changing him. A couple of days ago [CNA #6] worked that night and the resident and his [family member] said he wasn't changed or touched all night because [CNA #6] could not go in there and they were short [staffed] that night."</p> <p>On 11/3/16 at 1:00 pm, the Administrator stated he recalled the meeting with Resident #3's family member on 10/10/16, however, he said he was not aware of an allegation of mistreatment involving CNA #6. He said notes were not taken during the meeting and the issue was not processed as a formal grievance.</p> <p>Daily Nursing Schedules for 5/1/16 through 11/4/16 documented CNA #6 was assigned to provide cares to Resident #3, who resided on the 600 Hall, until 5/23/16, when she was assigned to another hall for the rest of that month. The daily nursing schedule, dated 6/1/16,</p>	F 226			

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F 226	<p>Continued From page 32</p> <p>documented CNA #6 was again assigned to the 600 Hall. The daily nursing schedules documented CNA #6 was again assigned to Resident #3 from that time forward, including the night shift of 10/1/16.</p> <p>An In-service Training Record, dated 5/16/16, documented 10 staff were re-educated on providing care to Resident #3. The in-service record documented, "[Resident #3] - ensure head is properly positioned and ears are not kinked. Have [Respiratory Therapy] check him after every reposition. Be mindful of head and leg position when repositioning."</p> <p>A 6/6/16 In-service Training Record documented, "[Resident #3] - Must be offered to turn and reposition and change brief every 2 hours."</p> <p>The daily nursing schedule for 10/1/16 night shift documented CNA #6 was reassigned from another area of the facility to the 600 Hall when two staff called in sick. The staffing schedule documented CNA #6 was the only night shift CNA assigned to the 600 hall on 10/1/16.</p> <p>The facility's Prevention and Reporting Mistreatment, Neglect, Abuse policy documented, "The [facility] is required to report these alleged violations to the Executive Director and DON/designee immediately. 'Immediately' means as soon as possible, but not to exceed 24 hours after discovery of incident...Provide training for all staff who provide care...Training will include...verbal, sexual, physical, and mental abuse, neglect, mistreatment, injuries of unknown source, and misappropriation of property. Suspend identified employee(s)</p>	F 226			

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F 226	<p>Continued From page 33</p> <p>immediately pending outcome of investigation. Additional steps to prevent further potential abuse include...protection from retaliation, staffing changes, follow-up counseling for the resident. Review and investigate...enter details of the investigation into the electronic accident/incident report...report the results to other officials in accordance with State law within 5 working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken. In the case of an employee being investigated for abusing, neglecting, or mistreating a resident, the Executive Director must relieve the individual of their duties without pay until the investigation is complete."</p> <p>NOTIFICATION AND REMOVAL OF IMMEDIATE JEOPARDY: F225 and F226</p> <p>On 11/3/16 at 6:45 pm, the Interim Administrator and DON were informed these systemic failures placed Resident #3 in Immediate Jeopardy (IJ) of serious harm, impairment, or death based on the facility's failure to identify, investigate, and report the allegation of mistreatment.</p> <p>On 11/14/16, the facility provided an acceptable plan to remove the immediacy at CFR 483.13 (c) [F225] and CFR 483.13(c)(3) [F226] and alleged removal of the immediacy as of 11/16/16. Refer to F225 for details of the plan</p> <p>On 11/17/16, an on-site revisit was conducted to confirm the immediate jeopardy had been removed. The on-site team confirmed the facility had removed the immediacy as of 11/16/16.</p> <p>2. Resident #23 was admitted to the facility on</p>	F 226			

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F 226	<p>Continued From page 34 3/13/15, with multiple diagnoses, which included anxiety and depression.</p> <p>A Social Service Progress Note, dated 5/5/16, documented Resident #23 was cognitively intact.</p> <p>The quarterly MDS assessment, dated 7/13/16, documented Resident #23 was able to make herself understood, could understand others, and was cognitively intact.</p> <p>An Incident Summary, dated 7/22/16, documented that a male resident, whose care plan stated he was to have 1:1 supervision, touched Resident #23's face, and then slid his hand down to her chest before staff could intervene. Resident #23 was upset from the incident and denied physical injury but was emotionally upset from the incident.</p> <p>A Reporter Statement, dated 7/22/16 at 8:50 am, documented Resident #23 called for RN #1 to come in to her room. When she entered the room Resident #23 burst into tears and stated, "I was just molested. Resident #24 across the hall came into my room and touched me inappropriately. He patted my head then moved his hands down to my breasts. I tried to stop him and [Hospitality Aide #1-Resident #24's 1:1] tried to get him out of my room."</p> <p>Nurses' Notes, dated 7/22/16 at 8:50 am, documented that Resident #23 reported to staff that a male resident pushed her wheelchair to her room, ran his hands over her head, down her shoulders, and to her breast. She stated that this brought up very bad memories from years ago. Resident #23 was in bed hugging her stuffed</p>	F 226			

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F 226	<p>Continued From page 35</p> <p>animal, as she spoke she began to cry.</p> <p>A Psychologist note, dated 7/22/16 at 3:35 pm, documented that Resident #23 was upset because one of the male residents took liberties with her that morning and it brought up memories of a past sexual abuse.</p> <p>Nurses' Notes, dated 7/22/16 at night, documented that Resident #23 had a resident-to-resident altercation initiated by a male resident, she had complaints of PTSD [post-traumatic stress disorder] from a past experience, that the staff would continue to monitor, and that there were no signs or symptoms of physical injury.</p> <p>Nurses' Notes, dated 7/24/16 at night, documented that Resident #23 had been talking about the assault and how no one seemed concerned.</p> <p>Nurses' Notes, dated 7/25/16 at 3:30 am, documented that Resident #23 was in bed throughout most of the shift except to smoke, and there were no signs or symptoms of physical injury related to the altercation.</p> <p>Nurses' Notes, dated 7/26-7/28/16, had no documentation of the sexual assault by a male resident.</p> <p>Social Services Progress Notes had no documentation of the sexual assault, or how Resident #23 was coping with the issue.</p> <p>The facility's procedure for incident investigation, 1.2.10 Section A, effective July 2015,</p>	F 226			

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F 226	<p>Continued From page 36</p> <p>documented that the following would be included in an investigation:</p> <ul style="list-style-type: none"> * Document after an accident for a minimum of 72 hours in the resident medical record. * Interviewing alleged victim and witness(es). * Interviewing accused individual. * Interviewing other residents to determine if they have been abused or mistreated. <p>An Incident Summary, dated 7/22/16, documented there was a resident statement of what happened written by Resident #24, and a witness statement by Hospitality Aid #1 [Resident #24's 1:1], neither of these statements were included in the Incident Report. There were also no statements or interviews from other staff members or other residents.</p> <p>On 11/1/16 at 10:30 am, in Resident Council meeting, Resident #23 stated she would like to talk to surveyors about a sexual assault that happened to her.</p> <p>On 11/3/16 at 8:30 am, Resident #23 stated that in early summer there was a male resident across the hall, who was to be on 1:1 supervision, who pushed her wheelchair, with her in it, into her room. He then touched her head, shoulders, and continued down to grab her breast. She called out for help and [Resident #24's 1:1] tried to get him out of her room. She started crying and thought that was why the Resident #24 left her room. She stated she was still upset because it brought up memories of a previous sexual assault that happened years prior. She called in a nurse who took her down to the administrator's office. She stated she</p>	F 226			

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F 226	<p>Continued From page 37</p> <p>believed they transported the accused out of the facility within 24 hours.</p> <p>On 11/3/16 at 2:45 pm, the investigation report was requested from the DON as it was not available in the monthly incident reports. The DON stated he would print it out. At 4:35 pm the report was again requested. The DON provided the incident report. While the report included a statement from Resident #23, it did not contain information from the Resident #23 related to where Resident #24's 1:1 staff was at the time of the incident, statements from other residents or staff who may have been in the area, or a statement from the staff member providing the 1:1 supervision.</p> <p>3. Resident #14 was admitted to the facility in May 2014 and readmitted in June 2015 with multiple diagnoses, including rheumatoid arthritis.</p> <p>The quarterly MDS assessment, dated 9/18/16, documented Resident #14 understood, and was understood by others; had adequate hearing and vision; had moderate cognitive impairment; needed extensive 2-staff assistance for bed mobility/dressing/toileting/hygiene; required required the total assistance of at least 2 staff for transfers/bathing; had limited ROM in both upper and both lower extremities; and had skin tears [ST].</p> <p>Resident #14's Skin Integrity Assessment: Prevention and Treatment Care Plan documented a ST to the right upper arm on 9/8/16, and a bath blanket between the sling and Resident #14, was added as an intervention. Another care planned intervention, undated, was</p>	F 226			

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F 226	<p>Continued From page 38 a sheet between Resident #14 and the Hoyer mechanical lift sling.</p> <p>On 11/4/16 at 9:30 am, Resident #14 was observed in bed and a large dark bluish purple and red bruise was noted on her right arm/elbow. The bruised area was covered with a transparent dressing and extended about 3 inches above the elbow and 2-to-3 inches below the elbow, and 2-to-3 inches in front of the elbow. The back of the elbow was not visualized as Resident #14 said it was "too painful" to move it. With Resident #14's permission, another resident, who asked to remain anonymous, joined the conversation and said every time staff used the Hoyer lift to get Resident #14 up the resident "gets an injury." The anonymous resident said Resident #14's right arm/elbow injury occurred "about 2 weeks ago" when 2 CNAs got her up for a shower. The anonymous resident said Resident #14 "refuses" to get up with the Hoyer now, to which Resident #14 added, "It hurts." The anonymous resident said Resident #14 used to get out of bed for showers twice a week and doctor appointments, but now she gets a bed bath. A Hoyer lift sling was observed on a chair near Resident #14's bed.</p> <p>A 9/7/16 Occurrence Report documented Resident #14 sustained a 3.5 cm by 4.5 cm ST to the right elbow when staff removed a Hoyer sling from under the resident in bed after a shower. The upper edge of the ST was "reapproximated" but the lower aspect could not be "reapproximated" and a transparent dressing was applied. A 9/12/16 Follow up Report to the 9/7/16 Occurrence Report documented the care plan was revised and staff were educated to place a</p>	F 226		

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F 226	<p>Continued From page 39</p> <p>bath blanket between Resident #14 and the shower sling.</p> <p>No other Occurrence Reports for September, October or November 2016 were found for Resident #14.</p> <p>Resident #14's PNs, dated 8/3/16 to 11/4/16, included documentation of the right elbow ST on 9/7/16 and resolution of the ST on 10/19/16. The 10/19/16 entry did not include bruising at the right elbow and there were no other entries about bruises or injuries.</p> <p>On 11/4/16 at 4:10 pm, RN #2, an RCM, said Resident #14's skin was "very fragile" and that a right elbow skin tear had resolved on 10/19/16. RN #2 said she was not aware of current bruising to Resident #14's right arm/elbow.</p> <p>On 11/4/16 at 4:15 pm, RN #2 accompanied the surveyor to Resident #14's room, where the resident was observed in bed with her spouse and a female visitor in the room and the Hoyer sling still on the chair. As RN #2 looked at the resident's right arm/elbow, the spouse stated, "Every time they get her out of bed that sling causes an injury."</p> <p>Immediately afterward, RN #2 reviewed Resident #14's September and October 2016 MARs and TARs and said that bruising was not monitored after the right elbow ST healed, but if there had been bruising it was "not like that." The RN said the transparent dressing over the right arm/elbow bruise was a treatment, but there was no documentation of the treatment. RN #2 said Resident #14 arose from bed only for showers</p>	F 226			

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F 226	<p>Continued From page 40</p> <p>and doctor appointments and her last doctor's appointment was 10/26/16. RN #2 also reviewed Bath Type Detail Reports, which documented Resident #14 was showered on 10/1/16, 10/4/16, 10/11/16, 10/15/16, 10/18/16 and 10/29/16 and received bed baths on 10/22/16 and 11/1/16. RN #2 said no new injuries had been reported to her, but that she would begin an investigation.</p> <p>Resident #14's September, October and November 2016 TARs included areas to document Weekly Skin Assessments with "-" to indicate no new areas and a "+" to indicate new area observed. A staff person's initials and "-" were documented weekly in September and on 10/5/16, 10/12/16, 10/19/16 and 11/2/16. However, on 10/26/16 the initials only were documented and the space to document "-" or "+" was blank.</p> <p>There was no documented evidence when Resident #14's right arm/elbow injury occurred, that staff were aware of the bruise, or that the injury of uncertain origin had been investigated to rule out potential abuse.</p> <p>4. Resident #20's 4/22/16 MDS assessment documented he was feeling down, depressed, or hopeless; had difficulty falling or staying asleep, or slept too much; experienced a poor appetite or overate; felt bad about himself or that he was a failure or had let himself or family down; and had trouble concentrating on things, such as reading the newspaper or watching television. Resident #20 was assessed with moderate cognitive impairment.</p> <p>On 11/3/16 at 4:25 pm, the DON provided a</p>	F 226			

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F 226	<p>Continued From page 41</p> <p>sign-out sheet for Resident #20 dated for 4/24/16 through 8/6/16; the sign-out sheet did not include the resident's signature that he had signed-out of the facility during that period.</p> <p>An undated and unsigned document titled, Missing Person Summary, documented, "[Resident #20] an alert and oriented resident with ... an active order to leave the facility left the facility on 10/25/16. He was last seen at approximately [8:30 pm] and noted to not return at [9:00 pm]. The resident was noted to not use the proper procedure to sign out in the resident sign out log. A missing person action plan was initiated at [9:00 pm]."</p> <p>An EDM [Emergency Department Medical] Record from the local hospital, dated 10/27/16, documented Resident #20 arrived in the emergency department at 9:31 am with "multiple complaints." The report documented, "[Resident #20 was] a missing person since [10/25/16]. [Resident #20] found this [morning] wet and shivering not too far from [facility name]." The report stated Resident #20 received intravenous fluids and described the resident as "in wet clothes and shaking [and] non verbal to staff." The report documented Resident #20 had been assessed with acute altered mental status, acute catatonia, acute dehydration, acute exposure to environmental cold, acute hyponatremia, acute confusion, acute dehydration, acute depression, acute paranoia, and acute vomiting.</p> <p>The facility's Missing Person Policy documented, "The Executive Director is responsible for follow-up of the incident, including any further reporting to state agencies...and completing and</p>	F 226			

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F 226	Continued From page 42 submitting of a detailed incident report." There was no evidence provided by the facility, nor found in the state agency office, that the incident was reported or fully investigated. The facility failed to operationalize its policies and procedures related to abuse and neglect.	F 226			
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, record review, and staff interview, it was determined the facility failed to provide medically related social services for a resident who had been sexually assaulted in the facility. This was true for 1 of 24 residents (#23) sampled for social services and resulted in harm when the resident exhibited signs of continued distress that were not addressed through on-going counseling or other services. Findings include: Resident #23 was admitted to the facility on 3/13/15, with multiple diagnoses which included depression, anxiety, diabetes, opiate dependency, and a history of alcoholism. A Social Service Progress Note, dated 5/5/16, documented Resident #23 was cognitively intact.	F 250	Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Resident #23 has had follow up with her psychologist and social services and is being monitored for psychological harm related to incident. Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility have the potential to be affected by this deficient practice. Residents residing at the facility with identified alleged abuse and neglect incidence have been reviewed and have social services follow-up as indicated.	1/23/17	

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F 250	<p>Continued From page 43</p> <p>The 14-day MDS assessment, dated 7/14/16, documented Resident #23 was able to make herself understood, understood others, and was cognitively intact.</p> <p>A Mood and Behavior Symptom Assessment care plan, initiated May 2016, documented the following interventions:</p> <ul style="list-style-type: none"> * Monitor for signs and symptoms of depression. * Visit with resident 1:1 to allow for communication of feelings and concerns. <p>A Social Service Progress Note, dated 5/5/16, documented Resident #23 was cognitively intact with minimal symptoms of depression.</p> <p>A Social Service Progress Note, dated 7/12/16, documented Resident #23 had major depression that was moderately severe.</p> <p>An Incident Summary, dated 7/22/16, documented that a male resident, whose care plan required him to have 1:1 supervision, touched Resident #23's face, and then slid his hand down to her chest before staff could intervene. Resident #23 denied suffering any physical injury from the incident, but stated she was emotionally upset from the assault.</p> <p>A Reporter Statement, dated 7/22/16 at 8:50 am, documented Resident #23 called RN #1 to her room. When RN #1 entered the room Resident #23 burst into tears and stated, "I was just molested. [Resident #24] across the hall came into my room and touched me inappropriately. He patted my head then moved his hands down to</p>	F 250	<p>Measures in place and systemic changes made to ensure that the deficient practice does not recur;</p> <p>Social Services employees have been inserviced on follow-up and documentation required related to abuse and neglect incidence for psychological harm monitoring and intervention as indicated.</p> <p>Monitor performance to ensure the corrective actions are effective and compliance is sustained;</p> <p>Residents with identified allegations of abuse will be monitored weekly X 12 by the Director of Nursing to ensure compliance with social service follow up. Additional oversight will be provided weekly by the Regional Director of Clinical Services or the Director of Operations to include review of the grievance log for negative findings. Negative findings will be corrected immediately and then presented to QAPI monthly for further educational opportunities.</p>		

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F 250	<p>Continued From page 44</p> <p>my breasts. I tried to stop him and [Resident #24's 1:1 aide] tried to get him out of my room."</p> <p>Nurses' Notes, dated 7/22/16 at 8:50 am, documented that Resident #23 reported to staff that a male resident pushed her wheelchair to her room, ran his hands over her head, down her shoulders and over her breast. She stated this brought up bad memories from her past. Resident #23 was in bed hugging a stuffed animal as she spoke and began to cry.</p> <p>A psychologist note, dated 7/22/16 at 3:35 pm, documented that Resident #23 was upset because a male resident took liberties with her that morning and it brought up memories of a past sexual abuse.</p> <p>Nurses' Notes documented the following:</p> <ul style="list-style-type: none"> * 7/22/16 - Resident #23 experienced a resident-to-resident altercation initiated by a male resident, she complained the encounter evoked symptoms of PTSD related to a past experience, staff would continue to monitor, and there were no signs or symptoms of physical injury. * 7/24/16 - Resident #23 had been talking about the assault and that facility staff did not seem concerned. * 7/25/16 at 3:30 am - Resident #23 was in bed most of the shift except to smoke, and there were no signs or symptoms of physical injury related to the altercation. * 7/26/16 at 12:45 pm - Resident #23 required excessive amounts of time from staff at that time. 	F 250			

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F 250	<p>Continued From page 45</p> <p>* Nurses' Notes, dated 7/26/16-7/28/16, did not include documentation of the sexual assault by a male resident.</p> <p>Social Services Progress Notes from 7/12/16 - 8/23/16 did not include documentation of the sexual assault, or how Resident #23 was coping with the incident.</p> <p>Resident #23's Mood and Behavior Symptom Assessment care plan, initiated May 2016, was not updated after the sexual assault.</p> <p>A psychologist note, dated 8/1/16, documented Resident #23 was frustrated by the facility's lack of response to the sexual assault by a male resident.</p> <p>On 11/1/16 at 10:30 am in a Resident Group meeting, Resident #23 stated she wanted to talk to surveyors about a sexual assault that happened to her in the facility. She asked surveyors not to come straight to her room so staff would not see surveyors meeting with her.</p> <p>On 11/3/16 at 8:30 am, Resident #23 stated that in early summer there was a male resident across the hall who was to have 1:1 supervision, but who pushed her wheelchair with her in it into her room, where he then touched her head, shoulders, and then grabbed her breast. She called out for help and the 1:1 aide tried to get him out of her room. She started crying and the male resident left her room. She stated that she was still upset, several months later, because it brought up memories of a previous sexual assault from years prior. She stated that she was</p>	F 250			

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F 250	Continued From page 46 spending more time in her room and not participating in activities she once enjoyed because of the assault. As the resident spoke with the surveyor, she stated she was worried staff would find out she was talking to "the State." On 11/3/16 at 4:35 pm, the DON provided an incident report, which did not contain statements from residents involved in the sexual assault, staff witness statements, or social service notes. The facility's Social Worker and 1:1 aide for the male resident at the time of the event were no longer at the facility or available for interview.	F 250			
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure assessments related to safety devices, transferring and repositioning, bowel and bladder function, and pressure ulcer risk were completed for 2 of 24 sampled residents (#8 and #10). This had the potential to cause more than minimal harm if developing health conditions went undetected and untreated. Findings include: 1. Resident #8 was admitted to the facility with diagnoses that included quadriplegia, chronic pain, and chronic respiratory failure.	F 276	Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Resident #8 and #10 have current assessments for safety devices, transferring and repositioning, bowel and bladder function, and pressure ulcer risk. Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility have the potential to be affected by this deficient	1/23/17	

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F 276	Continued From page 47 Resident #8's Braden Pressure Ulcer Risk Assessment, Safety Device Data Collection, Resident Lifting, Transferring, and Repositioning Data Collection Tool, Bowel Data Collection and Assessment, and Bladder Data Collection and Assessment were all last completed on 5/18/16. On 11/2/16 at 9:35 am, the 600 Hall Unit Manager stated the assessments should have been completed quarterly. 2. Resident #10 was admitted to the facility with diagnoses that included quadriplegia, respiratory failure, and pneumonia. Resident #10's Safety Device Data Collection Tool, Resident Lifting, Transferring, and Repositioning Data Collection Tool, and Bowel Data Collection were all last completed on 7/11/16. On 11/2/16 at 9:35 am, the 600 Hall Unit Manager stated the assessments should have been completed quarterly.	F 276	practice. Residents residing at the facility have current assessments for safety devices, transferring and repositioning, bowel and bladder function, and pressure ulcer risk in their medical record. Measures in place and systemic changes made to ensure that the deficient practice does not recur; Nurse Managers have been inserviced on the completion of assessments for safety devices, transferring and repositioning, bowel and bladder function, and pressure ulcer risk to be completed and current in the medical record. Utilizing the MDS communication tool residents will be identified for quarterly assessments due and reviewed daily Monday through Friday during the clinical triage meeting. Monitor performance to ensure the corrective actions are effective and compliance is sustained; Resident assessments for safety devices, transferring and repositioning, bowel and bladder function and pressure ulcer risk will be monitored through the comprehensive care plan meeting weekly X 12 in accordance with the MDS schedule. Findings will be corrected and presented to QAPI monthly X 3 for further educational opportunities. Date corrective action will be completed and who is responsible to ensure compliance; _____ Director of Nursing		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		1/23/17	

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F 280	<p>Continued From page 48</p> <p>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.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, it was determined the facility failed to ensure residents' care plans were updated to reflect current needs. This was true for 4 of 24 (#1, #2, #8, and #10) sampled residents and had the potential to result in harm if residents did not receive appropriate care due to lack of direction in their care plans. Findings include:</p> <p>1. Resident #10's record was reviewed on 11/2/16 at 9:30 am. Resident #10's diagnoses included quadriplegia, respiratory failure, and pneumonia.</p>	F 280	<p>Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Resident #10's has completed ordered antibiotic therapy and PICC line has been discontinued Resident #8's careplan has been reviewed and is current. Resident #2 has been reviewed and has revision dates added. Resident #1 has been reviewed and has revision dates added.</p>		

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F 280	<p>Continued From page 49</p> <p>Resident #10's re-admission nursing assessment, dated 10/20/16, indicated "...IV (Intravenous) PICC (peripherally inserted central catheter - circled) L (left) Brachial (upper arm) Double lumen patent X (times) 2..." There was a lack of documentation of further assessment of the PICC line or insertion site.</p> <p>Resident #10's re-admission physician's orders, dated 10/20/16, indicated the resident was to receive Vancomycin (an antibiotic) 1500 milligrams IV every 24 hours.</p> <p>Review of the resident's care plans, lacked documentation of a care plan for the PICC line or the IV antibiotic.</p> <p>During an interview on 11/2/16 at 5:45 pm, the 600 Hall registered nurse (RN) Unit Manager stated there was not a care plan for the IV antibiotic or the PICC line.</p> <p>2. Resident #8's record was reviewed on 11/1/16 at 9:00 am. Resident #8's diagnoses included quadriplegia, chronic pain, and chronic respiratory failure.</p> <p>Resident #8's care plans for Alteration in Bowel Elimination, Skin Integrity, Fall, Pain Management, ADL (Activities of Daily Living)/ Mobility, Safety Device, Sensory/ Communication, Respiratory Care, Cardiovascular/ Circulatory Care Plans all indicated a date due of 8/2016.</p> <p>During an interview on 11/2/16 at 9:35 am, the RN Unit Manager for the 600 Hall, stated the</p>	F 280	<p>Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility have the potential to be affected by this deficient practice.</p> <p>Residents residing at the facility have been reviewed and have care plans current to reflect resident care needs. Measures in place and systemic changes made to ensure that the deficient practice does not recur;</p> <p>Nurse Managers have been inserviced on the revision of careplans to accurately reflect resident care needs. Utilizing the MDS follow up too, resident careplans will be revised with the comprehensive care plan review meeting in accordance with the MDS schedule.</p> <p>Monitor performance to ensure the corrective actions are effective and compliance is sustained;</p> <p>Resident careplans will be monitored weekly X 12 to ensure revision as indicated. Findings will be corrected and then presented to QAPI monthly X 3 for further educational opportunities. Date corrective action will be completed and who is responsible to ensure compliance;</p> <p>_____ Director of Nursing</p>		

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F 280	<p>Continued From page 50</p> <p>care plans should have been reviewed and updated quarterly and that had not been done.</p> <p>3. Resident #2 was admitted to the facility on 12/19/15, with multiple diagnoses including paraplegia and pressure ulcers.</p> <p>On 12/19/15, Resident #2's Admission MDS Assessment included a CAA, which documented triggered care areas. The last Quarterly Assessment was completed on 9/12/16.</p> <p>Resident #2's care plan for Skin Integrity was last reviewed and revised on 6/1/16 with a goal due date of September 2016.</p> <p>On 11/1/16 at 9:05 am, an occupational therapist was providing treatment to Resident #2's right buttocks to promote continued healing to a pressure ulcer that was no longer open. Resident #2's care plan was not updated to include the treatment provided by the occupational therapist.</p> <p>Resident #2's care plans for ADL/Mobility, Sensory/Communication, Pain Management, Catheter care, were last reviewed and revised on 6/1/16, with a goal due date of September 2016.</p> <p>Resident #2's care plans for Actual/Potential Infection, Safety Device, and the Fall/Injury Assessment were last reviewed and revised in 6/20/16, with a goal date of September 2016.</p> <p>The care plans lacked review and revision dates based on the last MDS Quarterly Assessment of 9/12/16.</p> <p>4. Resident #1 was admitted to the facility on</p>	F 280			

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F 280	Continued From page 51 7/31/14, with multiple diagnoses including quadriplegia, respiratory failure, and pressure ulcer. On 7/30/15, Resident #1's Admission MDS Assessment included a CAA, which documented triggered care areas. The latest MDS Quarterly Assessment was dated on 9/21/16. Resident #1's care plans for ADL/Mobility, Fall/Injury, Safety Device, Skin Integrity, and Respiratory care, were last reviewed and revised on 7/20/16 with a goal due date of October 2016. The care plans lacked review and revision dates based on the last MDS Quarterly Assessment of 9/21/16.	F 280			
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review and resident interview, it was determined the facility failed to ensure residents were regularly bathed. This was true for 10 of 19 residents sampled for Activities of Daily Living (#6, #7, #8, #9, #10, #11, #12, and #19) and 2 random residents (#23 and #28). This deficient practice had the potential to adversely affect residents' physical comfort, dignity, sense of self-worth, and willingness to socialize with	F 312	Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Residents #6, #7, #8, #9, #10, #11 #12, #19, #28 and #28 have had their bathing records reviewed and residents are receiving baths/showers as scheduled. Other residents who have the potential to	1/23/17	

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F 312	<p>Continued From page 52 peers. Findings include:</p> <p>Group Bathing Type Charts tallying the total number of showers, tub baths, and bed baths for August 2016, documented 46 of 101 residents were bathed/showered five times (including Resident #6, #7, #10, and #12) or fewer during the 31-day period. Of that number, 4 residents were not showered/bathed; 7 residents were showered/bathed once; 6 residents were showered/bathed twice; and 6 residents were showered/bathed three times that month.</p> <p>The September 2016 Group Bathing Type Charts documented 49 of 100 residents were bathed/showered five times (including #8 and #10) or fewer during the 30-day period. Of that number, 4 residents, including Resident #19, were not showered/bathed; 4 residents were showered/bathed once; 4 residents, including Resident #2, were showered/bathed twice; and 7 residents were showered/bathed three times that month.</p> <p>The October 2016 Group Bathing Type Charts documented 17 of 86 residents were bathed/showered five times (including #6 and #28) or fewer during the 31-day period. Of that number, 4 residents, including Resident #9, were not showered/bathed; 4 residents were showered/bathed once; 6 residents, including Random Resident #23, were showered/bathed twice; and 5 residents, including Resident #11 and #12, were showered/bathed three times that month.</p> <p>On 11/1/16 at 10:30 am, 10 residents attending a group meeting stated the facility's shower aide</p>	F 312	<p>be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility have the potential to be affected by this deficient practice. CNA's have been educated on bathing schedules, preferences, refusals, documentation and communication. Measures in place and systemic changes made to ensure that the deficient practice does not recur; Resident bathing records have been reviewed and preferences have been updated. Daily bathing assignments will be provided to aides. Assignments will be validated during Grand Rounds to ensure completion. All refusal or barriers to completion will be report to floor nurse. Refusal will be documented and brought forward for review by ADON and DON. Action plans will focus on re-approach for completion of baths. Bathing records will be reviewed daily during the Nurse Manager meeting.</p> <p>Monitor performance to ensure the corrective actions are effective and compliance is sustained; Bathing/shower records will be monitored daily Monday through Friday X 30 days during the morning nurse managers meeting for completion and then weekly for two months. The Director of Clinical Services or the Director of Operations will review bathing/shower schedules weekly for compliance. Facility will conduct daily resident interviews related to bathing and showers. Findings will be corrected and</p>		

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F 312	Continued From page 53 staffing had been reduced from two CNAs to one CNA from 6:00 am to 8:00 pm, and that residents were not bathed/showered as frequently as they would like. When asked whether the reduced number of baths/showers were due to refusals, 3 residents in the group stated they had been falsely "accused" of refusing showers/baths. One resident stated, "You only get two [showers/baths] a week; why would I refuse my shower?"	F 312	then presented at QAPI monthly X 3 for further educational opportunities. Date corrective action will be done and who is responsible to ensure compliance; _____ Director of Nursing		
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. This REQUIREMENT is not met as evidenced by: Based on family member and staff interview, observation, and record review, it was determined the facility failed to prevent the development and worsening of pressure sores and failed to provide services to promote healing for 3 of 14 sampled residents reviewed for pressure ulcers (#3, #8 and #18). This failure resulted in harm to Resident #3 when he experienced a deep wound where bone and ligaments were exposed causing osteomyelitis (a serious bone and bone marrow infection requiring medical intervention). The facility also	F 314	Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Resident #3 is no longer at the facility. Resident #8 is receiving protein supplements to support wound healing. Resident #18 is no longer at the facility. Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility with	1/23/17	

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F 314	<p>Continued From page 54</p> <p>failed to provide protein supplements to promote wound healing for Resident #8, and failed to document or evaluate a stage 2 pressure ulcer for Resident #18, a closed record review. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 5/9/16, with diagnoses that included Guillain-Barre Syndrome, respiratory failure, depression, quadriplegia, and atrial fibrillation. The record indicated that Resident #3 was readmitted to the facility on 8/29/16.</p> <p>Resident #3's admission MDS assessment, completed on 5/16/16, stated the resident had no cognitive impairment, required total assistance with all activities of daily living due to the paralysis of all four limbs and below the neck caused by the sudden onset of Guillain-Barre Syndrome (a rare but serious autoimmune disorder in which the immune system attacks healthy nerve cells in the peripheral nervous system leading to paralysis). The MDS indicated that Resident #3 was admitted with a stage 3 (loss of full thickness of skin involving subcutaneous tissue) pressure sore on the coccyx (tailbone).</p> <p>Resident #3's Skin Grid-Pressure/Venous Insufficiency Ulcer-initial identification form, dated 5/13/16, 4 days after admission, documented, "One site per page, complete weekly." The weekly pressure ulcer forms showed worsening of the wound with infection from a stage 3 to a stage 4 with exposed bone and ligaments. The pressure ulcer forms documented the following:</p> <p>* 5/9/16 - Coccyx, stage three, 1.5 X 1.0 X 3 cm</p>	F 314	<p>pressure ulcers have the potential to be affected by this deficient practice. Residents residing at the facility with pressure sores have had their records reviewed. Residents with pressure ulcers have measures in place to prevent the development and worsening of pressure sores, including protein supplements as ordered, repositioning schedules and documentation of assessments as per facility policy and procedure. Measures in place and systemic changes made to ensure that the deficient practice does not recur; Nurse Managers have been inserviced on the prevention of, treatment for and documentation of pressure sores per policy and procedure. Protein supplements for residents with pressure sores have been inserviced to Nursing/Dietary to ensure compliance with orders. LN's have been inserviced on repositioning and measures to take for refusals of repositioning schedule for residents with pressure sores. Documentation of residents with pressure sores both progress/decline will be completed with weekly skin rounds to ensure compliance. Monitor performance to ensure the corrective actions are effective and compliance is sustained; Residents with pressure sores will have their medical record monitored weekly X 12 to ensure the delivery of supplements, repositioning schedule and</p>		

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F 314	<p>Continued From page 55 (Centimeters).</p> <ul style="list-style-type: none"> * 5/13/16 - Stage three, 1.7 X 1.0 X 0.25 cm * 5/23/16 - Stage three, 3.5 X 2.5 X 2 cm, stage 3 with 80% slough, moderate odor, santyl appears effective * 6/13/16 - Stage three, 3.8 X 2.0 X 1.0 cm * 6/16/16 - Stage three, 4.25 X 2.1 X 0.75 cm * 7/12/16 - Stage four, 4.0 cm X 3.3 cm X 3.0 cm, undermining X 4, wound is a stage 4 with exposed bone and ligament * 7/26/16 - Stage four, 4.4 X 2.8 X 1.4 cm. Small amount of bone exposed. MRI (Magnetic resonance imaging) results with diagnosis of osteomyelitis. (a serious infection of the bone caused by bacteria) * 8/16/16 - Stage four, 5.0 X 2.5 X 1.5 cm. undermining has opened and extending wound margins, MD (Medical Doctor) notified * 9/1/16 - Stage four, 4.5 X 3.5 X 1.0 cm, wound VAC dressing * 9/13/16 - Stage four, 3.7 X 2.8 X 0.7 cm, wound vac change, wound bed with healthy granular tissue, smaller in size <p>Physician's Orders, dated 11/1/16, included "Sacrum: wound VAC 125 continuous. Change every 3 days and as needed." (Wound VAC is a therapeutic technique using a vacuum dressing to promote healing in wounds to increase blood flow to the area).</p> <p>On 11/2/16 at 9:00 am, during an interview with the DON, he said he was aware of the worsening of the pressure ulcer for Resident #3. The DON stated Resident #3 refused to be repositioned. The DON provided a Refusal of Care or Treatment document, dated 6/6/16. The document included, "Worsening wound condition,</p>	F 314	<p>documentation is present per facility policy and procedure. Any findings will be corrected when identified and then presented to QAPI monthly X 3 for further corrective opportunities.</p> <p>Date corrective action will be done and who is responsible to ensure compliance; _____ Director of Nursing</p>		

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F 314	<p>Continued From page 56</p> <p>osteomyelitis, infection, sepsis, and possible death. Presented to family and resident, they are not in agreement and refuse to sign. Resident and family will not sign." The DON also provided a document that he had placed at the bedside of Resident #3. The DON stated that he instructed staff to write down every time Resident #3 refused to be turned or repositioned every 2 hours. The document included Progress Notes, dated 5/24/16 through 6/14/16. The document showed a total of 8 days where Resident #3 refused to be repositioned at least once every 2 hours.</p> <p>A Compressed Behavior Report, dated 5/9/16 through 8/29/16, Rejection of Care, documented a total of 18 days where Resident #3 refused to be repositioned at least once every 2 hours during a period of 100 days.</p> <p>On 11/2/16 at 9:30 am, the DON provided a document titled, Mitigating Factors for the Development of Pressure ulcers. The document specified non-compliance with care regarding turning and repositioning, and included laboratory results of low albumin (albumin is an indicator of the bodies protein level which is essential to help the body heal wounds) indicating risk factors for skin breakdown. The document did not indicate Resident #3 had experienced significant weight loss.</p> <p>On 11/2/16 at 2:00 pm, during an interview with the Registered Dietitian (RD), the RD stated Resident #3 was well known to her and she had been providing nutritional recommendations for Resident #3 from the time of admission to the facility. The RD stated, "He has not had</p>	F 314			

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F 314	<p>Continued From page 57</p> <p>significant weight loss, in fact, he has gained weight. He receives nutrition by way of a gastric tube and I added pro-stat when his wound got worse. The low albumin was likely affected by the infection in his wound. His tube feeding is providing adequate calories and protein with the added support of pro-stat AWC which is a protein supplement for advanced wound care."</p> <p>On 11/3/16 at 10:30 am, CNA #4 stated, "I've been working with him for two months, he had never refused to let me turn him. He will say to come back later and we go back in to turn him. He lets us know if he is soiled and we clean him up."</p> <p>On 11/3/16 at 10: 40 am, CNA #5 stated, "He sometimes refuses but if you talk to him to find out how he wants to be positioned he will let you turn him."</p> <p>On 11/3/16 at 4:00 pm, during an interview with a family member of Resident #3's, the family member verified that Resident #3 and the family member refused to sign the refusal of care or treatment document. The family member stated, "He only refuses when he is in pain, and they usually come back after a few minutes to ask him again. His wound got worse when therapy had him sitting in a wheelchair. He was put in a wheelchair on May 19 and 21. It hurt him so much to sit on the wound."</p> <p>Occupational Therapy Notes (OTN), dated 5/23/16, documented, "Therapy follow up with patient and wife regarding wheelchair, patient declined getting in wheel chair today due to respiratory issues and discomfort on bottom.</p>	F 314			

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F 314	<p>Continued From page 58</p> <p>Follow up with nursing, increase in size of wound."</p> <p>An OTN, dated 5/24/16, included, "Discussed with spouse and patient about being up in wheelchair, reports she would like to hold off due to the sacral sore. She reports appears larger since being up in wheelchair."</p> <p>An OTN, dated 5/26/16, documented, "Patient requiring passive range of motion and caregiver training for upper extremities and slow wound healing and pain prohibiting up in wheelchair this week."</p> <p>2. Resident #8's record was reviewed on 11/1/16 at 9:00 am. Resident #8's diagnoses included quadriplegia, chronic pain, and chronic respiratory failure.</p> <p>Resident #8's "Skin grid" for the pressure ulcer to his coccyx documented the resident was admitted with the stage IV (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcer. The form indicated the measurements of the pressure ulcer on 10/25/16 were 1.4 cm (centimeters) in length, 0.3 cm wide, and 0.2 cm in depth.</p> <p>A Progress Note, dated 10/25/16, by the Nurse Practitioner, documented, "Assessment/ Plan...Pressure ulcer of sacral region, stage 3 (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed)...Impression stalled...Continue sacral dressing change...Check renal panel (laboratory test for kidney function), CBC (blood test)...prealbumin (test for protein)...If available:</p>	F 314			

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F 314	<p>Continued From page 59</p> <p>trial Juven (a protein supplement) 1 pkt (packet) PO (orally)...or...BID (twice a day) x (times) 30 days."</p> <p>Resident #8's physician's orders lacked documentation of the above orders.</p> <p>During an interview on 11/1/6 at 10:30 am, the 600 Hall registered nurse (RN) Unit Manager stated the orders had not been followed up on. She indicated she did not know what happened and it was possible medical records filed the orders and did not tell nursing. She said she would take care of the orders now.</p> <p>During an interview on 11/1/6 at 11:18 am, the 600 Hall RN Unit Manager said the pressure ulcer to the sacrum was a healing stage IV.</p> <p>The physician's order, dated 11/1/16, included, "Renal Panel, CBC...Prealbumin...Juven 1 pkt PO BID X 30 days."</p> <p>Resident #8's pressure ulcer was observed on 11/2/16, with the 600 Hall RN Unit Manager present. The pressure ulcer to the resident's coccyx was pink in color and measured 1.5 cm long, 1 cm wide and 0.5 cm deep. These measurements indicated the wound had gotten larger since the assessment on 10/25/16, when it measured 1.4 cm in length, 0.3 cm wide, and 0.2 cm in depth.</p> <p>3. The closed clinical record for Resident #18 indicated that he was admitted to the facility on 6/14/16 and discharged on 7/5/16. Admission orders, dated 6/14/16, included diagnoses of Traumatic pneumothorax, hypertension, atrial</p>	F 314			

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F 314	<p>Continued From page 60 fibrillation, and urinary retention.</p> <p>A Skin assessment, dated 6/14/16, documented, "Stage 1 on the coccyx with measurements of 6 cm X 9 cm. Sacral area monitor for irritation every shift, apply barrier every shift."</p> <p>An MDS assessment, dated 6/21/16, documented Resident #18 was admitted with a stage 1 pressure ulcer (a stage one pressure ulcer has intact skin with redness of a localized area). The MDS assessment stated Resident #18 required supervision with bed mobility with the assistance of one person. Resident #18 required extensive assistance of one person with dressing, toileting and personal hygiene.</p> <p>A Progress note, dated 6/28/16, documented Resident #18 was alert and oriented, able to make needs known, and "Resident with checks to sacrum. Skin is non-blanchable: two open areas. Barrier cream applied. Skin condition placed on 24 hour book."</p> <p>A Progress note, dated 6/28/16, included, "Interdisciplinary Review, Resident admitted with possible stage one area to coccyx. Barrier cream was applied. Noted with areas of peeling skin on 6/28/16."</p> <p>Resident #18's clinical record did not include further documentation regarding the open areas on the sacrum. The record did not contain treatment orders for the open areas and no documentation regarding an evaluation of the open areas was found.</p> <p>On 11/4/16 at 4:00 pm, during an interview with</p>	F 314			

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F 314	Continued From page 61 the DON stated there were no records of Resident #18's skin condition following the documented open areas on 6/28/16.	F 314			
F 318 SS=G	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, staff and family member interview, and record review, it was determined the facility failed to provide range of motion services to prevent avoidable reduction in range of motion, failed to apply a hand splint and rolled wash cloths, and/or failed to provide restorative care for 3 of 24 sampled residents (#1, #3, and #12). This failure resulted in harm to Resident #3 when he experienced foot drop and further decline in ROM. It also placed Residents #1 and #12 at risk of decline in ROM due to lack of consistent implementation of restorative interventions. Findings include: 1. Resident #3 was admitted to the facility on 5/9/16, with diagnoses that included Guillain-Barre Syndrome, respiratory failure, depression, quadriplegia, and atrial fibrillation. Resident #3's admission MDS assessment, completed on 5/16/16, documented he had no	F 318	Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Resident #3 is no longer at the facility. Resident #12 is receiving ROM and splint therapy as per MD order. Resident #1 is receiving ROM and splint therapy as per MD order. Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility with limited ROM have the potential to be affected by this deficient practice. Residents residing at the facility with restorative programs in place for ROM needs have been reviewed and the programs are being completed as scheduled. Measures in place and systemic changes	1/23/17	

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F 318	<p>Continued From page 62</p> <p>cognitive impairment, required total assistance with all activities of daily living due to the paralysis of all four limbs and below the neck caused by the sudden onset of Guillain-Barre Syndrome (a rare but serious autoimmune disorder in which the immune system attacks healthy nerve cells in the peripheral nervous system leading to paralysis). The MDS stated Resident #3 was totally dependent on staff with two-person physical assistance.</p> <p>The MDS assessment further stated Resident #3 had functional limitation in range of motion in his upper extremities (shoulder, elbow, wrist, hand-impairment on both sides), and lower extremities (hip, knee, ankle, foot) impairment on both sides.</p> <p>On 11/2/16 at 9:00 am, a family member stated s/he provided range of motion services to Resident #3. Resident #3 was observed in bed lying on his back. Both of Residents 3's feet were in cushioned boots. Resident #3's feet were dropped at the ankle and his knees were touching. (Foot drop is a general term for difficulty lifting the front part of the foot. When there is foot drop, the foot may be dragged on the ground when walking. Foot drop is a sign of an underlying neurological, muscular or anatomical problem." [Mayo Clinic Staff 2016]) The family member stated Resident #3 was unable to lift the front part of the foot due to weakness and paralysis. The family member stated, s/he brought a hard boot in that prevented Resident #3's feet from dropping, but therapy said not to use it because it could cause skin breakdown.</p>	F 318	<p>made to ensure that the deficient practice does not recur; Restorative programs including ROM and splint use for residents residing at the facility have been reviewed. Staff ratio to program has been evaluated and there is adequate staffing to complete restorative programs for residents with ROM programs. Restorative aides and nurse managers have been inserviced on ROM/splint programs Monitor performance to ensure the corrective actions are effective and compliance is sustained; Residents with program for ROM and splint use will be monitored by the restorative nurse daily X 30 and then weekly X 12 to ensure compliance with the restorative program by review of their daily minutes. Random observations of programs will be performed by the restorative nurse and will be documented by using audit tool. Findings will be corrected, reported to the DON and then presented to QAPI monthly X 3 for further corrective opportunities. Date corrective action will be done and who is responsible to ensure compliance; _____ Director of Nursing</p>		

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F 318	<p>Continued From page 63</p> <p>A Physical Therapy (PT) initial Evaluation, dated 5/10/16, documented, "Diagnoses Description Guillain-Barre Syndrome with generalized muscle weakness." The therapy evaluation documented, "Short-term goals, establish range of motion program to prevent contractures with training of family and staff. Long-term goals, Client will demonstrate return of trunk/extremity mobility through neuromuscular stimulation techniques applied, target date 6/14/16." The evaluation included, "Cognition-Client is cognitively aware and able to fully field entire body, however unable to move voluntarily except for some face and neck."</p> <p>A Physical Therapy Treatment Encounter Note" (TEN), dated 5/19/16, stated, "Response to Session interventions: Pt communicated he was able to feel the nerves in his legs and can communicate through head nods and shakes and an alphabetical piece of paper by using rows and head nods."</p> <p>The TEN, dated 6/20/16, documented, "Response to Session interventions: The patient compliant with skilled interventions."</p> <p>A TEN, dated 6/22/16, stated, "Client and his wife spoken to at bedside regarding skilled PT plateauing and need to establish restorative nursing program. Clients wife and client expressed understanding that any additional progression to be monitored, with therapy notified to assess for restart of skilled intervention in the future. Discussed and established restorative nursing program with guidelines."</p> <p>The Restorative Program Summary Report</p>	F 318			

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F 318	<p>Continued From page 64</p> <p>documented the restorative start date was 7/10/16. The report included, "Passive ROM (Range Of Motion) Program: FLOOR CNA (Certified Nursing Assistant). GOALS: To help maintain current level of function. PLAN: Passive range of motion to all extremities, flexion and extension to wrist, elbows, shoulders, ankles, knees, hips for a minimum of 15 min/day up to 6 days/week. Notify licensed nurse of refusals, pain, or intolerance."</p> <p>The "restorative program summary report", dated 7/1/16 through 11/3/16, showed there were a total of 6 documented refusals by Resident #3. The summary report stated that ROM services were provided by the facility restorative program an average of three times per week with the week of 8/21/16 through 8/27/16 having provided ROM once on 8/21/16. There was no documented refusal by Resident #3 during that week.</p> <p>On 11/4/16 at 10:00 am, during an interview with LN #5, who stated she was the facility restorative nurse, LN #5 stated there were a total of two restorative CNAs for the facility. LN #5 stated the goal was to provide each resident restorative nursing 6 times a week, but that sometimes they did not have time. She said the CNAs on the floor were to do ROM during cares. LN #5 stated there were 49 residents on the restorative program and 43 of them were on range of motion programs. She stated the 600 Hall where residents with ventilator's resided, had the highest number of residents on the restoration program. LN #5 said the CNAs on the 600 hall were to do ROM. She stated there was one resident who could get out of bed and come to the gym and have treatment</p>	F 318			

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F 318	<p>Continued From page 65 completed there.</p> <p>On 11/4/16 at 10:15 am, CNA #7, a restorative aide, stated there were too many residents who need restorative and not enough restorative aides. CNA #7 stated, they talked to the DON a couple of months ago and asked for a third restorative aide, and the DON said he was working on it.</p> <p>On 11/4/16 at 9:15 am, during an interview with PT #1, she said Resident #3 was well-known by the therapist and she had provided services to him since his admission to the facility. PT #1 stated that she had no referral to evaluate Resident #3 for decline in ROM or foot drop. PT #1 went to Resident #3's room to do a screen for therapy services. PT #1 said, "He has foot drop now, he did not have that when he came here, I'm sorry about that. The harder boots did not work and were causing him to be at risk for skin breakdown. We will get orders today for the screen, there have been a lot of changes with him and we will pick him back up." PT #1 provided passive range of motion during the observation with Resident #3 and stated, "There are changes in the hips and the knees are together, this is from the wedge cushions under his hips to keep pressure off the wound on his sacral area. He has lost some range in his left shoulder too. Thank you for alerting me."</p> <p>2. Resident #12's record was reviewed on 11/4/16 at 10:30 am. Resident #12's diagnoses included paraplegia, contractures, and adult failure to thrive.</p> <p>A quarterly MDS assessment, dated 10/25/16,</p>	F 318			

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F 318	<p>Continued From page 66</p> <p>documented Resident #12 had limitation in range of motion to bilateral upper and lower extremities.</p> <p>A physician's order, dated 8/25/16, stated, "Splint to R (right) hand 4 o (hours) a day as tolerated...RA (restorative aide) to report any redness/ impairment to LN (licensed nurse)/ RCM (resident care manager) of splinting daily. See restorative plan."</p> <p>Resident #12 was observed on 11/3/16 at 10:35 am, 11/4/16 at 10:25 am, and 1:40 pm, without a splint to her right hand.</p> <p>Resident #12's restorative program summary, dated 10/5/16 through 11/4/16, stated the splint had been applied on 3 days and refused on 10 days. There was nothing documented for the other 17 days.</p> <p>During an interview on 11/4/16 at 1:15 pm, LN #5 indicated the splint had not been applied daily as ordered by the physician.</p> <p>3. Resident #1 was admitted to the facility on 7/31/14, and readmitted on 9/24/15, with multiple diagnoses including quadriplegia and contractures.</p> <p>Resident #1's quarterly MDS assessment, dated 9/21/16, documented intact cognition, able to make needs known, and to understand others, requires total assistance with all ADL's, had impaired ROM to both upper and lower extremities, received PROM 4 out of 7 days and assistance with splint or brace 6 out of 7 days.</p> <p>Resident #1's ADL/Mobility Care plan, dated as</p>	F 318		

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F 318	Continued From page 67 reviewed on 7/20/16, included an intervention for "finger spreader splints" to be placed in the evening and to be removed at the start of every day shift. The intervention stated, "When off - roll up wash cloth and place in hands to keep fingers and thumbs from curling down fully and replace as they get damp." Resident #1's current Physician Orders for November 2016, included an order for "bilateral palm guards" to bilateral hands on at bedtime, and off in the morning. a. Resident #1 was observed without a rolled up wash cloth in either hand palm on 11/1/16 at 1:35 pm, and 11/2/16 at 10:45 am. Resident #1 stated he had to ask the staff to put the rolled up wash cloth in the palms of his hands. He stated he asked the staff about once a week. b. Resident #1's TAR's for August and September 2016 contained documentation that the bilateral palm guards were not consistently applied to and/or removed from Resident #1's bilateral palms as ordered. In August, the palm guards were not applied 5 out of 31 times and not removed 5 out of 31 times. In September, the palm guards were not applied 5 out of 30 times and there was no documentation that the palm guards were removed 30 out of 30 times. On 11/2/16 at 4:10 pm, LPN #1 stated Resident #1 did not wear splints during the day, he wore them at night.	F 318			
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		1/23/17	

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F 323	<p>Continued From page 68</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review; staff, resident, and family interviews; and policy review, it was determined the facility failed to ensure adequate supervision was provided to prevent 2 of 24 sampled residents (#20 and #24) from physically and sexually assaulting other residents and eloping from the facility. The failure to prevent elopement placed all cognitively impaired and cognitively intact residents who were independently mobile in Immediate Jeopardy of serious impairment, harm, or death. It also resulted in serious harm and impairment to Resident #20.</p> <p>The Immediate Jeopardy was identified to have existed since 10/25/16, when Resident #20, with mental health diagnoses and moderate cognitive impairment, left the facility and was not located until 36 hours later - unsupervised near a high-traffic area with fast-moving vehicles and in cold, rainy weather without a coat - when he was admitted to a hospital with diagnoses of hypothermia, dehydration, and catatonia.</p> <p>Adequate supervision was also not provided for Resident #24, who sexually assaulted Resident</p>	F 323	<p>Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Resident #20 is no longer at the facility. Resident #24 is no longer at the facility. Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility have the potential to be affected by this deficient practice. There are no other residents identified. Measures in place and systemic changes made to ensure that the deficient practice does not recur; Residents with the ability to leave center independently have been re-assessed to ensure appropriate cognitive capabilities, mobility status and that physician orders for leave of absences are in place. Residents assessed as safe to leave center have been educated on the leave of absence policy and procedure. Field Education and Training Director have educated staff on the facility's leave</p>		

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F 323	<p>Continued From page 69</p> <p>#23 in her room when the 1:1 staff physician-ordered and care planned to supervise the resident failed to prevent Resident #24 from sexually assaulting Resident #23.</p> <p>Findings include:</p> <p>1. A PASRR-MI Evaluation Form (Preadmission Screening for Mental Illness), dated 4/21/16, documented Resident #20 had functional limitations related to "interpersonal functioning." The form stated Resident #20 had serious difficulty interacting appropriately and communicating effectively with other persons, had a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships, and social isolation.</p> <p>Resident #20's MDS assessment, dated 4/22/16, documented he was admitted from an acute hospital on 4/22/16. The assessment stated Resident #20 was feeling down, depressed, or hopeless, had trouble falling or staying asleep, or slept too much, had poor appetite or overeating, felt bad about himself or that he was a failure or had let himself or family down, and had trouble concentrating on things, such as reading the newspaper or watching television. The MDS also documented Resident #20 had moderate cognitive impairment.</p> <p>A Progress Note, dated 6/20/16, in Resident #20's medical record documented, "Per 24 hour report nursing notes resident charted for suicidal thoughts & walking."</p> <p>Resident #20's Mood and Behavior Symptom Assessment Care Plan, last dated August 2016,</p>	F 323	<p>of absence policies and procedures. Residents will be assessed upon admission, quarterly and with significant changes for the ability to leave center independently during the facility's clinical meetings and comprehensive care plan review meeting.</p> <p>Residents will be educated to the process of signing out if they are leaving the facility on an outing. Nursing staff will note Resident has left the facility and the time they departed on the 24 hour report shift to shift report.</p> <p>Management team has been inserviced on supervision guidelines and provision for residents assessed to need increased supervision to include 1:1. Monitor performance to ensure the corrective actions are effective and compliance is sustained; Residents at risk for elopement will be monitored daily using the condition changes from the 24 hour report and from the mood and behavior tracking report for 30 days Monday through Friday and then weekly X 12 to ensure measures are in place to minimize elopement risk. Findings will be corrected as identified and presented at QAPI monthly X 3 for further educational opportunities. Residents requiring increased supervision will be monitored daily Monday through Friday X 30 days and then weekly X 12 to ensure supervision is in place as careplanned. Findings will be correcte as identified and presented to QAPI for further corrective opportunities. Date corrective action will be done and</p>		

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F 323	<p>Continued From page 70</p> <p>documented, "Potential for side effects related to psychotropic drug use: Seroquel. Diagnosis: Thought Disorder. Hallucinations. Disturbed Sleep. Psychotropic drug use: Prozac, Remeron. Major Depression Dependent personality disorder. Repetitive physical movement, Dizziness/Vertigo, Unsteady gait. Fell in past 31-180 days."</p> <p>Resident #20's Elopement Plan of Care: Assessment, Prevention, and Management, dated 8/8/16, documented Resident #20, "Expresses desire to leave. Impaired Cognition: Major depressive disorder. Independently mobile. Anxious, fearful." The interventions in the care plan documented a wander alert system was initiated but discontinued on 5/6/16. Other interventions included, "allow for safe wandering." No other evidence of supervision of Resident #20 could be found in the medical record and the DON was unable to provide evidence of enhanced supervision after the wanderguard was discontinued.</p> <p>During the 3-4 weeks (October 1-October 25) prior to Resident #20 leaving the facility unsupervised, the progress notes documented he was refusing medications and baths, refused to participate in conversations, and exhibited an "odd behavior." An untimed progress note, dated 10/25/16, documented, "Resident was in room in bed @ (at) start of shift. He left his room before dinner, did not sign out. Resident is (unable to interpret) in*out of facility but had not returned by 2100 (9:00 pm)."</p> <p>Resident #20's MDS assessment, with a reference date of 10/24/16, documented he</p>	F 323	<p>who is responsible to ensure compliance; _____ Administrator</p>		

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F 323	<p>Continued From page 71</p> <p>experienced little interest or pleasure in doing things, had trouble falling or staying asleep, or slept too much, was feeling tired or had little energy, poor appetite or overeating, felt bad about himself-or felt he was a failure or had let himself or family down and had trouble concentrating on things, such as reading the newspaper or watching television, 7-11 days during the 14 day lookback period. The MDS also documented Resident #20 had moderate cognitive impairment.</p> <p>An MDS assessment, dated 10/25/16, was completed to "modify an existing record." The changes on this assessment were to clarify that Resident #20 was admitted on 4/22/16 from a psychiatric hospital, instead of an acute hospital as noted on his 4/22/16 admission MDS assessment, and to add a diagnosis of Chronic Obstructive Pulmonary Disease.</p> <p>The Emergency Department Medical Record, from the local hospital, dated 10/27/16, documented Resident #20 arrived in the emergency department at 9:31 pm, with, "Multiple Complaints." The report documented, "Pt a missing person since Tues night. Pt resident at (name of facility). Pt found this PM wet and shivering not to far from (facility name)." The report stated Resident #20 received intravenous fluids and described him as, "Pt in wet cloths and shaking pt none verbal to staff." The report listed problems, "Altered mental status (Acute), Catatonia (Acute), Dehydration (Acute), Exposure to environmental cold (Acute), Acute hyponatremia (Acute), Confusion (Acute), Dehydration (Acute), Depression (Acute), Paranoia (Acute), Vomiting (Acute)."</p>	F 323			

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F 323	Continued From page 72 Another Emergency Department Record, dated 10/27/16, documented, "He (Resident #20) was reported missing 2 nights ago from (facility name). The patient is found to have scattered abrasions of the back and extremities, he appears cold and disheveled, fingers and toes appear whitish and cold with no signs of frostbite, he has petechiae (small red or purple spots caused by bleeding into the skin) of the shins, and he follows commands. On re-evaluation, the patient is noted to take exaggerated breaths and grimaces in addition to not significantly moving his body, which is consistent with catatonia and his previous history of the same during his last hospitalization. Laboratory results show hyperglycemia, hypochloremia (electrolyte disturbance), low CO2, and elevated WBC, BUN, and AST levels. Urine dip shows elevated ketones, small bilirubin, and moderate blood. Chest X ray shows mild bronchovascular crowding at the lung bases likely related to atelectasis (collapsed or closed lung). Subtle infiltrate at the right lung base not entirely excluded. Patient was administered 2.5 L (liters) saline IV while in the department." Earlier in the day on 11/03/16, the DNS stated there was no investigation or report of Resident #20 ever leaving the facility unsupervised. However, the same day, at 4:20 pm, the DNS stated that the resident "did sign himself out at times," and produced documents regarding Resident #20 being out of the facility unsupervised. A sign-out document with Resident #20's name at the top, had no signature that he signed himself out of the facility. The first entry on the sign-out form was dated 4/24/16 and the last	F 323			

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F 323	<p>Continued From page 73 was dated 8/6/16.</p> <p>An undated and unsigned document titled, Missing Person Summary, was provided. It documented, "(Resident #20) an alert and oriented resident with a BIMS>12 per MDS assessment and an active order to leave the facility left the facility on 10-25-16. He was last seen at approximately 2030 (8:30 pm) and noted to not return at 2100 (9:00 pm). The resident was noted to not use the proper procedure to sign out in the resident sign out log. A missing person action plan was initiated at 2100."</p> <p>An additional document, with one typed paragraph, dated 10/25/16, signed by the DNS and dated 10/26/16, stated, "(Resident #20) is a (Resident #20's age) year old male. Independently mobile with a BIMS of 13 on his last MDS. Was last seen at approximately 2030 outside in the employee parking lot. Not an unusual occurrence for the resident. He is alert and oriented. He will walk to the store or other local places to get food or other items from time to time. He was reported missing to myself via phone call at 2116 (9:16 pm)."</p> <p>A phone interview was conducted with Resident #20's family member on 11/4/16 at 10:00 am. Resident #20's family member stated she was awakened by police at her door early in the morning on 10/26/16. Resident #20's family member said she had silenced her phone before bedtime on 10/25/16 and reported she had missed calls from the police and the facility stating that (Resident #20) had left the facility at approximately 8:00 pm on 10/25/16, unsupervised and his whereabouts continued to</p>	F 323			

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F 323	<p>Continued From page 74</p> <p>be unknown. Resident #20's family member stated the resident did not have a car and relied on herself and (a friend) for transportation, which consisted of occasional doctor appointments. Resident #20's family member was aware the resident had initially had a Wanderguard and questioned its removal per staff as she believed Resident #20's mental health had declined since being admitted to the facility. Resident #20's family member and (a friend) drove around town and visited several 24 hour stores in hopes of finding him. The family member stated that on 10/27/16 at approximately 9:30 am, she was notified that Resident #20 was located "on Northwest Boulevard, south of the 95 overpass." She said police had taken Resident #20 to the local hospital. Resident #20's family member reported being very frightened since the resident had attempted suicide 8 years ago and had received many inpatient events since that time with the most recent at a state mental facility immediately before arriving at this facility.</p> <p>Resident #20 was taken to the local hospital the day he was found (10/27/16) and remained there throughout the survey.</p> <p>NOTIFICATION AND REMOVAL OF IMMEDIATE JEOPARDY: F323</p> <p>On 11/4/16, at 5:15 pm, the facility's Interim Administrator, Director of Nursing (DON), and Director of Operations were notified that the failure to provide adequate supervision to prevent elopement for Resident #20, placed other cognitively intact and cognitively impaired, independently mobile residents in Immediate Jeopardy.</p>	F 323			

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F 323	<p>Continued From page 75</p> <p>On 11/15/16, the facility provided an acceptable plan to remove the immediacy at CFR 483.25 (H) and alleged removal of the immediacy as of 11/16/16.</p> <p>The systems, procedures, and protocols implemented by the facility to assure removal of the IJ for F323 were:</p> <ul style="list-style-type: none"> * Residents with the ability to leave center independently have been re-assessed to ensure appropriate cognitive capabilities, mobility status and that physician orders for leave of absences are in place. * Field Education and Training Director has educated staff on Leave of Absence policy and procedure which includes but is not limited to staff actions required if resident does not return as scheduled, medication management and appropriate attire for outings. * Residents assessed as safe to leave center have been educated on the leave of absence policy and procedure. * Residents will be assessed upon admission, quarterly and with significant changes for the ability to leave center independently during the facility's clinical meetings and comprehensive care plan review meeting. * Residents who are independently mobile and cognitively impaired have been re-assessed for elopement risk and care plans and care delivery guides reviewed for appropriate interventions. * Field Education and Training Director have educated the staff on policies and procedures related to elopement management to include interventions and management of wanderguards. * Residents will be assessed upon admission, 	F 323			

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F 323	<p>Continued From page 76</p> <p>quarterly and with significant changes for elopement risks during the facility's clinical meetings and comprehensive care plan review meeting.</p> <p>On 11/17/16, an on-site revisit was conducted to confirm the immediate jeopardy had been removed. The on-site team confirmed the facility had removed the immediacy as of 11/16/16.</p> <p>2. Resident #24 was admitted to facility on 7/5/16, with multiple diagnoses which included viral meningitis, anxiety, encephalitis, dementia with behavioral disturbances, depression, and pain.</p> <p>Nurses' Notes, dated 7/7/16 on the evening shift, documented Resident #24 was combative, kicked at walls, threw items, and nearly hit another resident.</p> <p>Nurse' Notes, dated 7/11/16 on the night shift, documented Resident #24 had a 1:1 caregiver all night due to behaviors and eloping.</p> <p>The 14 day MDS assessment, dated 7/18/16, documented Resident #24 was having physical and verbal behaviors.</p> <p>A Comprehensive Care Plan Review Summary, that was not dated, documented Resident #24 had mood issues, and had a BIMS score of 0; indicating Resident #24 was cognitively impaired.</p> <p>A Safety Device Care Plan, initiated 6/6/16, documented Resident #24 had impaired cognition, was exit seeking, and had a Wanderguard ankle bracelet in place.</p>	F 323			

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F 323	Continued From page 77 A Mood and Behavior Symptom Assessment Care Plan, initiated 7/2016, documented Resident #24 was verbally abusive, physically abusive, disrobed in public, entered other residents rooms, and slept in other beds. An Elopement Care Plan, dated 7/6/16, documented Resident #24 was independently mobile, and initiated 7/12/16, an intervention for 1:1 observation. A Physician Order, dated 7/8/16, documented an order for Seroquel [anti-psychotic medication] 25mg at bedtime, for increasing agitation. A Psychiatric consult note, dated 7/11/16 at 4:00 pm, documented Resident #24's medication regime did not appear to have been effective in reducing his agitation, restlessness, confusion, and hyper-sexuality. A Physician Order, dated 7/12/16, documented an order for behaviors to be monitored and for the resident to be placed with a 1:1 caregiver. Nurses' Notes, dated 7/16/18 at 2:15 am, documented Resident #24 was on 1:1 supervision due to behaviors, that he had shoved a wheel chair with a resident sitting in it, kicked at the wall, and hit the door alarm. Nurses' Notes, dated 7/16/16 on the day shift, documented Resident #24 was touching inappropriately and had been updated to 2 person cares at all times. A Physician Order, dated 7/18/16, documented	F 323			

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F 323	<p>Continued From page 78</p> <p>an increase in Seroquel to 50 mg, due to Resident #24 being combative, multiple threats to the 1:1 caregiver, physical outburst resulting in broken equipment, and that he had shoved a wheelchair with another resident in it.</p> <p>Nurses' Notes, dated 7/19/16 [no time given], documented Resident #24 was given an extra dose of Ativan for anxiety, that he was throwing a wheelchair, pulling phone and bed cord out of the wall and bed, was crying and yelling, that Ativan was only slightly effective, and that he was switched to a male 1:1 caregiver.</p> <p>Nurses' Notes, dated 7/19/16 at night, documented that Resident #24 was on a 1:1 supervision for recent displays of unpredictable behaviors.</p> <p>Nurses' Notes, dated 7/21/16 at 10:00 pm, documented that Resident #24 was on a 1:1 supervision for his pattern of extreme behaviors including threats of violence.</p> <p>A Physician Order, dated 7/19/16, documented a change in his Seroquel to 25 mg in the morning and 50 mg at bedtime.</p> <p>A Physician Order, dated 7/22/16 at 5:30 am, documented an increase in his Ativan [anti-anxiety medication] dose for anxiety and agitation.</p> <p>Nurses' Notes, dated 7/22/16 [no time given], documented that Resident #24 grabbed a female resident and shook her, the physician was notified, a dose of Seroquel was given, and Resident #24 was sent out to the Emergency</p>	F 323			

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F 323	<p>Continued From page 79 Room.</p> <p>A Physician Order, dated 7/22/16, documented an extra dose of Seroquel 100 mg for agitation, and an order to send him to the Emergency Room.</p> <p>An Incident Summary, dated 7/22/16, documented that a male resident, who was care planned to have 1:1 supervision with him, sexually assaulted Resident #23.</p> <p>The facility's Resident Supervision Procedure, effective July 2015, documented the following:</p> <ul style="list-style-type: none"> * That the center strives to provide the appropriate level of supervision, ensure an immediate and optimal level of safety and outcome for the resident...will continually evaluate the level of supervision needed through assessment and observation of the resident's cognitive, behavioral, medical or other conditions that put them at risk to self or others. * The staff will document supervision using the 24 Hour Resident Flow Record * Transfer supervision checks from one staff member to another by signing and initialing the 24 Hour Resident Flow Record. * The assigned staff member must stay within close physical proximity, example one to two arm lengths of the resident at all times and see the resident at all times. Observations will be documented every 15 minutes using the 24 Hour Resident Flow Record. 	F 323			

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F 323	Continued From page 80 On 11/4/16 at 4:35 pm, when asked for documentation that 1:1 supervision was provided as physician ordered and care planned, the DON stated, "We don't do that." When asked how the facility ensured 1:1 supervision actually took place, the DON stated he knew it took place because the 1:1 was assigned.	F 323			
F 328 SS=D	The facility failed to ensure Resident #24 received the level of supervision necessary to prevent him from sexually assaulting Resident #23, shoving a wheelchair with a resident in it, and grabbing and shaking a female resident. 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents who required PICC lines and respiratory services received appropriate care. This was true for 2 of 10 residents reviewed for specialized services. This deficient practice created the potential for harm when a) Resident	F 328	Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Resident #10 has completed his antibiotics and the PICC line has been removed.	1/23/17	

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F 328	<p>Continued From page 81</p> <p>#10's PICC line was not assessed or the dressing changed, and b) Resident #1 was not provided with care consistent with her respiratory needs. Findings include:</p> <p>1. Resident #10's record was reviewed on 11/2/16 at 9:30 am. Resident #10's diagnoses included quadriplegia, respiratory failure, and pneumonia.</p> <p>Resident #10's re-admission nursing assessment, dated 10/20/16, stated, "IV (Intravenous) PICC (circled) L (left) Brachial (upper arm) Double lumen patent X (times) 2." There was a lack of documentation of further assessment of the PICC line.</p> <p>Nurses' notes documented:</p> <ul style="list-style-type: none"> -10/21/16 at 8 pm, "PICC to left brachial double lumen flushed per order patent x (times) 2" -10/22/16 at 3:15 am, "IV abt (antibiotic) Vanco (Vancomycin) infusing per PICC to L Brachial no (indicated by an o with a line through it) s/s (signs and symptoms) of infection" -10/22/16 at 2:25 pm, "PICC line flushed & patent x 2 lumens" -10/23/17 at 4:20 am, "PICC patent and flushing well" -10/28/16 at 1:00 am, "PICC double lumen to left brachial patent & flushed per order" -10/28/16 at 2:00 pm, "PICC line dsg (dressing) change (indicated by a triangle) done per MD order, no (indicated by an o with a line through it) issues, no c/o (complaints of) pain" -10/28/16 at 9:10 pm, "PICC to LUA (left upper arm) patent & flushes well" -10/29/16 at 3:00 pm, "PICC patent x2 IV infused" 	F 328	<p>Resident #1 has oxygen therapy documented as per order and facility policy and procedure.</p> <p>Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility utilizing PICC lines for IV therapy and oxygen have the potential to be affected by this deficient practice.</p> <p>Residents utilizing PICC lines have been reviewed and have assessment and documentation as per facility policy and procedure.</p> <p>Residents with oxygen orders have accurate documentation per facility guidelines.</p> <p>Measures in place and systemic changes made to ensure that the deficient practice does not recur;</p> <p>Licensed Nurses have been inserviced related to PICC line assessment and documentation per facility protocol. IV documentation for PICC lines will be documented on the Omniview(pharmacy) IV flowsheet.</p> <p>Licensed Nurses have been inserviced on the required documentation related to oxygen therapy.</p> <p>Monitor performance to ensure the corrective actions are effective and compliance is sustained;</p> <p>Residents with PICC lines in use will be monitored daily X 30 Monday through Friday and then 2 X a week for 12 weeks to ensure assessment, treatment and documentation. Findings will be corrected as identified and results will be</p>		

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F 328	<p>Continued From page 82 -11/1/16 at 6:00 pm, "Received an order to D/C (discontinue) PICC line...PICC removed s (without) difficulty"</p> <p>Resident #10's MAR (medication administration record), dated 10/2016, documented, "Flush c (with) 10 ml (milliliters) NS (normal saline) both lumens before & after Q (every) IV dose or Q shift. Noc (nights) Day"</p> <p>The facility's policy, titled Central Vascular Access Device (CVAD) Dressing Change, dated 2016, provided by the DON as current, documented, "Sterile dressing change using transparent dressing is performed...24 hours post insertion or upon admission...At least weekly...Assessment of the vascular access site is performed...Upon admission and during dressing changes...Before and after administration of intermittent infusions." The policy stated there was to be an assessment of the resident's entire arm with indwelling vascular access device (VAD) for infusion related complications, which included, but were not limited to, the absence or presence of:</p> <ul style="list-style-type: none"> * Erythema (redness) * Drainage * Swelling or induration * Change in skin temperature at site * Tenderness at the site of along vein tract * Integrity of transparent dressing - length of external catheter was to be obtained 24 hours post insertion or upon admission, and during dressing changes * For PICC lines, the upper arm circumference was to be obtained upon admission if no insertion measurement were available, then weekly. 	F 328	<p>presented at QAPI monthly X3 for further corrective opportunities. Residents using oxygen therapy will be monitored daily X 30 Monday through Friday and then weekly X 8 to ensure required documentation is on the TAR. Findings will be presented at QAPI monthly X 3 for further educational/ corrective opportunities. Date corrective action will be done and who is responsible to ensure compliance; _____ Director of Nursing</p>		

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F 328	<p>Continued From page 83</p> <p>The facility's policy titled Central Venous Catheter (CVC) Removal, dated July 2012, provided by the 600 Hall RN Unit Manager as current, documented "Measure catheter and assess catheter tip to ensure entire catheter was removed...Documentation in the medical record includes, but is not limited to...Date and time...Length and condition of catheter and tip...Site assessment...Resident response to procedure..."</p> <p>During an interview on 11/2/16 at 3:45 pm, the 600 Hall RN Unit Manager stated there was not an assessment of Resident #10's PICC line other than what was in the nurses' notes. She said there were not any measurements of the external catheter or of the arm circumference. She further stated the dressing was not changed timely and there was not a measurement of the PICC line or whether the tip was intact when the PICC line was removed. She also stated there was no assessment of the PICC line site.</p> <p>2. Resident #1 was admitted to the facility on 7/31/14 with multiple diagnoses including quadriplegia and respiratory failure.</p> <p>The quarterly MDS assessment, dated 9/21/16, documented Resident #1 received oxygen therapy.</p> <p>Resident #1's Physician's Orders Recapitulation, dated 11/1/16, documented:</p> <p>* Oxygen at 1-5 liters via (mask/nasal cannula) continuously for respiratory failure to keep saturations at or above 90%, titrate to keep</p>	F 328		

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F 328	<p>Continued From page 84 saturations above 90%.</p> <ul style="list-style-type: none"> * Document Liters and Saturations every shift. * Oxygen saturations every shift and as needed. * Oxygen saturations on room air every week. * Change, label, and date oxygen tubing every week. * Wash concentrator filters every week. <p>Resident #1's care plan for October 2016, updated 7/20/16, documented:</p> <ul style="list-style-type: none"> * Problem - Need for oxygen therapy, history of chronic aspiration pneumonia. * Goal - Oxygen saturations will be greater than or equal to 90% daily. * Interventions - Oxygen as ordered. Change tubing/devices per protocol. Oxygen saturations: per protocol. <p>Resident #1's TAR for May 2016 did not include documentation for the following occurrences:</p> <ul style="list-style-type: none"> * 6 of 62 occurrences to monitor oxygen at 1-5 liters continuous to keep saturations at or above 90%. * 7 of 62 occurrences to monitor oxygen saturations every shift. * 3 of 5 occurrences to monitor oxygen saturations on room air every week. 	F 328			

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F 328	<p>Continued From page 85</p> <ul style="list-style-type: none"> * 3 of 5 occurrences to change and label the oxygen tubing every week. * 2 of 4 occurrences to wash oxygen concentrator filters every week. <p>Resident #1's TAR for June 2016 did not include documentation for the following occurrences:</p> <ul style="list-style-type: none"> * 2 of 60 occurrences to monitor oxygen at 1-5 liters continuous to keep saturations at or above 90%. * 4 of 60 occurrences to monitor oxygen saturations every shift. * 2 of 4 occurrences to monitor oxygen saturations on room air every week. * 1 of 4 occurrences to change and label the oxygen tubing every week. * 4 of 4 occurrences to wash oxygen concentrator filters every week. <p>Resident #1's TAR for July 2016 did not include documentation for the following occurrences:</p> <ul style="list-style-type: none"> * 11 of 62 occurrences to monitor oxygen at 1-5 liters continuous to keep saturations at or above 90%. * 17 of 62 occurrences to monitor oxygen saturations every shift. * 4 of 4 occurrences to monitor oxygen saturations on room air every week. 	F 328			

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F 328	<p>Continued From page 86</p> <ul style="list-style-type: none"> * 5 of 5 occurrences to change and label the oxygen tubing every week. * 3 of 4 occurrences to wash oxygen concentrator filters every week. <p>Resident #1's TAR for August 2016 did not include documentation for the following occurrences:</p> <ul style="list-style-type: none"> * 20 of 62 occurrences to monitor oxygen at 1-5 liters continuous to keep saturations at or above 90%. * 14 of 62 occurrences to monitor oxygen saturations every shift. * 4 of 5 occurrences to monitor oxygen saturations on room air every week. * 4 of 4 occurrences to change and label the oxygen tubing every week. * 3 of 5 occurrences to wash oxygen concentrator filters every week. <p>Resident #1's TAR for September 2016 did not include documentation for the following occurrences:</p> <ul style="list-style-type: none"> * 12 of 60 occurrences to monitor oxygen at 1-5 liters continuous to keep saturations at or above 90%. * 17 of 60 occurrences to monitor oxygen saturations every shift. 	F 328			

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F 328	Continued From page 87 * 4 of 4 occurrences to change and label the oxygen tubing every week. * 1 of 4 occurrences to wash oxygen concentrator filters every week. On 11/3/16 at 4:45 pm, the DON stated he would have expected his licensed staff to document for the work they have done.	F 328			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		1/23/17	

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F 329	<p>Continued From page 88</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed ensure physician orders to obtain laboratory tests related to IV antibiotics were followed for 1 of 24 sampled residents (#10). This failure created the potential for more than minimum harm when Resident #10's Vancomycin trough laboratory tests was not completed done for 3 days. Findings include:</p> <p>Resident #10's record was reviewed on 11/2/16 at 9:30 am. Resident #10's diagnoses included, but were not limited to, quadriplegia, respiratory failure, and pneumonia.</p> <p>Resident #10's re-admission physician's orders, dated 10/20/16, documented the resident was to receive Vancomycin (an antibiotic) 1500 milligrams IV PICC every 24 hours and was to have a Vancomycin trough (blood level test) before the 10/21/16 dose. (Some drugs have a narrow therapeutic index. That means that too much of it could easily cause toxicity. Peak and trough blood levels need to be drawn to make sure levels in the blood are at an adequate range to not cause toxicity. Trough (or the low amount) is drawn prior to administering the drug. A peak (or the high amount) is drawn at a specified time after administering drug. This way subsequent dosages can be adjusted accordingly to prevent toxicity.)</p> <p>Resident #10's nurses' notes, dated 10/21/16, documented "pt (patient) hypotension (sic)...pt lethargic responds to painful stimuli, low grade fever, MD contacted." There was no documented</p>	F 329	<p>Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Resident #10 has completed IV antibiotics. (vancomycin) Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility with orders for vancomycin have the potential to be affected by this deficiency. Residents with orders for vancomycin have been reviewed and laboratory testing is completed and reported to MD as per order. Measures in place and systemic changes made to ensure that the deficient practice does not recur; Licensed Nurses have been inserviced on vancomycin and ordered laboratory testing needed for dosing consideration. Ordered laboratory tests for vancomycin will be reviewed with MD order review during the Nurse Managers morning meeting. Unit managers will ensure that ordered tests have been drawn and MD notification has occurred. Monitor performance to ensure the corrective actions are effective and compliance is sustained; Laboratory testing for vancomycin will be monitored daily Monday through Friday X 30 days and then 2X a week for 8 weeks. Facility lab tracking system will be compared to MD orders to facilitate</p>	

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F 329	<p>Continued From page 89</p> <p>evidence the Vancomycin trough had been done as ordered.</p> <p>The resident's record did not include documentation of Vancomycin trough test results for 10/21/16.</p> <p>The nurses' notes documented:</p> <ul style="list-style-type: none"> * 10/22/16 at 3:15 am, "Resident lying in bed c (with) eyes open. Confused...IV abt (antibiotic) Vanco (Vancomycin) infusing..." * 10/22/16 at 2:25 pm, "pt...elevated temp (temperature), + (positive) hallucinations & delusions...minimal urinary output, < (less than) 200 cc (cubic centimeters) x (times) 8 hours..." * 10/23/16 at 4:20 am, "Resident has been alert and oriented all shift...continues c IV abx (antibiotic)" * 10/24/16 at 2:00 am, "Continues on IV ABX" * 10/24/16 at 6 pm, "Resident c (with) increased (indicated by an arrow pointed up) confusion t/o (throughout) day...Vanco through (sic) drawn stat (now). Received critical lab back. Hold vanco today. Vanco through (sic) to be drawn on 10/25/16..." <p>The laboratory test result, dated 10/24/16, documented the Vancomycin trough was 35.8 normal values range from 10 to 20 micrograms per milliliter.</p> <p>Resident #10's nurses' notes, dated 10/25/16, included:</p> <ul style="list-style-type: none"> * 11:00 am, "Vanco trough obtained" * 2:00 pm, "Stat results 29.1 received" <p>A physician's order, dated 10/25/16, stated to,</p>	F 329	<p>monitoring. Findings will be corrected as identified and presented at QAPI for 3 months for further educational/corrective opportunities.</p> <p>Date corrective action will be done and who is responsible to ensure compliance; _____ Director of Nursing</p>		

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F 329	Continued From page 90 "Hold 10-25-16 vancomycin repeat vanco trough @ (at) 1130 (11:30 am) 10-26" A laboratory test, dated 10/26/16, documented the Vancomycin trough was 23.1, remaining above the normal value range. A nurses' note, dated 10/27/16 at 4:30 am, documented, "Rs (resident) slept most of shift...vanco trough was 23.1 new order to cont (continue) to hold vanco and redraw vanco today" A laboratory test, dated 10/27/16, documented Resident #10's Vancomycin trough was 18.5 mcg/ml, within normal value range. During an interview on 11/2/16 at 5:45 pm, the 600 Hall RN Unit Manager stated the Vancomycin trough was not drawn on 10/21/16, as ordered. She stated it was not drawn until the stat order on 10/24/16.	F 329			
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 353		1/23/17	

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F 353	<p>Continued From page 91</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident, family member, and staff interview, and record review, it was determined the facility failed to ensure sufficient numbers of nursing staff were available to meet the bathing, restorative, and ADL needs of residents. This failure affected 12 of 24 sampled residents (#1, #3, #6, #7, #8, #9, #10, #11, #12, #19, #23, and #28). This resulted in a lack of timely repositioning and incontinence care for Resident #3; 10 sampled residents (#6, #7, #8, #9, #10, #11, #12, #19, #23, and #28) receiving five or fewer showers per month; and 3 residents (#1, #3, and #12) not receiving restorative services to prevent a reduction in range-of-motion. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 5/9/16 with diagnoses that included Guillain-Barre Syndrome and quadriplegia.</p> <p>The admission MDS assessment, dated 5/16/16, documented Resident #3 was cognitively intact, and totally dependent on at least two staff for all activities of daily living due to paralysis below the neck from a sudden onset of Guillain-Barre Syndrome, a rare autoimmune disorder in which</p>	F 353	<p>Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Resident # 3 is no longer at the facility. Refer to F-312 as it relates to the corrective action for bathing/showers Refer to F-318 as it relates to the corrective action for restorative nursing care. Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility have the potential to be affected by this deficiency. Residents were interviewed and careplanning was evaluated, there are no other identified residents. Measures in place and systemic changes made to ensure that the deficient practice does not recur; The staffing coordinator has been inserviced on scheduling needs to honor resident preference related to care needs from nurses aides. Recruitment/Retention efforts are in place</p>		

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F 353	<p>Continued From page 92</p> <p>the immune system attacks healthy nerve cells in the peripheral nervous system leading to paralysis.</p> <p>On 11/2/16 at 4:00 pm, Resident #3's family member stated, "Right after we got here we had a problem. A night shift CNA [#6] was rough with him. She tried to turn him by herself and when she left the room his head, arms, and legs [were] hanging off of the bed. He uses his head to press against the call light and he was unable to use his call light. He told me that he was left in that position for several hours and unable to ask for help. He told me a nurse came into the room several hours later and with the help of another CNA repositioned him correctly. I wrote a note about it and gave it to the Unit Manager who said she would write it up. I never heard what happened, but she [CNA #6] didn't come back to care for him again."</p> <p>On 11/2/16 at 4:00 pm, Resident #3, when asked if he felt CNA #6 was "rough" with him, nodded his head, "Yes." The family member stated, "The Unit Manager asked him if it would be alright if she brought [CNA #6] into the room to teach her how to reposition him. He told her, 'No,' by moving his head from side to side. She is the only one [staff] he has a problem with and he insisted that she not come back into the room."</p> <p>During this conversation with the family member on 11/2/16 at 4:00 pm, Resident #3, who was unable to speak due to a tracheostomy tube providing oxygen via ventilator, motioned for a communication board. The resident then nodded his head back and forth or side-to-side as his family member pointed out letters that eventually</p>	F 353	<p>for nurses aides. Response time to applicants is followed up on a daily basis for nursing staff. Facility has expanded advertising efforts. Facility has increased sign on bonus's to include relocation and tuition reimbursement for nursing staff. System review of bathing/showers has been completed with the addition of completed resident interviews and bathing/shower assignments. Changes to support bathing/showers and restorative nursing include oversight by ADON, DON and restorative respectively. Any variation from these systems will generate immediate resolution.</p> <p>Monitor performance to ensure the corrective actions are effective and compliance is sustained;</p> <p>Floor staff schedule will be reviewed daily X 30 Monday through Friday through morning Nurse Manager meeting (and on weekends by weekend manager) and then weekly X 8 to ensure PPD needs are met.</p> <p>Executive Director and Director of Nursing will evaluate PPD's for the following day daily indefinitely.</p> <p>Findings will be reviewed weekly by the Administrator and Director of Nursing for modification as needed and presented to QAPI monthly X 3 for further corrective opportunities.</p> <p>Date corrective action will be done and who will be responsible to ensure compliance;</p> <p>_____Administrator</p>		

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F 353	<p>Continued From page 93</p> <p>spelled, "Tell her what happened." The family member stated, "On 10/2/16 he told me something that happened the night before on the night shift. He said there were only two people on the shift and one of them was [CNA #6]. He said a nurse came into the room and told him she couldn't reposition him by herself and the other CNA on duty was [CNA #6], who was not allowed in the room. He wasn't repositioned or changed [when incontinent] all night."</p> <p>The family member, who kept a journal in which she documented what Resident #3 reported to her, contained the following entry: "10/2/16 - Arrive 8:35 leave 9:45 couldn't get changed during night-called for help-because other aide was one he had problems with. She refused to come in, he wouldn't have her." The family member stated, "I told (the DON) and he said, "We have trouble finding CNAs that are comfortable with vent patients."</p> <p>On 11/3/16 at 11:00 am, the DON said he was aware CNA #6 was not allowed into Resident #3's room to provide care, but did not know the reason. The DON stated he scheduled CNA care assignments and that he assigned CNA #6 to an area of the facility where she would not come into contact with Resident #3 or his family member.</p> <p>On 11/3/16 at 12:30 pm, LN #2 said she worked the night shift and knew CNA #6 was not allowed to provide care to Resident #3. LN #2 stated, "When [CNA #6] works...we have to watch her call lights because she is not allowed to care for [Resident #3]. [CNA #6] trades with someone else on duty when it comes to [Resident #3's] care; everyone knows she can't go in there."</p>	F 353			

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F 353	<p>Continued From page 94</p> <p>On 11/3/16 at 12:40 pm, Resident #3's family member stated she met with the Administrator and DON on 10/10/16, at which time she stated she did not want CNA #6 in the resident's room. At the time of this interview, Resident #3 stated his participation in Speech Therapy enabled him to now speak. Resident #3 stated, "She's the only one I had trouble with. At that time I had no strength in my neck and I couldn't position my head. She left me on my bed sore for hours and I couldn't use my call button. I couldn't explain to them then what I needed and they didn't have time to use the communication sheet." When asked if he felt he had been mistreated by CNA #6, Resident #3 said, "Yes."</p> <p>On 11/3/16 at 12:45 pm, CNA #4 said she knew CNA #6 was not allowed in Resident #3's room and stated, "I heard [CNA #6] was being too rough when changing him. A couple of days ago [CNA #6] worked that night and the resident and his [family member] said he wasn't changed or touched all night because [CNA #6] could not go in there and they were short [staffed] that night."</p> <p>Daily Nursing Schedules for 5/1/16 through 11/4/16 documented CNA #6 was assigned to provide cares to Resident #3, who resided on the 600 Hall, until 5/23/16, when she was assigned to another hall for the rest of that month. The daily nursing schedule, dated 6/1/16, documented CNA #6 was again assigned to the 600 Hall. The daily nursing schedules documented CNA #6 was again assigned to Resident #3, including the night shift of 10/1/16.</p> <p>An In-service Training Record, dated 5/16/16,</p>	F 353			

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F 353	<p>Continued From page 95</p> <p>documented 10 staff were re-educated on providing care to Resident #3. The in-service record documented, "[Resident #3] - ensure head is properly positioned and ears are not kinked. Have [Respiratory Therapy] check him after every reposition. Be mindful of head and leg position when repositioning."</p> <p>A 6/6/16 In-service Training Record documented, "[Resident #3] - Must be offered to turn and reposition and change brief every 2 hours."</p> <p>The daily nursing schedule for 10/1/16 night shift documented CNA #6 was reassigned from another area of the facility to the 600 Hall when two staff called in sick. The staffing schedule documented CNA #6 was the only night shift CNA assigned to the 600 Hall on the night shift on 10/1/16.</p> <p>The facility failed to ensure sufficient numbers of nursing staff were available to effectively communicate with Resident #3, and to meet his repositioning and incontinence care needs, without requiring him to accept care from a staff by whom he felt mistreated.</p> <p>2. Refer to F312 as it relates to the failure of the facility to ensure sufficient numbers of staff were available to regularly bathe or shower 10 of 19 residents sampled for Activities of Daily Living (#6, #7, #8, #9, #10, #11, #12, and #19) and 2 random residents (#23 and #28).</p> <p>3. Refer to F318 as it relates to the failure of the facility to ensure sufficient numbers of staff were available to provide restorative nursing services for 3 of 24 sampled residents (#1, #3, and #12).</p>	F 353			

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F 425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, review of narcotic count sheets, and staff interview, it was determined the facility failed to ensure medication was available from the pharmacy for administration to residents per physician orders. This was true for 1 of 24 sampled residents (#8) and created the potential for harm if residents did not receive PRN and/or scheduled medications as physician ordered to treat their medical condition. Findings include: Resident #8 was admitted to the facility with diagnoses that included quadriplegia, chronic</p>	F 425	<p>Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Resident #8 is receiving analgesics and catheter flushing as per order and the needed pharmaceutical medications are available to staff. Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility have the</p>	1/23/17	

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F 425	<p>Continued From page 97 pain, and chronic respiratory failure.</p> <p>Resident #8's physician's orders, dated 9/21/16, included Methadone 5 mg, every 8 hours for pain.</p> <p>The October 2016 MAR documented the medication had not been administered on 10/13/16 at 8:00 am and 10/24/16 at 8:00 am because the medication was not available.</p> <p>Narcotic count sheets documented the Methadone was not administered on 10/13/16 at 8:00 am and 4:00 pm and on 10/24/16 at 8:00 am and 4:00 pm.</p> <p>Resident #8's nurses' notes for the above dates did not include documentation that the physician was notified that the medication was not available and, therefore, not administered as ordered.</p> <p>Resident #8's physician's order, dated 9/22/16, documented Renacidin, 30 ml, was to be used to flush the resident's suprapubic catheter daily.</p> <p>Resident #8's October 2016 MAR documented the suprapubic catheter had not been irrigated with the Renacidin on 10/18/16 and 10/19/16 because it was not available.</p> <p>On 11/2/16 at 5:45 p.m., the 600 Hall RN Unit Manager stated she was not sure why the medications were not available.</p>	F 425	<p>potential to be affected by this deficiency. Residents residing have had their MD orders compared to the MAR's to ensure ordered medications are available for resident.</p> <p>Measures in place and systemic changes made to ensure that the deficient practice does not recur; Licensed Nurses have been inserviced on required availability of medications ordered by the physician. Licensed Nurses have been inserviced on measures to take including notifying pharmacy and Director of Nursing for medications not available as ordered by the MD. Licensed Nurses have been inserviced on documentation of medication delivery as ordered by the physician. Monitor performance to ensure the corrective actions are effective and compliance is sustained; Residents with new orders will be monitored by unit managers daily Monday through Friday X 30 and then 2 X a week to ensure availability of medication at the facility. Residents admitting to the facility will have their physician orders compared to the MAR (medication administration record) to ensure daily X 30 and then 2X a week X 8 to ensure medications are given as per MD order. Date corrective action will be done and who will ensure compliance; _____ Director of Nursing</p>		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		1/23/17	

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F 441	<p>Continued From page 98</p> <p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	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	<p>Continued From page 99</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of medical records and facility policy, the facility failed to ensure staff washed their hands after providing incontinent care and when providing wound care for 2 of 24 (#1 and #4) sampled residents, and 1 random resident (#25). These deficient practices placed residents at risk of developing avoidable infections. Findings include:</p> <p>1. After observing the RN Unit Manager on 200-300 Halls and LPN #1 performing wound care to Resident #4, they also provided personal care. While the resident was turned on the lateral position for sacral wound care, LPN #1 also cleaned stool from the resident's rectum. The resident was then turned in the supine position for cleaning. LPN #1 cleaned the resident from back (rectum) to the front genitalia. LPN #1 did not change her gloves nor wash her hands after the wound care began until after a clean incontinent brief was applied. The RN Unit Manager observed the LPN throughout the process.</p> <p>Resident #4's medical record documented diagnoses of dementia, type 2 diabetes mellitus, hemiplegia, and osteoporosis. An MDS assessment, dated 10/5/16, documented the resident required extensive assistance from 2 or more staff for toileting and personal hygiene. Resident #4's Alteration in Bowel Elimination Care Plan, stated the resident should expect, "Change incontinent product PRN." The Catheter Plan of Care, documented, "Strive to keep residents catheter free of feces." The CORP</p>	F 441	<p>Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Residents #1 and #4 are receiving wound care with infection control practices in place as per facility protocol. Resident #1 is receiving incontinent care as per standard of care. Resident #25 is not identified on the surveyor identifier list LPN #1 has been inserviced on handwashing and related to personal care and wound care. The unit manager for 200-300 no longer manages the unit.</p> <p>Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility have the potential to be affected by this deficiency. There are no other residents specifically identified. Measures in place and systemic changes made to ensure that the deficient practice does not recur; Staff has been inserviced on handwashing related to infection control. Nurses aide #1 and #2 have been inserviced on hand washing and incontinent care with turn demonstration related to perineal care by the field director of education and training. LPN #1 has been inserviced on handwashing and related to personal care</p>		

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F 441	<p>Continued From page 100</p> <p>report documented the resident had been incontinent of feces 39 times in the previous month.</p> <p>During an interview on 11/01/16 at 9:55 am, the Staff Development Coordinator was asked about the facility's policy and education of the staff for incontinent peri-care. The Staff Development Coordinator stated there was a written policy and description of new staff training. The Staff Development Coordinator said new staff were given instruction regarding the facility manuals on the first day of training and worked with nursing on the second day and then alongside another, seasoned, CNA before completing various task checklists.</p> <p>On 11/04/16 at 9:15 am, an interview was completed with the Staff Development Coordinator and the RN Unit Manager for 200-300 Halls. The RN Unit Manager stated she had also observed the failure to provide proper wound and peri-care during procedures performed by the LPN #1 for Resident #4. The Staff Development Coordinator acknowledged the correct procedures for wound care and peri-care as important parts of infection control measures in the facility.</p> <p>The facility's undated policy, Guidelines for Providing Perineal Care, documented, "Remove your gloves and wash your hands before touching clean clothing, linens, or the resident. Gloves worn while providing perineal care are considered contaminated."</p> <p>2. On 11/1/16 at 9:40 am, CNA #1 and CNA #2 were observed providing perineal care (peri-care)</p>	F 441	<p>and wound care.</p> <p>Licensed Nurses have been inserviced on handwashing related to wound care. Monitor performance to ensure the corrective actions are effective and compliance is sustained; Handwashing will be monitored 3 X a week on different shifts during perineal care and with licensed nurses during wound care for 12 weeks by the field director of education and training. Findings will be corrected as identified, reported to the Director of Nursing and then presented at QAPI monthly X 3 for further educational opportunities. Incontinent care will be monitored 3 X a week X 12 by the field director of education and training delivered by caregivers to ensure infection control protocol is in practice. Findings will be corrected as identified, reported to the director of Nursing and then presented to QAPI monthly X 3 for further educational opportunities. Date corrective action will be done and who will be responsible to ensure compliance; _____ Director of Nursing</p>		

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F 441	Continued From page 101 to Resident #25. As the CNAs performed care, neither CNA washed their hands or changed gloves from the beginning of the peri-care through the placement of the clean incontinent brief. The CNAs did not remove their gloves after providing incontinent care nor did they wash or sanitize their hand before applying a clean incontinent brief to the resident. 3. Resident #1's medical record documented he had diagnoses of pressure ulcer and quadriplegia. An MDS assessment, dated 9/11/16, documented Resident #1 was totally dependent on staff and required the assistance of 2 or more staff for toileting and personal hygiene. Resident #1's Care Delivery Guide documented he was incontinent of bladder. Documentation on the CORP-Bowel and Bladder Chart Detail Report, showed Resident #1 was incontinent 90 times during the previous month. On 11/2/16 at 1:42 pm, CNA #1 and CNA #2 were observed providing perineal care (peri-care) to Resident #1. The CNA's did not clean his entire perineal area. Although Resident #1's groin and scrotum were cleaned, his penis was not cleaned when the CNA's provided incontinent care.	F 441			
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	F 465		1/23/17	

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F 465	Continued From page 102 by: Based on observation and staff interview, it was determined the facility failed to ensure residents' clothing and linen were protected from the potential of contamination by the backflow of drain water into washing machines. This created the potential for harm for residents whose clothes and linens were laundered at the facility. Findings include: On 11/2/16 at 3:20 pm, during a tour of the facility's laundry room with the Laundry Supervisor, one drainage hose from a large washing machine and one drainage hose from a smaller machine were observed lying in a trough behind the machines where dirty wash- and rinse water drained into the building's elimination system. When shown the drainage hoses lying in the trough, the Laundry Supervisor stated, "I don't have anything to do with this." The International Association of Plumbing and Mechanical Officials' International Plumbing Code, Section 801.2, documented, "Indirect waste piping shall discharge into the building drainage system through an air gap or air break...the minimum vertical distance measured from the lowest point of the indirect waste pipe...to the flood-level rim of the receptor shall be not less than 1 inch." A backflow of wastewater in the trough created the potential for contagions to come into contact with residents' clothes and linens inside the facility's washing machines.	F 465	Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; There are no residents identified. Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility and utilizing laundry services have the potential to be affected by this deficiency. Measures in place and systemic changes made to ensure that the deficient practice does not recur; The washing machine drainage is discharging into the building drainage system through an air gap. Monitor performance to ensure the corrective actions are effective and compliance is sustained; The drainage of the washing machine will be monitored weekly X 12 by the maintenance department to ensure air gap system is in place. Findings will be corrected and presented to QAPI monthly X 3 for further corrective opportunities. Date corrective action will be done and who will ensure compliance; _____ Director of Maintenance		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	F 490		1/23/17	

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F 490	<p>Continued From page 103</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation; resident, family member, staff, and resident group interviews; and review of facility policies and procedures, staffing records, resident clinical records, the facility's grievances, and Resident Council minutes, it was determined the facility was not administered in a manner to effectively use its resources to assist residents attain or maintain their highest practicable well being. The facility's administration failed to ensure:</p> <p>a) All allegations of mistreatment, elopement, and injury of unknown origin were identified, investigated, and/or reported,</p> <p>b) Resident and family member grievances were promptly investigated and resolved,</p> <p>c) Residents were provided with social services necessary to avoid psychosocial harm,</p> <p>d) Residents were provided with the supervision necessary to protect themselves and others,</p> <p>e) Sufficient numbers of staff were provided to avoid harm to residents and meet their needs, and</p> <p>f) Previously cited deficient practices did not</p>	F 490	<p>Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Refer to F-225, F-226, F-250, F-280, F-312, F-314, F-318, F-323, F-329, F-353 and F-441 for measures put in place and for correction as it relates to identified residents.</p> <p>Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility have the potential to be affected by these deficiencies. Refer to F-225, F-226, F-250, F-280, F-312, F-314, F-318, F-323, F-329, F-353 and F-441 for how the nursing home will act to protect residents in similar situations.</p> <p>Measures in place and systemic changes made to ensure that the deficient practice does not recur; Facility will complete listed measures and system changes for the above citations to prevent recurrence. Management team will be inserviced through policy and procedure recognition by Field Educator, Director of Clinical Services and</p>		

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F 490	<p>Continued From page 104 recur.</p> <p>These negative systemic practices directly impacted 20 of 30 residents reviewed (#1, #3, #4, #6 - #12, #14, #18, #19, #20, #23, #24, and #26 - #29. Resident #3 and all cognitively impaired and cognitively intact residents who were independently mobile were found to be in Immediate Jeopardy of serious impairment, harm, or death. It also resulted in serious harm and impairment to Resident #20, further harm to Resident #3, and harm to Resident #23. Findings include:</p> <p>1. Immediate Jeopardy to residents' health and safety were identified in the following areas:</p> <p>* Refer to F225 and F226 as they relate to failure of the facility's administration to ensure allegations of mistreatment, elopement, and injury of unknown origin were investigated and/or reported for 4 of 24 sampled residents (#3, #14, #20, and #23). This deficient practice placed Resident #3 in Immediate Jeopardy (IJ) for serious harm, impairment, or death.</p> <p>Specifically, Resident #3 alleged he was mistreated by a CNA who was allowed to provide cares for his roommate for 5 months following the allegation, which was neither reported nor investigated by the facility. Resident #3 was in Immediate Jeopardy for repeat instances of mistreatment and continued to experience anxiety when the alleged perpetrator was allowed to continue assisting with cares for his roommate over a 5-month period.</p> <p>Additionally, Resident #14 presented with</p>	F 490	<p>Executive Director of Business Administration to effectively use its resources to ensure residents attain or maintain their highest practicable level of well being.</p> <p>Monitor performance to ensure the corrective actions are effective and compliance is sustained;</p> <p>Refer to F-225, F-226, F-250, F-280, F-312, F-314, F-318, F-323, F-329, F-353, and F-441 for monitoring plan to ensure compliance is maintained for these deficiencies.</p> <p>Date corrective action will be done and who is responsible to ensure compliance; _____ Administrator</p>		

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F 490	<p>Continued From page 105</p> <p>significant bruising of unknown origin that was neither reported nor investigated in a timely manner by the facility. This deficient practice placed Resident #14 at risk of potential abuse as the source of her injuries had not been investigated.</p> <p>The facility additionally failed to investigate the elopement of Resident #20, who was not located until he was admitted to a hospital approximately 36 hours later with diagnoses that included hypothermia, catatonia, and dehydration. The facility failed to investigate this elopement as a possible case of neglect or address supervision concerns for other residents in the facility who were also at risk of elopement.</p> <p>* Refer to F323 as it relates to the failure of the facility's administration ensure adequate supervision was provided to prevent 2 of 24 sampled residents (#20 and #24) from physically and sexually assaulting other residents and eloping from the facility. The failure to prevent elopement placed all cognitively impaired and cognitively intact residents who were independently mobile in Immediate Jeopardy of serious impairment, harm, or death. It also resulted in serious harm and impairment to Resident #20.</p> <p>The Immediate Jeopardy was identified to have existed since 10/25/16, when Resident #20, with mental health diagnoses and moderate cognitive impairment, left the facility and was not located until 36 hours later - unsupervised near a high-traffic area with fast-moving vehicles and in cold, rainy weather without a coat - when he was admitted to a hospital with diagnoses of</p>	F 490			

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F 490	<p>Continued From page 106 hypothermia, dehydration, and catatonia.</p> <p>Adequate supervision was also not provided for Resident #24, who sexually assaulted a female resident in her room when the 1:1 CNA physician-ordered and care planned to supervise the resident failed to prevent Resident #24 from sexually assaulting Resident #23.</p> <p>* Also refer to a related deficiency not cited as IJ, identified at F166 as it relates to the failure of the facility's administration to ensure that resident and family grievances were promptly investigated and resolved, and residents and family members were appropriately apprised of the progress toward resolution of their grievances. This was true for 1 of 24 sampled residents (#3) and 4 random residents (#26, #27, #28, #29) and had the potential to impact all residents in the facility. The deficient practice created the potential for residents and family members to experience frustration and/or psychosocial harm when their concerns, including those of mistreatment, were not investigated and resolved.</p> <p>2. Refer to F250 as it relates to the failure of the facility's administration to ensure medically related social services were provided for a resident who had been sexually assaulted in the facility. This was true for 1 of 24 residents (#23) sampled for social services and resulted in harm when the resident exhibited signs of continued distress that were not addressed through on-going counseling or other services.</p> <p>3. The facility's administration failed to ensure sufficient numbers of staff were available to meet the needs of residents, as follows:</p>	F 490			

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F 490	Continued From page 107 a. Refer to F312 as it relates to the failure of the facility's administration to ensure sufficient numbers of staff were available to bathe residents regularly. This was true for 10 of 19 residents sampled for Activities of Daily Living (#6, #7, #8, #9, #10, #11, #12, and #19) and 2 random residents (#23 and #28). This deficient practice had the potential to adversely affect residents' physical comfort, dignity, sense of self-worth, and willingness to socialize with peers. b. Refer to F318 as it relates to the failure of the facility's administration to provide sufficient numbers of staff were provided to provide range of motion services to prevent avoidable reduction in range of motion, apply a hand splint and rolled wash cloths, and provide restorative care for 3 of 24 sampled residents (#1, #3, and #12). This failure resulted in harm to Resident #3 when he experienced foot drop and further decline in ROM. It also placed Residents #1 and #12 at risk of decline in ROM due to lack of consistent implementation of restorative interventions. c. Refer to F353 as it relates to the failure of the facility failed to ensure sufficient numbers of nursing staff were available to meet the bathing, restorative, and ADL needs of residents. This failure affected 12 of 24 sampled residents (#1, #3, #6, #7, #8, #9, #10, #11, #12, #19, #23, and #28). This resulted in a lack of timely repositioning and incontinence care for Resident #3; 10 sampled residents (#6, #7, #8, #9, #10, #11, #12, #19, #23, and #28) receiving five or fewer showers per month; and 3 residents (#1, #3, and #12) not receiving restorative services to	F 490			

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F 490	Continued From page 108 prevent a reduction in range-of-motion. 4. The facility failed to ensure previously cited deficient practices did not recur. Examples include: * F280 related to care plan revisions was cited at the time of the facility's 10/23/15 recertification survey, 1/28/16 follow up survey, and current 11/7/16 recertification survey. * F312 related to ADLs provided to dependent residents was cited at the time of the facility's 10/23/15 recertification survey, 1/28/16 follow up survey, and current 11/7/16 recertification survey. * F314 related to pressure ulcers was cited at the time of the facility's 10/23/15 recertification survey and current 11/7/16 recertification survey. * F318 related to ROM and restorative services was cited at the time of the facility's 10/23/15 recertification survey and current 11/7/16 recertification survey. * F323 related to accident hazards and supervision was cited at the time of the facility's 10/23/15 recertification survey and current 11/7/16 recertification survey. * F329 related to unnecessary drugs was cited at the time of the facility's 10/23/15 recertification survey and current 11/7/16 recertification survey. * F441 was cited at the time of the facility's 10/23/15 recertification survey, 1/28/16 follow up survey, and current 11/7/16 recertification survey.	F 490			

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C 762	<p>02.200,02,c,ii When Average Census 60-89 Residents</p> <p>ii. In SNFs with an average occupancy rate of sixty (60) to eighty-nine (89) patients/residents a registered professional nurse shall be on duty for each a.m. shift (approximately 7:00 a.m. - 3:00 p.m.) and p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) and no less than a licensed practical nurse on the night shift.</p> <p>This Rule is not met as evidenced by: Based on record review, it was determined the facility failed to ensure an RN was on duty for day shift and evening shift 7 days a week to provide care and treatment to residents. This was true for 1 of the 21 days reviewed. This affected 24 of 24 (#1-#24) sampled residents and all other residents in the facility. It created the potential for more than minimal harm if residents' nursing needs went unmet. Findings include:</p> <p>The facility's Three-Week Nursing Schedule between 10/9/16 and 10/29/16 documented there was no RN coverage on 10/23/16 from 6:00 pm to 10:00 pm for the census of 87.</p>	C 762	<p>Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Resident #24 is no longer at the facility Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; There are no other residents identified. Measures in place and systemic changes made to ensure that the deficient practice does not recur; Staffing coordinator has been in serviced on RN requirements at the facility. Any failure to this requirement will be brought to the DON's attention prior to the shift requiring RN coverage for corrections. Monitor performance to ensure the corrective actions are effective and compliance is sustained; DON will review staffing schedules for RN coverage daily at stand up to ensure compliance. Administrator will monitor staffing schedules to ensure RN coverage is in compliance. Audits will be performed daily for 30 days and weekly x2 months.</p>	1/23/17

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
12/27/16

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001350	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2016
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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814
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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) COMPLETE DATE
C 762	Continued From page 1	C 762	Date corrective action will be done and who is responsible to ensure compliance; _____ Administrator	
C 763	<p>02.200,02,c,iii When Average Census 90 or More</p> <p>iii. In SNFs with an average occupancy rate of ninety (90) or more patients/residents a registered professional nurse shall be on duty at all times.</p> <p>This Rule is not met as evidenced by: Based on record review, it was determined the facility failed to ensure an RN was on duty 24 hours a day 7 days a week to provide care and treatment to residents. This was true for 2 of the 21 days reviewed. This affected 24 of 24 (#1-#24) sampled residents and all other residents in the facility. It created the potential for more than minimal harm if resident's nursing needs went unmet. Findings included:</p> <p>The facility's Three-Week Nursing Schedule between 10/9/16 and 10/29/16 documented there was no RN coverage on 10/9/16 (census of 94) and 10/16/16 (census of 92) from 6:00 pm to 6:00 am.</p>	C 763	<p>Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Resident #24 is no longer at the facility Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; There are no other residents identified. Measures in place and systemic changes made to ensure that the deficient practice does not recur; Staffing coordinator has been in serviced on RN requirements at the facility. Any failure to this requirement will be brought to the DON's attention prior to the shift requiring RN coverage for corrections. Monitor performance to ensure the corrective actions are effective and compliance is sustained; DON will review staffing schedules for RN coverage daily at stand up to ensure compliance. Administrator will monitor staffing schedules to ensure RN coverage is in compliance. Audits will be performed daily for 30 days and weekly x2 months. Date corrective action will be done and</p>	1/23/17

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001350	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2016
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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CEN1	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814
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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) COMPLETE DATE
C 763	Continued From page 2	C 763	who is responsible to ensure compliance; _____ Administrator	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
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PHONE: (208) 334-6626
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E-mail: fsb@dhw.idaho.gov

April 21, 2017

Gary Liesner, Administrator
Lacrosse Health & Rehabilitation Center
210 West Lacrosse Avenue
Coeur d'Alene, ID 83814-2403

Provider #: 135042

Dear Mr. Liesner:

On **November 7, 2016**, an unannounced on-site complaint survey was conducted at Lacrosse Health & Rehabilitation Center. The complaint was investigated in conjunction with the facility's federal recertification and state licensure survey of October 31, 2016 through November 4, 2016.

Immediately upon entering the facility, the survey team conducted a general tour of residents' rooms and common areas. Throughout the survey, nineteen individual residents and all residents in general were observed for quality of life and quality of care concerns, as well as resident rights.

The facility's Grievance files from January 2016 to October 2016 were reviewed. The medication destruction logs from February 2016 through October were reviewed. The medication room was observed. The pharmacy receipts from January 2016 to March 2016 were reviewed. The admission packet was reviewed. The facility's policy and procedures for medications from an alternate pharmacy was reviewed.

The Director of Nursing was interviewed for concerns related to quality of care, quality of life and resident rights. Several staff members were interviewed for these same concerns.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007277

ALLEGATION #1:

The reporting party said an identified resident's admission and discharge process was "chaotic."

FINDINGS:

The identified resident was no longer residing in the facility at the time the complaint was investigated.

The clinical records of the identified resident were reviewed regarding the admission and discharge process and no concerns were identified. Three other residents were reviewed regarding the admission and discharge process and no concerns were identified. The admission agreement packet was reviewed and no concerns were identified.

The Director of Nursing said the identified resident's admission and discharge process was conducted appropriately.

Based on record review and interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

An identified resident brought medications from home to the facility, which were discovered missing at the time of discharge.

FINDINGS:

The medication storage room was observed for medications from an alternate pharmacy for residents and no concerns were identified. The nurses' medication carts were observed for medications from an alternate pharmacy and no concerns were identified.

The clinical records of the identified resident and three other discharged residents' records were reviewed for misplaced medications and no concerns were identified. The medication destruction logs were reviewed and no concerns were identified. The pharmacy receipts were reviewed and no concerns were identified.

Gary Liesner, Administrator
April 21, 2017
Page 3 of 3

The Director of Nursing said when families bring medications from an alternate pharmacy, staff instructs the family to take those medications home.

Based on observations, record reviews, and interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

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

DS/lj



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April 21, 2017

Gary Liesner, Administrator
Lacrosse Health & Rehabilitation Center
210 West Lacrosse Avenue
Coeur d'Alene, ID 83814-2403

Provider #: 135042

Dear Mr. Liesner:

On **November 7, 2016**, an unannounced on-site complaint survey was conducted at Lacrosse Health & Rehabilitation Center. The complaint was investigated in conjunction with the facility's federal recertification and state licensure survey October 31, 2016 through November 4, 2016.

Immediately after entering the facility, the survey team conducted a general tour of residents' rooms and common areas. Throughout the survey, nineteen individual residents and all residents in general were observed for quality of life and quality of care concerns, as well as resident rights.

The facility's Grievance files, shower logs, maintenance logs, Incident and Accident reports, and employee files for April 2016 through November 2016 were reviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007292

ALLEGATION #1:

An identified resident was unable to contact her family member because the Wi-Fi was not working.

FINDINGS:

The clinical record of the identified resident was reviewed. Nineteen other residents' records were reviewed for quality of life concerns. The facility's Grievance files from April 2016 to November 2016

were reviewed. Resident Council minutes from April 2016 to November 2016 were reviewed. Maintenance logs with IT support were reviewed from April 2016 to November 2016.

The Director of Nursing, Maintenance Manager, and Director of Operations were interviewed regarding quality of life and quality of care concerns, and resident rights.

Residents were observed communicating on the phone and using the Wi-Fi for their computers and smart phones.

The facility's Grievance files, maintenance logs, and Resident Council minutes were reviewed.

Residents were interviewed with no concerns identified.

The identified resident was no longer residing in the facility at the time the complaint was investigated.

Based on observation, record review, and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The identified resident and other residents are not receiving showers according to the care plan frequency.

FINDINGS:

Based on record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F312. Please refer to Federal Report 2567 for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

Residents are not having their bed linen changed routinely and as needed.

FINDINGS:

Nineteen individual residents and all residents in general were observed for dirty linens on beds.

The facility's Grievance files were reviewed from April 2016 through November 2016 and no concerns

Gary Liesner, Administrator
April 21, 2017
Page 3 of 4

were identified. The facility ' s policy and procedures for changing bed linens were reviewed and no concerns were identified.

Several staff members said the bed linens are changed twice a week and when needed.

The Director of Nursing said the bed linens are changed every scheduled shower day and when needed.

Based on observation, record review, and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

An identified resident complained of staff being rough with him/her during cares.

FINDINGS:

Based on record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F225 and F226.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

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

DS/lj



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April 21, 2017

Gary Liesner, Administrator
Lacrosse Health & Rehabilitation Center
210 West Lacrosse Avenue
Coeur d'Alene, ID 83814-2403

Provider #: 135042

Dear Mr. Liesner:

On **November 7, 2016**, an unannounced on-site complaint survey was conducted at Lacrosse Health & Rehabilitation Center. Eight surveyors conducted on-site complaint investigations at the facility from October 31, 2016 through November 4, 2016.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007395

ALLEGATION #1:

The facility failed to provide residents with personal care due to insufficient staffing.

FINDINGS:

Observations were conducted throughout the facility. Multiple interviews were conducted with residents, family members, and staff. Twenty-four residents were reviewed in the sample. There was no evidence to support the allegation.

Interviews with the Interim Administrator and scheduler determined staff from a temporary staffing agency or from one of the facility's sister facilities is utilized to cover staffing shortfalls.

The identified resident's clinical record did not include evidence of improper peri-care was performed or caused a Urinary Tract Infection as there were many other factors which may have also contributed to the development of the Urinary Tract Infection, including immobility, decreased fluid intake, numerous

Gary Liesner, Administrator
April 21, 2017
Page 2

medications, and terminal illness.

Although the allegation could not be substantiated for the resident named in the complaint, the allegation was substantiated for other residents in the sample. The facility failed to respond appropriately to the subject of the allegation and deficiencies were written.

The facility was cited with deficient practice F441, infection control. Please refer to the Federal 2567 Report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility failed to ensure residents' clothing was not misappropriated.

FINDINGS:

The grievance log during the previous six months documented the missing items were found, replaced, or reimbursed.

Interviews with other residents revealed no problem with missing items..

CONCLUSIONS:

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,

A handwritten signature in blue ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a clear "Scott" following.

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

Gary Liesner, Administrator
April 21, 2017
Page 3

DS/lj



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April 21, 2017

Gary Liesner, Administrator
Lacrosse Health & Rehabilitation Center
210 West Lacrosse Avenue
Coeur d'Alene, ID 83814-2403

Provider #: 135042

Dear Mr. Liesner:

On **November 7, 2016**, an unannounced on-site complaint survey was conducted at Lacrosse Health & Rehabilitation Center. Eight surveyors conducted an onsite complaint investigation at the facility from October 31, 2016 through November 4, 2016. Observations were conducted of pressure ulcers. Multiple interviews were conducted with residents, family members, and staff members. Twenty-four residents were reviewed in the sample.

The complaint allegations, findings and conclusions are as follows:

Complaint or Entity-Report Incident #ID00007400

ALLEGATION:

The facility failed to prevent the development of pressure ulcers.

FINDINGS:

The investigation determined the resident was admitted to the facility with pressure ulcers and refused care including tube feedings and incontinence care, pressure ulcer care, and repositioning. Although the allegation could not be substantiated for the resident named in the

Gary Liesner, Administrator
April 21, 2017
Page 2 of 5

complaint, the allegation was substantiated for other residents in the sample and deficiencies were written.

The facility was cited with deficient practice F 314 Pressure Ulcer Prevention and Treatment to promote healing of pressure ulcers. Please refer to the Federal 2567 Report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION#2:

The facility did not provide care and services for residents.

FINDINGS:

The investigation determined the clinical record did not include documentation that the resident ever stated he was going to die in the facility. The resident refused all care, including tube feedings, incontinent care, pressure ulcer treatments, and repositioning. The identified resident refused to go to the hospital when ordered to do so by the physician. The physician was updated on the resident's refusals and psychiatric services were initiated.

The allegation was not substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility failed to provide toileting/activities of daily living for residents.

FINDINGS:

The investigation determined the identified resident refused all care, including toileting and incontinence care. There was documentation in the clinical record documenting the resident was toileted. No concerns with the provision of toileting or other activities of daily living were identified through the clinical records, interviews, or observations of other residents included in the investigation. The allegation was not substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Residents are not provided with adequate hydration.

FINDINGS:

The investigation determined the resident had refused all care, including tube feedings and flushes of the G-tube. Review of the resident's weights indicated the resident had not sustained a weight loss. Review of the resident's laboratory results did not indicate dehydration. Other residents were observed for nutrition and hydration needs and no deficient practices were identified related to nutrition/hydration.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

Residents are not allowed to speak with physicians.

FINDINGS:

The clinical record contained documentation that physicians were notified of families' wishes to be called when warranted. According to a Nurse's Note, the physician stated he would call a family member. Interviews and record reviews did not indicate any deficient practices with the physician not speaking to a family when asked.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION#6:

Facility administration hung up on a resident's family member when they called.

FINDINGS:

The investigation determined a family member hung up the phone as facility staff held the receiver for an identified resident to take and speak with the family member. The family member did not understand that facility staff was holding the phone for the resident and the resident was having difficulty speaking. There was no indication of these kinds of difficulties with phone conversations during interviews and record reviews for other residents.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The facility failed to obtain a psychiatric evaluation for a resident when asked.

FINDINGS:

The investigation determined the resident received psychiatric services that had been physician ordered due to the resident's multiple and repeated refusal of all care, nutrition, and hydration. The resident refused to attend the first scheduled meeting with the outside psychiatric provider, but participated in subsequent appointments. There were no deficient practices noted for other residents in the sample related to receiving psychiatric services.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

The facility made no effort to assist the resident transfer to another facility.

FINDINGS:

The investigation determined there was no indication a family member requested the resident transfer to another facility. The facility received an order for the resident to be transferred to the hospital due to multiple and repeated refusals of care, hydration, and nutrition, but the resident refused to be transferred. No other related issues of concern were identified in other residents' clinical records.

Gary Liesner, Administrator
April 21, 2017
Page 5 of 5

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #9:

The facility failed to provide psychosocial care to an identified resident.

FINDINGS:

The investigation determined the resident had multiple and repeated refusals related to all care, nutrition, and hydration. The facility provided the resident with psychiatric services, but the resident continued to refuse care, nutrition, and hydration almost the entire length of her/his stay at the facility. The resident began accepting some care, nutrition, and hydration after family visited and a plan for discharging from the facility was completed.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

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

DS/lj