



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
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

December 9, 2016

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

Provider #: 135092

Dear Mr. Clark:

On **November 16, 2016**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **October 28, 2016**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- F0157 -- Notify Of Changes (injury/decline/room, Etc)**
- F0250 -- Provision Of Medically Related Social Service**
- F0309 -- Provide Care/services For Highest Well Being**
- F0323 -- Free Of Accident Hazards/supervision/devices**
- F0329 -- Drug Regimen Is Free From Unnecessary Drugs**
- F0520 -- Qaa Committee-Members/meet Quarterly/plans**
- F0201 -- Reasons For Transfer/discharge Of Resident**
- F0202 -- Documentation For Transfer/discharge Of Res**
- F0203 -- Notice Requirements Before Transfer/discharge**
- F0315 -- Catheter, Prevent Uti, Restore Bladder**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided

listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 19, 2016.**

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

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

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

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

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

Remick "Micky" Clark, Administrator
December 9, 2016
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As noted in the Bureau of Facility Standards' letter of **September 13, 2016**, following the survey of **August 16, 2016**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **February 12, 2017**, if substantial compliance is not achieved by that time. The findings of non-compliance on **November 16, 2016**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **August 26, 2016**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after November 16, 2016
- A civil money penalty

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

If you believe the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

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

Remick "Micky" Clark, Administrator
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This request must be received by **December 19, 2016**. If your request for informal dispute resolution is received after **December 19, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

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

David Scott, RN, Supervisor
Long Term Care

DS/lj

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

PRINTED: 01/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/16/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS The following deficiencies were cited during the on-site follow-up federal recertification survey conducted at the facility from November 14, 2016 to November 16, 2016. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Nina Sanderson, BSW, LSW Edith Cecil, RN Survey Definitions: CNA = Certified Nurse Aide COPD = Chronic Obstructive Pulmonary Disease DC = Discharge DNS = Director of Nursing Services d/t = Due to DX = Diagnosis E/B = Exhibited By IP = Interested Party LCSW = Licensed Clinical Social Worker LN = Licensed Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = Milligram NP = Nurse Practitioner r/t = related to SS = Social Services SSD = Social Services Director UA = Urinalysis	{F 000}			
{F 157} SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative	{F 157}		1/2/17	

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

TITLE

(X6) DATE

Electronically Signed

12/15/2016

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

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{F 157}	<p>Continued From page 1</p> <p>or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a resident and physician were informed of a significant change of status, and a physician was informed of a resident's change in condition. This was true for 2 of 8 sampled residents (#3 & #18). This failed practice had the potential for more</p>	{F 157}	<p>1. Resident # 3 physician was notified on 11/17/16 that 30 day notice was rescinded, care plan was updated and responsible party and resident notified on 11/14/16 that 30 day notice was rescinded.</p>		

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{F 157}	<p>Continued From page 2</p> <p>than minimal harm when the facility failed to involve or notify Resident #3 of the decision to discharge her, failed to notify Resident #3's physician of the resident's and Interested Party's resistance to the discharge, and failed to notify a physician of Resident #18's fall in the facility. Findings included:</p> <p>1. Resident #3 was admitted to the facility on 11/12/10 with multiple diagnoses, including schizoaffective disorder, depression, and delusions.</p> <p>The 10/6/16 quarterly MDS documented Resident #3 was independent for cognitive skills for daily decision making.</p> <p>a. Resident #3's 10/28/16 Social Service note documented: "Visited with [IP] regarding the continued possibility of res[ident] discharging to another facility. Visited with her about the option of [another facility] as they have a behavioral unit. [IP] stated, 'Absolutely not. I want her to stay at [the facility]. [Facility #2's Administrator]...highly suggested that we do not transfer her and statistics show that at her age people usually die 30 days after a transfer. So we are talking life and death here. I've talked to [Resident #3's Physician] and he is in agreement that [Resident #3] should not be transferred as it would be more detrimental for her.' Notified Administrator. Will continue working on discharge options for res." No documentation was found that the resident was notified of the decision to discharge her.</p> <p>b. Resident #3's 11/4/16 Physician's Order documented, "30 day discharge notice to be</p>	{F 157}	<p>Resident # 18 physician and family notified via telephone and documentation of response of second fall and change in condition on 11/16/16. Physician orders received for medication reduction.</p> <p>2. Residents who need Physician/family notification level have the potential to be affected by this practice.</p> <p>3. Root cause is a communication problem between physician and facility.</p> <p>Urgent medical issues will be called to the Physicians for immediate notification. Resident/Family/responsible party will also be notified of significant change in a timely manner.</p> <p>Licensed nursing staff and Physician's offices will be educated by the DNS or designee by 12/15/16 on the change in notification to Physician or on call Physician for after-hours urgent/immediate issues.</p> <p>4. HIM Director or designee will be responsible for the - Audits of notification and response by Physician that will occur weekly X 4, Monthly X 2, Quarterly X 3. All audit results will be reported to QAPI and Medical Director for further monitoring and modification based on finding.</p> <p>5. Compliance on or before 1/2/17. DNS will ensure compliance.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 157}	<p>Continued From page 3</p> <p>given for resident to DC to a long term care psychiatric hospital or care center, as this facility can no longer meet this resident's psychiatric needs."</p> <p>Resident #3's 11/9/16 Progress Note documented:</p> <p>"Administrator and LSW met with resident, [IP] and ombudsman to discuss res being given a 30 day discharge as facility is no longer able to meet res psychiatric needs. Res has continued to have distressed behavior including statements of being fearful and not feeling safe. Res sees [NP's office name] twice a month and a psychiatrist quarterly for her psychiatric needs which has proven to not be sufficient to meet her psychiatric needs. Discussed options in meeting as res physician stated that res needs to be discharged to a psychiatric hospital or long term care facility. [IP] has previously had [Facility #2] assess res and the [Facility #2] did not feel it would be an appropriate setting for res. Discussed [Facility #3] and [IP and Resident #3] stated they wanted to explore options, but were okay with res information being sent to [Facility #3] for review. Res and [IP] refused to sign 30 day discharge notice, but voice understanding that res would be discharged on or before 12/9/16. Physician's order in place and ombudsman notified. Care plan updated to reflect current discharge plan and res information sent to [Facility #3] for review." No documentation was found that the resident's physician was notified of the resident's resistance to the 30 day discharge notice.</p> <p>On 11/15/16 at 3:45 pm, the SSD said she did not inform Resident #3 of the impending involuntary discharge until she and the</p>	{F 157}			

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{F 157}	<p>Continued From page 4</p> <p>administrator presented the discharge letter to Resident #3 on 11/9/16, although the SSD knew about a possible discharge on 10/19/16. She said Resident #3's physician was not notified when the resident and the IP did not agree with the involuntary discharge.</p> <p>2. Resident #18 was admitted to the facility on 4/18/16 with diagnoses to include acute renal failure, UTI, dementia, and atrial fibrillation.</p> <p>On 11/8/16 at 1:30 am, an incident report documented Resident #18 fell in her room. Her blood pressure at the time of the fall was documented as 90/48. A "Fax Communication to Physician" form documented the fall and blood pressure reading, as well as information that the resident's blood pressure 30 minutes after the fall was 111/56. The physician signed that the information was received and "noted" on 11/8/16.</p> <p>On 11/8/16 at 12:25 pm, Resident #18's blood pressure was documented as 92/52. No further blood pressures were documented until 4:38 pm.</p> <p>An incident report for Resident #18 documented she fell on 11/8/16 at 4:30 pm. The resident was assessed with skin tears to her right hand and arm. The form documented Resident #18's family and physician were notified on 11/8/16 at 6:57 pm. There was no documentation of how the physician was notified (call, email, fax, etc.), or of the physician's acknowledgement or reponse to the notification. The incident report documented the resident's blood pressures would be faxed to the physician.</p>	{F 157}			

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{F 157}	Continued From page 5 On 11/8/16 at 4:38 pm, Resident #18's Nurse's Notes described the fall and injury, but did not document physician or family notification, acknowledgement, or response. The facility had no documentation the physician was informed of the continued low blood pressure readings until 11/9/16, when a "Fax Communication to Physician" form, marked as "urgent," notified the physician, "Resident [blood pressures] have been low," and requested the physician review the resident's medication orders. Resident #18's Nurse's Notes documented this communication at 10:37 am on 11/9/16, 33 hours after Resident #18's first fall, and 19 hours after the resident's second fall. F 201 SS=G 483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; The safety of individuals in the facility is endangered; The health of individuals in the facility would otherwise be endangered; The resident has failed, after reasonable and	{F 157}			
		F 201			1/2/17

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F 201	<p>Continued From page 6</p> <p>appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or</p> <p>The facility ceases to operate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure appropriate assessments were completed, or a new care plan was developed, prior to issuing a notice of involuntary discharge to a long-term resident. This was true for 1 of 1 resident (Resident #3) sampled for involuntary discharge. Resident #3 experienced psychosocial harm when she became apprehensive that the stress of being forced to move from her long-time home in the facility would hasten her demise. Findings included:</p> <p>Resident #3 was admitted to the facility on 11/12/10, and had resided in the facility since that time except for a hospitalization between 3/27/16 and 4/8/16, with diagnoses of schizoaffective disorder, depression, and delusions.</p> <p>The most recent quarterly MDS, dated 10/6/16, documented Resident #3 was independent in daily decision making, had minimal depression, displayed hallucinations and delusions, and rejected care 1 to 3 days of the 14-day assessment period.</p>	F 201	<ol style="list-style-type: none"> 1. Resident # 3 <input type="checkbox"/> Discharge was rescinded 11/14/16. Psychiatrist evaluated resident 11/15/16. Care plan was updated to include interventions based on evaluation. Resident continues to receive counseling and psychiatrist services. Physician was notified on 11/17/16 of 30 day notice being rescinded. 2. Residents who require transfer or discharge have the potential to be affected by this practice. 3. Root cause of issue is misunderstanding of involuntary discharge process. <p>Admission/transfer/discharge team will review potential involuntary discharges prior to issuing notice.</p> <p>Administrator, Social Services, and Director of Nursing were re-educated on regulatory requirements of involuntary discharge on 12/16/16.</p>		

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F 201	<p>Continued From page 7</p> <p>Resident #3's behavior monitors for October 2016 documented target behaviors of hallucinations, resistance to care, "excessive call light use," and suicidal ideation. The monitors documented hallucinations were present on 4 of 36 shifts between 10/1/16 and 10/18/16. No other target behaviors were documented on the behavior monitors for those dates.</p> <p>On 10/19/16, a Psychotropic Medication Review form documented Resident #3 had no episodes of refusing care, "repeated use of call light," or suicidal ideation/self-harm. The form documented 6 episodes of "hallucinations people are going to harm her." The form documented recommendations of a psychiatric re-evaluation of her medications related to increased behaviors, and to seek alternative placement to meet her psychiatric needs.</p> <p>Resident #3's Progress Notes documented episodes of altered thought processes on 10/19/16 and 10/22/16. In both instances the notes documented Resident #3 was easily assured of her safety with interventions from staff.</p> <p>On 10/28/16 at 5:53 pm, Resident #3's Progress Notes documented the LSW talked with Resident #3's family about transferring the resident to another facility. The note documented the family's response as, "...Absolutely not. I want her to stay at [this facility]. [Facility #2's Administrator] highly suggested that we do not transfer her and statistics show that at her age people usually die within 30 days after a transfer. So we are talking life and death here. And I've talked to [Resident #3's physician] and he is in</p>	F 201	<p>4. Audits by Quality Coordinator or designee of Involuntary Discharge Paperwork will occur as circumstances arise prior to being given to resident or responsible party. Audits will be completed Weekly X4, Monthly X2, and Quarterly X3. All audit results will be reported to QAPI for further monitoring and modification based on finding.</p> <p>5. Compliance on or before 1/2/17. Administrator will ensure compliance.</p>		

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F 201	<p>Continued From page 8</p> <p>agreement that [Resident #3] should not be transferred as it would be more detrimental for her.' Notified administrator. Will continue working on discharge options for [Resident #3]."</p> <p>On 11/4/16 at 12:38 pm, Resident #3's record documented a "verbal" communication with her primary care physician. The communication documented, in its entirety, "30 day discharge notice to be given for resident to [discharge] to a long-term psychiatric hospital or care center, as the facility can no longer meet the resident's psychiatric needs." The verbal communication form was signed by the physician. There was no further assessment from Resident #3's physician, and no assessment from a psychiatrist regarding unmet psychiatric needs. There was no documentation of recent behavioral changes for Resident #3, assessment of the root cause of those changes, or care plan updates regarding behavioral changes or unmet psychiatric needs.</p> <p>On 11/7/16, Resident #3's Individual Therapy progress note documented she was cooperative with an appropriate affect and pleasant mood. Her thought processes were documented as intact and her thought content was documented as non-psychotic. Active symptoms were documented as, "Doing well at this time."</p> <p>On 11/9/16, a "Notification of Transfer or Discharge" form in Resident #3's record documented the resident would be discharged on 12/9/16 as the facility was "unable to meet psychiatric needs." The form provided boxes for the resident to check she would either agree to move and waive her right to 30 day notice, or she requested the full notice period before the move</p>	F 201			

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F 201	<p>Continued From page 9</p> <p>occured. The box next to the request for the full notice period was checked. The spaces for the resident's signature, resident's representative's signature, and employee signature were all blank.</p> <p>On 11/14/16, an Individual Therapy progress Note documented Resident #3 "told me that a resident 'pulled my leg last night.'" The note documented the resident "...appeared to be confused and afraid. Talked [with] Social Services [and] reported my findings. [Resident #3] has received a 30 day notice to find a facility that can adequately meet her needs. She noted her leg hurt." The note documented her attitude as cooperative, her affect flat, her mood "fatigued," her thought process "obsessive," and her thought content "bizarre." Active symptoms were documented as "psychosis, anxiety, and depression."</p> <p>On 11/15/16 at noon, Resident #3's IP stated the facility presented the 30 day discharge notice during a care conference on 11/9/16. The IP stated the facility previously broached the topic of an involuntary discharge with family, but it was not clear why the resident could not remain at the facility. The IP stated the facility previously asked a long-term psychiatric facility to assess the resident for admission, but it had declined to admit the resident as she was behaviorally stable. The IP stated the facility's LSW informed the family the discharge was necessary because the resident at times made allegations of abuse, and the facility did not have enough staff to investigate them; the Administrator confirmed that statement. The IP stated Resident #3's family was concerned because the resident had</p>	F 201			

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F 201	<p>Continued From page 10</p> <p>lived in the facility for a number of years, considered the facility her home, and being forced to change residences at this stage in her life could "kill her." The IP stated Resident #3 had seen her psychiatrist that morning and the psychiatrist told Resident #3 and the IP that the resident was appropriately placed in the current facility and did not need placement with additional psychiatric support.</p> <p>The facility documented no allegations of abuse from Resident #3 between 10/28/16 and 11/14/16. One allegation was reported on 11/14/16.</p> <p>On 11/15/16 at 1:40 pm, LN # 1 stated she had worked at the facility for approximately 4 years, and had cared for Resident #3 during that time. LN # 1 stated Resident #3 had no recent behavioral changes that she noticed, and was "at baseline."</p> <p>On 11/15/16 at 2:45 pm, Resident #3 was observed sitting in a wheelchair in her room. Resident #3 was facing her over bed table, with a letter from the facility rescinding the 30 day discharge notice, dated 11/14/16, on top of a stack of books. Resident #3 discussed the books she was currently reading and stated she had lived at the facility for "a long time." Resident #3 stated she had previously been in a different "retirement home," but realized she needed more help. Resident #3 stated she suffered from "bladder cancer, Alzheimer's, and that other disease," pointing to her head. Resident #3 stated, "I had to consider where I wanted to spend the rest of my days." Resident #3 stated she and her family "surveyed" all of the nursing</p>	F 201			

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

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F 201	<p>Continued From page 11</p> <p>homes in the area, and selected this particular facility as her "final residence." Resident #3 reported she was happy and content with her choice, but recently the facility had given her "some trouble about staying because of my other disease," again pointing to her head. Resident #3 stated, "I don't want to move. It will kill me."</p> <p>On 11/15/16 at 3:45 pm, the LSW stated the facility issued the involuntary discharge notice on 11/9/16 at a care conference, with Resident #3, her family, and the Ombudsman present. The LSW stated the facility issued the notice due to "more frequent statements that she is not feeling safe," which she said indicated the facility was unable to meet Resident #3's psychiatric needs. The LSW was unable to show evidence through nursing, social services, or physician documentation of behavioral increases prior to the notice being served. The LSW stated the facility was "still developing a baseline" for Resident #3's normal behaviors. The LSW stated the facility had not worked with Resident #3's psychiatrist to develop thresholds of behaviors related to the resident's mental illness; how many of those behaviors were typical for the resident; or how the facility could determine when the number or persistence of the behaviors indicated the resident was psychiatrically unstable. The LSW stated the resident had not been seen by a psychiatrist since August 2016, at which time the psychiatrist indicated Resident #3 would need to be seen on an outpatient basis once every three months. The LSW stated she called the psychiatrist's office on 11/2/16 to make a quarterly appointment for Resident #3, but the office had not called back by 11/3/16, so the facility decided to proceed with the involuntary</p>	F 201			

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F 201	<p>Continued From page 12</p> <p>discharge based on the lack of response from the psychiatrist's office. The LSW stated the psychiatrist had not been involved with the determination of unmet psychiatric needs in the facility. The LSW stated she had not assessed the resident prior to initiation of the discharge notice because "her daughter didn't want me to." The LSW stated the psychiatrist's office called back on 11/5/16 to schedule an appointment for Resident #3, and the appointment had taken place earlier that day.</p> <p>On 11/16/15 at 9:15 am, the Administrator stated the facility issued the involuntary discharge letter to Resident #3 due to "statements of fear." The Administrator said the statements occurred "all the time" and were "increasing." The Administrator stated the statements were documented in Resident #3's Social Services notes, Nursing Notes, and Behavior Monitors. When informed of the lack of documentation in those areas of Resident #3's record, the Administrator stated, "Well, you [the State Agency] gave us an [Immediate Jeopardy] on her during the first survey [August 2016]." The Administrator stated the facility requested a long-term psychiatric facility evaluate Resident #3 for possible admission "and they said she would not fit in with their population." The Administrator stated after the facility spoke with Resident #3's family and discovered their opposition to that transfer, the facility identified a second discharge location, and issued an involuntary notice so the resident could have her psychiatric needs met.</p> <p>Please see F157 as it pertains to physician notification, and F250 as it pertains to the</p>	F 201			

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F 201	Continued From page 13 provision of Social Services for Resident #3. Resident # 3 was harmed when she experienced fear that an involuntary discharge notice would result in her premature demise. The facility documented the discharge was necessary due to "unmet psychiatric need," however the physician documented an awareness the facility intended to issue the discharge notice, but did not document an assessment to evaluate the nature or extent of Resident #3's alleged behavioral changes, or to rule out possible medical factors underlying those changes. Resident #3 had was not assessed by either her psychiatrist or the facility LSW before the discharge notice was issued, and no new care plan interventions were developed and implemented in an effort to avoid the discharge.	F 201			
F 202 SS=D	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure Resident	F 202	1. Resident # 3 was included in discussions of her care and/or plans for	1/2/17	

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F 202	<p>Continued From page 14</p> <p>#3's physician had assessed Resident #3 to be a danger to herself or others, or had improved and no longer needed nursing home level of care, and transfer or discharge was medically appropriate. a resident's physician assessed a reported change in a resident's condition prior to the facility issuing a notice of involuntary discharge. This was true for 1 of 1 resident (Resident #3) sampled for involuntary discharge. The deficient practice had the potential for harm to residents discharged without first receiving a physician's assessment that the facility could no longer provide for their needs. Findings included:</p> <p>Resident #3 was admitted to the facility on 11/12/10, and had resided in the facility since that time except for a brief hospitalization in March-April 2016, with diagnoses of schizoaffective disorder, depression, and delusions.</p> <p>On 11/4/16 at 12:38 pm, Resident #3's record documented a "verbal" communication with her primary care physician that documented, "30 day discharge notice to be given for resident to [discharge] to a long-term psychiatric hospital or care center, as the facility can no longer meet the resident's psychiatric needs." The form was signed by Resident #3's physician, but no further assessment from the physician was documented.</p> <p>On 11/9/16, a "Notification of Transfer or Discharge" form in Resident #3's record documented the resident would be discharged on 12/9/16 as the facility was "unable to meet psychiatric needs." The form was not signed by the resident's physician.</p>	F 202	<p>discharge on 11/14/16. Documentation shows Involuntary discharge was rescinded on 11/14/16. Psychiatrist documentation received 11/21/16 stated continuation of present plan of care. Primary care physician updated on 11/17/16 regarding the rescinding of the involuntary discharge.</p> <p>2. Residents who require documentation of involuntary transfer/discharge have the potential to be affected by this practice.</p> <p>3. Root cause of issue is that there was a gap in communication to determine the need for an involuntary transfer/discharge of a resident.</p> <p>Admission/transfer/discharge team will review potential involuntary discharges prior to issuing notice.</p> <p>Administrator, Social Services, and Director of Nursing were re-educated on regulatory requirements of involuntary discharge documentation on 12/16/16.</p> <p>4. HIM director or designee will Audit Involuntary discharge documentation. Weekly X 4, Monthly X 2, Quarterly X 3. All audit results will be reported to QAPI for further monitoring and modification based on finding.</p> <p>5. Compliance on or before 1/2/17. Administrator will ensure compliance.</p>		

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F 202	Continued From page 15 On 11/15/16 at noon, Resident #3's IP stated the facility presented the resident with a 30 day discharge notice during an 11/9/16 care conference. On 11/15/16 at 3:45 pm, the LSW stated the facility issued the involuntary discharge notice to Resident #3 on 11/9/16 at a care conference with Resident #3, her family, and the Ombudsman present. The LSW was unable to show evidence through nursing, social services, or physician documentation of behavioral increases prior to the notice being served.	F 202			
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more	F 203		1/2/17	

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F 203	<p>Continued From page 16</p> <p>immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to ensure all necessary content was included in a notice of involuntary discharge. This was true for 1 of 1 residents (Resident #3) sampled for involuntary discharge. The deficient practice created the potential for harm if Resident #3 was unable to file an appeal of the notice or contact pertinent advocacy groups. Findings included:</p>	F 203	<ol style="list-style-type: none"> 1. Resident # 3 <input type="checkbox"/> the notice of discharge was rescinded on 11/14/16. 2. Residents who require notice of involuntary transfer/discharge have the potential to be affected by this practice. 3. Root cause of issue is misunderstanding of involuntary 		

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F 203	Continued From page 17 BFS Informational Letter # 2014-02 documented the state-specific contact information required in an involuntary discharge notice included the Idaho state long-term care ombudsman and the advocacy group for individuals with mental illness. Resident #3 was admitted to the facility on 11/12/10, and resided in the facility since that time except for a brief hospitalization earlier in the year, with diagnoses of schizoaffective disorder, depression, and delusions. On 11/9/16, a "Notification of Transfer or Discharge" form in Resident #3's record documented the resident would be discharged on 12/9/16 as the facility was "unable to meet psychiatric needs." The area on the form to document the contact information for the State long-term care ombudsman contained the name, address, and telephone number for the local ombudsman, but not the contact information for the State ombudsman. The notice did not include documentation of the contact information for the designated advocacy group for individuals with mental illness, or the information the resident would need to file an appeal of the notice. On 11/16/15 at 10:15 am, the Administrator stated he had reviewed the notice of discharge and believed it to meet all requirements, except for listing the contact information for the advocacy group for individuals with mental illness.	F 203	transfer/discharge process. Including notification of the State Ombudsman and the Advocacy Groups for Individuals with Mental Illness and the information the resident would need to file an appeal. Discharge/transfer form will be amended to include State Ombudsman and the Advocacy Groups for Individuals with Mental Illness and the information the resident would need to file an appeal. Admission/transfer/discharge team will review form prior to any transfer/discharge. Administrator/Social Services/DNS will be educated on changes to this process on 12/16/16. 4. HIM Director or designee will Audit Involuntary Transfer/discharge forms prior to being given to Resident/family/responsible party. Weekly X 4, Monthly X 2, Quarterly X 3. All audit results will be reported to QAPI for further monitoring and modification based on finding. 5. Compliance on or before 1/2/17. Administrator will ensure compliance.	1/2/17	
{F 250} SS=G	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	{F 250}			

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{F 250}	<p>Continued From page 18</p> <p>The facility must provide medically-related social services 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 record review and resident, interested party and staff interview, it was determined the facility failed to provide medically related social services when it failed to provide support for a resident during the process of discharging her from her home of 16 years. This was true for 1 of 8 (#3) sample residents. Resident #3 sustained psychosocial harm when she felt fearful the move would lead to her demise after she was presented with an involuntary discharge notice without social services support or involvement prior to or after the notification was given. Findings included:</p> <p>Resident #3 was admitted to the facility on 11/12/10 with multiple diagnoses, including schizoaffective disorder, depression and delusions.</p> <p>The 10/6/16 quarterly MDS documented Resident #3 was independent for cognitive skills for daily decision making.</p> <p>Resident #3's October and November 2016 MARs documented 9/23/16 as the initiation of tracking the behaviors of "people going to harm her" and "suicidal ideation/self harm." The October MAR documented the resident had four hallucinations "of people going to harm her" and</p>	{F 250}	<ol style="list-style-type: none"> 1. Resident # 3 involuntary discharge was rescinded on 11/14/16. Rescinded discharge was discussed with resident and daughter on 11/14/16, noted in resident's medical record and care plan updated on 11/17/16. 2. Residents who may need involuntary transfer/discharge have the potential to be affected by this practice. 3. Root cause of issue is misunderstanding of required support needed by social services in setting prior to and after a potential involuntary transfer/discharge. <p>Social Services Director was re-educated on requirements of support needed prior to discharge. Social Services Director and Administrator will review documentation prior to discharge.</p> <p>The administrator has hired an outside MSW mentor, to evaluate the current processes of medically related social services. MSW arrived 11/29/16.</p> <p>Social Services Director will be provided</p>		

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{F 250}	<p>Continued From page 19</p> <p>no incidents of "suicidal ideation/self harm." The MAR from 11/1/16 to 11/14/16 documented the resident had no hallucinations and no incidents of suicidal ideation.</p> <p>Resident #3's care plan documented on 9/30/16 a focus of "[Resident #3] has ... hallucinations of people going to harm her and suicidal ideation/self harm" and a goal of "[Resident #3] will have less than daily episodes of target behaviors by review date." Revised interventions dated 10/11/16 included, "Reassure that no one will be allowed to harm her and Safety checks, notify Administer/DNS/SS immediately if talking about suicide."</p> <p>Resident #3's NP, LCSW and progress notes (PN) documented: * 10/11/16-(NP) - "She reports that she feels safe here." * 10/13/16-(NP) - "She reports that she feels unsafe here ... She continues to feel that several men are going to drag her out and stomp on her until she is dead." * 10/17/16-(LCSW) - "She has been treated well in the facility ... She was not suicidal [and] did not talk of recent harm from anyone." * 10/17/16-(PN) - "...Doing really good today. Happy with family and facility." * 10/19/16-(PN) - "... resident ... stating 'there [sic] going to feed me to the wolves' and wheeling herself to the front door. 1 [on] 1 and reassurance voiced by nursing staff which calms resident down some ... resident expressed that cops came in and killed the man in charge of this place ... CNA once again assured her and was able to calm her down."</p>	{F 250}	<p>with guidance and education by outside MSW mentor to ensure involvement and support is provided to residents prior to and during discharge.</p> <p>4. HIM director or designee will complete an Audit for psychiatric evaluation/assessments, and social service involvement progress notes. Weekly X 4, Monthly X 2, Quarterly X 3. All audit results will be reported to QAPI for further monitoring and modification based on finding.</p> <p>5. Compliance on or before 1/2/17. Administrator will ensure compliance.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/16/2016
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{F 250}	<p>Continued From page 20</p> <p>Resident #3's 10/19/16 Psychotropic Medication Review documented, "Just started tracking this specific behavior," and included the resident had six episodes of hallucinations of "people are going to harm her." "Previous" committee "Recommendations" included, "Behaviors have improved; duplicate antipsychotic therapy has improved symptoms." Under "new recommendations," the committee documented, "Psychiatrist to re-evaluate her medications r/t increased behaviors. Seek alternative placement to meet her psychiatric needs." The form was signed by the physician on 10/24/16 and documented he agreed to the recommendation.</p> <p>Resident #3's NP, LCSW, PN, Social Services (SS) note, fax communication to the physician, physician visit notes and physician orders documented:</p> <p>* 10/22/16-(PN) - "Resident came to the nurse's station and saw the computer monitor with the cameras on it. She said that they were watching her with the camera to know when to attack. Staff reassured resident that she was safe and moved her to a different location ... Resident then voiced that she feels safe and isn't worried about anything here." Note: The computer monitor had a web camera on top of the screen and did not point outside of the enclosed nurses' station.</p> <p>* 10/26/16-(NP) - "She feels it is a good home and that she is treated well. She reports that 'they still tell me they are going to take me out and jump on me until I'm dead' but is not able to identify who 'they' are."</p> <p>* 10/26/16-(Fax to Physician) - Documented the computer monitor incident on 10/22/16 and the physician documented a response on 10/28/16 of "Noted."</p>	{F 250}			

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{F 250}	Continued From page 21 * 10/27/16-(Physician note) - "She is reported to have had frequent use of the call light. She still has paranoid ideation and has reported to the nurses that there are people out to get her, etc. Today, however, she is more calm and does not express any of those ideas to me in person..." * 10/28/16-(SS) - "Visited with [IP] regarding the continued possibility of res[ident] discharging to another facility. Visited with her about the option of [another facility] as they have a behavioral unit. [IP] stated, 'Absolutely not. I want her to stay at [the facility]. [Facility #2's Administrator] ... highly suggested that we do not transfer her and statistics show that at her age people usually die 30 days after a transfer. So we are talking life and death here. I've talked to [Resident #3's physician] and he is in agreement that [Resident #3] should not be transferred as it would be more detrimental for her.' Notified Administrator. Will continue working on discharge options for res." * 10/31/16-(LCSW) - "She did not appear suicidal." * 11/1/16-(SS) - "Left message with [psychiatrist] regarding scheduling res quarterly appointment with psychiatrist." * 11/2/16-(SS) - "Left 2nd message with [psychiatrist] to schedule res quarterly psychiatrist appointment." * 11/4/16-(NP) - "RN and LSW had conversation with [Resident #3's physician] regarding resident's need for 30 day DC notice d/t facility no longer able to meet residents psychiatric needs. Discussed with doctor resident's recent hallucinations, and delusions which make resident feel fearful and unsafe, as well as the psychiatrist not returning facility phone calls to schedule quarterly appointments which contributes to the facility being able to meet her	{F 250}			

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{F 250}	<p>Continued From page 22</p> <p>needs. [Resident #3's physician] state that he supported the 30 day DC as long as the resident would be placed in a psychiatric long term care hospital or care facility."</p> <p>* 11/4/16-(Verbal Physician order) - "30 day discharge notice to be given for resident to DC to a long term care psychiatric hospital or care center, as this facility can no longer meet this resident's psychiatric needs."</p> <p>* 11/7/16-(PN) - "Spoke with [psychiatrist] regarding res quarterly appointment. Scheduled an appointment for res on November 15th ... Left message with res [IP]."</p> <p>* 11/7/16-(LCSW) - "[Resident #3] said that she has felt good ... She noted to feel like she is doing well with her moods."</p> <p>* 11/8/16-(SS) - "Meeting scheduled to meet with [Resident #3's family member], res, and ombudsman for 30 day discharge notice tomorrow ..."</p> <p>* 11/9/16-(PN) - "Laundry Supervisor reported to the administrator ... resident stated that she thinks 'they are going to throw me off the grand' ... reassured resident she was safe ..."</p> <p>* 11/9/16-(PN) - "Administrator and LSW met with resident, [IP] and ombudsman to discuss res being given a 30 day discharge as facility is no longer able to meet res psychiatric needs. Res has continued to have distressed behavior including statements of being fearful and not feeling safe. Res sees [Name of NP's office] twice a month and a psychiatrist quarterly for her psychiatric needs which has proven to not be sufficient to meet her psychiatric needs. Discussed options in meeting as res physician stated that res needs to be discharged to a psychiatric hospital or long term care facility. [IP] has previously had [Facility #2] assess res and</p>	{F 250}			

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{F 250}	<p>Continued From page 23</p> <p>[Facility #2] did not feel it would be an appropriate setting for res. Discussed [Facility #3] and [IP and Resident #3] stated they wanted to explore options, but were okay with res information being sent to [Facility #3] for review. Res and [IP] refused to sign 30 day discharge notice, but voice understanding that res would be discharged on or before 12/9/16. Physician's order in place and ombudsman notified. Care plan updated to reflect current discharge plan and res information sent to [Facility #3] for review."</p> <p>* 11/14/16-(LCSW) - "We talked of her being safe. She said she does not feel safe. [Resident #3] appeared to be confused [and] afraid ... talked with social services [and] reported my findings. [Resident #3] has received a 30 day notice to find a facility that can adequately meet her needs. She reported her leg hurt ... appearing ... depressed w[ith] more anxiety."</p> <p>There were no notes documenting Social Services was involved with notifying the resident of the impending discharge, alternative options for placement, advocacy on behalf of the resident regarding discharge, arrangement of a psychiatric assessment prior to the discharge notice, and psychological or emotional support after the notice was delivered to the resident.</p> <p>On 11/15/16 at 12:30 pm, the IP said the resident had been at the facility for years and feared if the resident was moved to another facility the resident would die. She said the facility had been in trouble with a recent state survey regarding the resident and she was told by the SSD that it took a lot of time to complete abuse investigations whenever Resident #3 alleged potential abuse,</p>	{F 250}			

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{F 250}	<p>Continued From page 24</p> <p>however most of the allegations were her normal repetitive allegations and those allegations did not warrant an investigation. She also said the SSD told her there would be better psychiatric support for the resident at a different facility. She said the Administrator told her the facility did not have enough staff to take care of Resident #3's psychiatric needs.</p> <p>On 11/15/16 at 2:45 pm, Resident #3 said, "I don't want to move. It will kill me."</p> <p>On 11/15/16 at 3:45 pm, the SSD said Resident #3's behavior monitoring began on 9/23/16 and the facility had been in the process of establishing a baseline for the resident's behaviors. She reviewed the 10/19/16 Psychotropic Medication Review and said the facility had not set a threshold on how many behavioral episodes would constitute the need for increased psychiatric supervision. She said she and the administrator worked on the discharge notice letter together. She said she felt the facility could not meet Resident #3's psychiatric needs and needed to be discharged, but had not arranged for a psychiatric assessment to determine the discharge need. She said she was aware Facility #3's behavior unit was a men's only unit, but noted the facility would probably have better psychiatric support in general for Resident #3's psychiatric disorders. She said she did not inform Resident #3 of the impending involuntary discharge until she and the administrator presented the discharge letter to Resident #3 on 11/9/16, although the SSD knew about a possible discharge on 10/19/16. She said her role was to advocate for the resident and stated she did not follow-up with the</p>	{F 250}			

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{F 250}	Continued From page 25 resident to determine if the resident understood the discharge letter or to offer support after the letter was presented. She said she had not asked Resident #3 if she wanted to move to another facility. On 11/16/16 at 10:15 am, the Administrator said the information he received from Social Services indicated the facility could not meet Resident #3's psychiatric needs and the facility relied on psychiatric professionals to help make those decisions. He said he was not aware Facility #3's behavioral unit was a men's only unit. He said he was responsible for oversight of the facility's Social Service department. Social Services did not have sufficient information regarding Resident #3's behavioral status, did not arrange a psychiatric assessment prior to the decision of an involuntary discharge for the resident, did not involve- or inform the resident of the potential involuntary discharge, did not advocate for Resident #3's rights to stay in the facility, and did not offer emotional or psychosocial support after the discharge notice was presented. Resident #3 sustained psychosocial harm when she experienced increased anxiety and depression, and feared the move would "kill" her.	{F 250}			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315			1/2/17

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F 315	<p>Continued From page 26</p> <p>who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure toileting programs to maintain or restore urinary continence. This was true for 1 of 6 residents (Resident #18) sampled for incontinence. The deficient practice created the potential for harm when a resident fell after becoming incontinent. Findings included:</p> <p>Resident #18 was admitted to the facility on 4/18/16 with diagnoses that include acute renal failure, UTI, dementia, and atrial fibrillation.</p> <p>The most recent Quarterly MDS assessment, dated 10/21/16, documented Resident #18 was moderately cognitively impaired, required extensive assistance of one staff for transfers and hygiene, and supervision for toileting. The MDS documented Resident #18 needed physical assistance from staff for stability when moving from a seated to a standing position, and was occasionally incontinent of bladder with no toileting plan attempted or in place.</p> <p>The care plan from 8/2/16 to 11/8/16 documented Resident #18 required one staff assistance for toileting. On 11/8/16, Resident #8's care plan was updated to include, "Assist to toilet [every 3 hours] while awake."</p>	F 315	<ol style="list-style-type: none"> 1. Resident # 18 Resident passed away 12/10/16. 2. Residents who have had a catheter removed have the potential to be affected by this practice. 3. Root cause of issue was gap in the process for assessing residents after catheter removal. Residents that have a catheter removed will be re-assessed for individualized toileting retraining program to restore bladder function/continence based on the assessment. DNS or designee will educate licensed staff on the requirement of assessment and the creation of individualized toileting retraining programs by 12/15/16. 4. MDS Coordinator or designee will complete Audits of Residents that have had catheters removed to ensure assessments are completed and individualized plans are in place. Weekly X 4, Monthly X 2, Quarterly X 3. All audit results will be reported to QAPI for further monitoring and modification based on 	

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F 315	<p>Continued From page 27</p> <p>A bladder assessment completed on 4/21/16 documented Resident # 18 had an indwelling catheter.</p> <p>On 11/8/16 at 1:30 am, a Fall Scene Huddle Worksheet documented Resident #18 fell in her room after an incontinent episode.</p> <p>On 11/9/16 at 2:12 am, Resident #18's Nurse's Notes documented, "Resident has been having increased number of incontinent episodes, CNA charting states: 'toileting program implemented.'" There was no further assessment documented.</p> <p>On 11/14/16 at 5:10 pm, Resident #18 was in her bed, asleep. There was a strong urine odor in the room, which became faint in the hallway outside the resident's room. This was noted again at 5:25 pm and 5:37 pm.</p> <p>On 11/15/16 at 8:02 am, a faint urine odor was noted in the hallway outside Resident #18's room. The odor was strong inside the room. Resident #18 was not in the room, however linens and bedding had been stripped from the mattress and were piled at the foot of her bed. At 9:55 am, Resident #18's bed was made and the soiled bedding removed from her room. Resident #18 was observed asleep in bed on her right side. No urine odor was detected in the room.</p> <p>On 11/15/16 at 10:00 am, CNA #1 stated Resident #18 would "sometimes" take herself to the toilet, but at other times needed help. CNA #1 stated, "Lately [Resident #18] has been more dependent" for toilet use. CNA #1 referred to a paper s/he pulled from his/her pocket when asked about Resident #18's toileting plan, then</p>	F 315	<p>finding.</p> <p>5. Compliance on or before 1/2/17. DNS will ensure compliance.</p>		

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F 315	<p>Continued From page 28</p> <p>stated, "I guess she's not on one." CNA #1 stated if Resident #18 had not taken herself to the toilet, staff were to take her every two hours. CNA #1 stated staff determined if Resident #18 had taken herself to the toilet by asking her if she had self-toileted. CNA #1 stated the 2 hour interval was based on "just standard, what we usually do," and was not individualized for Resident #18. CNA #1 stated Resident #1 had mixed episodes of continence and incontinence.</p> <p>On 11/16/16 at 9:30 am, the MDS nurse stated the facility did not have a structured bladder retraining program, but was planning to initiate a program soon. The MDS nurse stated Resident #18 had been admitted to the facility with a catheter in April 2016, which was when the resident's bladder assessment was completed. The MDS nurse stated the catheter was discontinued a few days after the resident's admission, as there was no clinical indication to continue its use. The MDS nurse stated Resident #18's bladder assessment should have been repeated when the catheter was removed and with any change in condition. The DNS stated the facility had initiated a "every 3 hour" toileting program following Resident #18's falls on 11/8/16 by reviewing the previous two weeks of toileting times documented by CNAs. The DNS stated, "Sometimes she went every 2 hours, sometimes not for 4 or 5. [Resident #18] was sometimes continent, sometimes not. Three hours seemed about average." The DNS was unable to explain how an individualized toileting program had been developed to restore bladder continence based on the data she used. The DNS stated the facility had no further nursing assessment regarding the "incontinent program" initiated by the CNAs.</p>	F 315			

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{F 323} SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</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 observation, staff interview, and record review, it was determined the facility failed to provide adequate supervision and a safe environment to prevent falls. This was true for 1 of 4 residents (Resident #18) sampled for falls. The deficient practice had the potential for harm if Resident #18 sustained an injury as a result of a fall. Findings included:</p> <p>Resident #18 was admitted to the facility on 4/18/16 with diagnoses of acute renal failure, UTI, atrial fibrillation, dementia, COPD, and Type II diabetes mellitus.</p> <p>The most recent quarterly MDS, dated 10/21/16, documented Resident #18 was moderately cognitively impaired, required extensive assistance of 1 staff for transfers, dressing, and hygiene; and was occasionally incontinent of bowel and bladder. The MDS documented Resident #18's balance was not steady, and she needed physical assistance from staff to stabilize while moving from a seated to standing position and surface-to-surface transfers.</p>	{F 323}	<ol style="list-style-type: none"> 1. Resident # 18 passed away on 12/10/16. 2. Residents who need supervision and a safe environment have the potential to be affected by this practice. 3. Root cause of issue implemented interventions but needed to investigate for further medical underlying causes. System change put in place includes Falls committee will meet on all new admissions and after falls to identify root cause, risk factors and to rule out medical issues that could contribute to a fall. Staff education will occur on 12/15/16 at all staff and will include information on safety hazards, communication, and change in resident status. 4. Environmental Services Director or designee will be responsible for Audits of Accidents/Supervision/device. Weekly X 	1/2/17	

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{F 323}	<p>Continued From page 30</p> <p>The falls care plan, initiated on 4/18/16, documented Resident #18 should have a night light in her room to maximize safety. The care plan documented no interventions for toileting prior to 11/8/16.</p> <p>On 11/8/16 at 1:30 am, a Fall Scene Huddle Worksheet for Resident #18 documented she was found on the floor in her room near her bed, and had been incontinent of urine. The form documented Resident #18's bed was wet with urine, and the resident was wearing a clean adult brief. The form documented there was a soiled adult brief in the trash can in the resident's bathroom, and her soiled pajama pants and nightgown were hanging on the handrail in the bathroom. The form was blank in the area available to document when the resident had last been toileted, but form documented Resident #18 was placed on a toileting program following the fall. No additional supervision was documented. There was no documentation as to the presence or absence of a night light at the time of the fall.</p> <p>On 11/8/16, Resident #18's blood pressures were documented as 90/48 at 1:35 am (5 minutes after the fall), 111/56 at 2:25 am, 102/61 at 2:48 am, 106/58 at 9:26 am, with a re-check at 106/48 at 9:27 am, and 92/52 at 12:25 pm. There was no documented assessment of the low blood pressure values as it pertained to the resident's ability to ambulate without increased supervision.</p> <p>On 11/8/16 at 4:38 pm, a Fall Scene Huddle Worksheet documented Resident # 18 was found on the floor in the facility's TV room, with her walker nearby. The form documented Resident #18 had been walking too fast with a walker too</p>	{F 323}	<p>4, Monthly X 2, Quarterly X 3. All audit results will be reported to QAPI for further monitoring and modification based on finding.</p> <p>5. Compliance on or before 1/2/17. Administrator will ensure compliance.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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{F 323}	<p>Continued From page 31</p> <p>far out in front of her on her way to dinner. Resident #18 sustained skin tears to her right hand and arm. The form documented the facility obtained a UA for Resident #18, sent a list of her medications to the physician with her blood pressures, and referred Resident #18 to physical therapy. The location of Resident #18's fall was approximately 250 feet from her room.</p> <p>On 11/14/16 at 5:10 pm, Resident #18 was observed in her room. It was dark outside, so no light came through the resident's window. No night light was observed in the resident's room. Resident #18 was observed in this same situation at 5:25 pm and 5:37 pm.</p> <p>On 11/15/16 at 10:00 am, Resident #18's room was observed with a stack of boxes, bags, and various loose possessions stacked along the east wall of her room, extending approximately 2 to 3 feet up from the floor. CNA #1 was in the room, and stated she was assigned to care for Resident #18, but was not aware the resident had recently fallen. CNA #1 stated Resident #18 was at risk for falls, and to compensate for that staff placed her bed in a low position when she was in it. CNA #1 consulted a sheet of paper from her pocket and stated there were no further fall prevention measures for Resident #18. CNA #1 stated she had worked at the facility "a few months" and the boxes, bags, and possessions in Resident #18's room had been there "at least as long as I've worked here." CNA #1 stated the night light in Resident #18's room worked but because it was located on the wall behind the stack of boxes "it doesn't really help." CNA #1 stated she did not feel the resident could see well when the room was dark "so I try to leave the</p>	{F 323}			

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{F 323}	Continued From page 32 bathroom light on to help." The location CNA #1 identified as the location where the night light was as blocked by Resident #18's possessions. On 11/16/16 at 9:30 am, the MDS nurse, DNS, Corporate Nurse, and Administrator stated facility did not implement a plan for increased supervision, beyond a "every three hour" toileting plan, after Resident #18's first fall on 11/8/16 and subsequent low blood pressure readings. No other underlying medical factors, such as oxygen saturation fluctuations related to her COPD or blood glucose readings related to her diabetes were evaluated or ruled out. They were not aware that the care planned intervention of a night light in Resident #18's room was not effective due to the blockage of light by the resident's possessions.	{F 323}			
{F 329} SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents 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	{F 329}		1/2/17	

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{F 329}	<p>Continued From page 33</p> <p>drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, it was determined the facility failed to adequately monitor the behaviors of residents receiving psychotropic medications. This was true for 1 of 3 residents sampled for psychotropic medications (#3) and created the potential for harm should unmonitored medication regimens result in unanticipated declines or newly emerging or worsening symptoms. Findings included:</p> <p>Resident #3 was admitted to the facility on 11/12/10 with multiple diagnoses, including schizoaffective disorder and delusions.</p> <p>The 10/6/16 quarterly MDS assessment documented Resident #3 experienced hallucinations and delusions.</p> <p>Resident #3's October and November 2016 MARs documented orders dated 10/4/16 of Risperdal 1 mg in the evening for Schizoaffective Disorder and orders dated 10/7/16 of Haloperidol 5 mg in the morning and 10 mg at bedtime for Schizoaffective Disorder.</p> <p>Refer to F250 regarding Social Service</p>	{F 329}	<ol style="list-style-type: none"> 1. Resident # 3 LSW had a conversation with resident Psychiatrist on 11/17/16 clarifying resident's behaviors of delusions/hallucinations. Behaviors monitored daily. Behavior legend modified to indicate behavior symbols on 11/16/16. Care plan and interventions for delusions were added 11/17/16. 2. Residents who are on psychotropic medications and have behavior monitoring have the potential to be affected by this practice. 3. Root cause of issue is need for clarification of symbol documentation for behavior monitoring. <p>The legend symbol for documentation of no behaviors was clarified. If delusions or hallucinations are identified each will be monitored and documented separately.</p> <p>LSW and licensed nursing staff will be educated on 12/15/16 of changes made to legend symbol documentation and monitoring and documentation of</p>		

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{F 329}	<p>Continued From page 34 involvement with Resident #3.</p> <p>Resident #3's care plan, dated 9/30/16, documented, "[Resident #3] has a dx of Schizoaffective disorder and depression E/B refusals of care, repeated use of call light, hallucinations of people going to harm her and suicidal ideation/self harm. [Resident #3] will have less than daily episodes of target behaviors by review date." Revised interventions, dated 10/11/16, included, "Reassure that no one will be allowed to harm her and Safety checks, approach again, change staff, and notify Administer/DNS/SS immediately if talking about suicide."</p> <p>Resident #3's October and November 2016 MARs, beginning 9/23/16, included behavior tracking documentation including "refusal of care ... repeated use of call light ... hallucinations of people going to harm her ... suicidal ideation/self harm." The MARs from 10/28/16 to 11/14/16 documented either an "0" an "x" or an "n" two times a day for each behavior exhibited and a similar notation under the interventions implemented section. The legend on the MAR did not document what those symbols represented.</p> <p>Resident #3's LCSW and progress notes (PN) from 10/28/16 to 11/14/16 documented: * 10/31/16-(LCSW) - "She did not appear suicidal." * 11/7/16-(LCSW) - "[Resident #3] said that she has felt good ... She noted to feel like she is doing well with her moods." * 11/9/16-(PN) - "Laundry Supervisor (LS) reported to the administrator ... resident stated that she thinks they are going to throw [her] off</p>	{F 329}	<p>delusions and hallucinations.</p> <p>4. DNS or designee will complete audits for Behavior Monitoring weekly X 4, Monthly X 2, Quarterly X 3. All audit results will be reported to QAPI for further monitoring and modification based on finding.</p> <p>5. Compliance on or before 1/2/17. Social Services Director will ensure compliance.</p>		

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{F 329}	<p>Continued From page 35</p> <p>the grand. LS went on to say that roommate spoke up and said that she thinks she means the roof. LS reassured resident she was safe ... This is a reoccurring [sic] comment to prior statements made by resident about "they" and she can not say who "they" are. LSW will be notified ..."</p> <p>On 11/14/16 and 11/15/16 at 5:27 pm and 8:10 am respectively, Resident #3 was observed in a wheelchair in the dining room waiting for dinner and breakfast respectively. On 11/15/16 at 9:35 am, the resident was observed sitting in a recliner looking out her bedroom window.</p> <p>On 11/15/16 at 12:30 pm, the IP said she and Resident #3 had just come from a psychiatrist appointment, where they were told by the psychiatrist that the resident was at baseline for her behaviors. She said the resident had similar repetitive statements and allegations, which were being addressed by the facility through medication.</p> <p>On 11/15/16 at 1:40 pm, LN #1 said she had worked with Resident #3 for about four years and the resident was at baseline with her behaviors. She said the resident had both hallucinations and delusions and said the behavior monitors only had space provided to chart hallucinations. She said the call light monitors referred to when the resident pressed the call light when staff were already in the room assisting her. She said when the resident exhibited one of the behaviors, she would place an 'N' if there were no behaviors and a 'Y' or a number to indicate the number of times the resident exhibited the behavior. The interventions section was marked similarly and LN #1 would also write a corresponding progress</p>	{F 329}			

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{F 329}	<p>Continued From page 36</p> <p>note regarding the behavior and interventions attempted.</p> <p>On 11/15/16 at 2:45 pm, Resident #3 was observed sitting in a wheelchair in her room, where she discussed books she was currently reading and stated she had lived at the facility for "a long time." Resident #3 stated she had previously been in a different "retirement home," but realized she needed more help. Resident #3 stated she suffered from "bladder cancer, Alzheimer's, and that other disease," while pointing to her head.</p> <p>On 11/15/16 at 3:45 pm, the SSD said Resident #3's behavior monitoring began on 9/23/16 and the facility had been in the process of establishing a baseline for the resident's behaviors. She said she reviewed behavior monitors and progress notes to help monitor the behaviors and then would bring that data to the Psychotropic Medication Review Committee, where medication recommendations were made. She said the behavior monitors did not differentiate between a hallucination or delusion and did not specify Resident #3's repetitive behaviors or how nurses were to chart on the MAR. She said call light usage when staff were meeting her needs were also tracked, and noted there were no non-pharmalogical interventions, including pain assessments, when the resident exhibited this behavior.</p> <p>On 11/16/16 at 8:45 am, LN #2 said the resident experienced both hallucinations and delusions, but the MAR did not provide a place to track delusions. LN #2 said there was not a care-planned intervention to assess for pain if the</p>	{F 329}			

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{F 329}	Continued From page 37	{F 329}			
{F 520} SS=F	<p>resident repetitively used her call light, but she would ask the resident if she had pain.</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's compliance history, and staff interview, it was determined the facility's Quality Assessment and Assurance (QAA) committee failed to make corrections and resolve systemic problems for 2</p>	{F 520}		1/2/17	
			1. QAPI Committee met on 12/12/2016 to discuss the process and actions that were developed for a plan for compliance with the current re-survey and specifically with citations for resident #3 and #18		

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{F 520}	<p>Continued From page 38 of 8 sampled residents (#3 and #18), which had the potential to affect all residents in the facility. This failure resulted in the QAA committee providing insufficient direction and control necessary to ensure residents' quality of care needs were met. This failed practice had the potential to harm residents due to insufficient and/or inadequate care. Findings included:</p> <p>The QAA committee failed to provide sufficient monitoring and oversight to sustain regulatory compliance as evidenced by the following citations from the 8/16/16 annual recertification survey and the 11/16/16 on-site follow up survey to the recertification survey.</p> <ol style="list-style-type: none"> 1. The facility failed to maintain compliance since the alleged compliance date of 10/28/16 from the facility's 8/16/16 annual recertification survey for F157, F250, F309, F323 and F329. The facility was also cited for new deficiencies at F201, F202, F203, F204 and F315. Refer to these citations for additional information. 2. The facility failed to notify a resident of an impending discharge and failed to notify physicians of residents' change of status; this deficient practice was recited at F157. 3. The facility failed to provide appropriate social service support and was recited at F250. 4. The facility failed to provide appropriate bowel care and was recited at F309. The facility was cited at F309 on the three previous recertification surveys conducted 12/14/12, 12/20/13, and 3/30/15. 	{F 520}	<ol style="list-style-type: none"> 2. All residents have the potential to be affected by this practice. 3. A system change is that weekly QAPI meetings were implemented on 11/21/16 to review most current audits and address any negative findings and concerns in a timely manner. Initiation of a QAPI Planning Review and Planning Sub-Committee consisting of the Administrator, Quality Coordinator and DNS. This team will meet monthly prior to monthly QAPI committee meeting to discuss current survey issues, audit results and data reports, and to identify and prioritize areas to be discussed for the QAPI meeting. 4. An audit has been developed to monitor the Planning Review and Planning Sub-Committee and QAPI committee meetings to ensure facility concerns are being identified, resolved and corrections sustained through the QAPI process. The audits for F520 will be completed by corporate Quality Performance Improvement Consultant (QPIC) and will occur weekly X 4, Monthly X 12. All audit results will be reported to QAPI for further monitoring and modification based on findings. 5. Compliance on or before 1/2/17. Administrator will ensure compliance. 		

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{F 520}	<p>Continued From page 39</p> <p>5. The facility failed to provide appropriate fall prevention for residents and was recited at F323. The facility was cited at F323 on the previous recertification survey conducted on 3/30/15.</p> <p>6. The facility failed to adequately monitor residents' behaviors and was recited at F329. The facility was cited at F329 on the four previous recertification surveys conducted on 8/26/11, 12/14/12, 12/20/13, and 3/30/15.</p> <p>On 11/16/16 at 11:00 am, the Quality Care Coordinator, with the Administrator present, said she knew the facility was out of compliance at F157 after the alleged compliance date. The Administrator said the facility missed the assessment for Resident #3's involuntary discharge notice (see F201, F202, F203, F204, F250 and F329). The Quality Care Coordinator said the committee was working to ensure compliance with the cited deficiencies.</p>	{F 520}			