



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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December 20, 2016

Peter Smith, Administrator
Kindred Nursing And Rehabilitation - Caldwell
210 Cleveland Boulevard,
Caldwell, ID 83605-3622

Provider #: 135014

Dear Mr. Smith:

On **December 2, 2016**, a survey was conducted at Kindred Nursing And Rehabilitation - Caldwell by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes immediate jeopardy to resident health or safety, as documented on the enclosed CMS-2567, whereby significant corrections are required.** You were informed of the immediate jeopardy situation in writing on **November 30, 2016**.

On **December 1, 2016**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the residents had been removed. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction.

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.

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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 31, 2016**. Failure to submit an acceptable PoC by **December 31, 2016** , may result in the imposition of additional civil monetary penalties by **January 7, 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).

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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:

F0367 -- S/S: K -- 483.60(e)(1)(2) -- Therapeutic Diet Prescribed By Physician

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

Civil money penalty, **per day**, effective **December 2, 2016**.
Denial of payment for all new admissions **March 2, 2017**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 2, 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.

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, 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>

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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 31, 2016**. If your request for informal dispute resolution is received after **December 31, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nina Sanderson, LSW, Supervisor
Long Term Care

NS/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/02/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - CALDWELL			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility November 28, 2016 to December 2, 2016.</p> <p>Immediate Jeopardy was identified at:</p> <p>CFR 483.60(e)(1): Therapeutic Diets (F367).</p> <p>The Immediate Jeopardy at F367 was removed prior to the survey exit conference on December 2, 2016.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Teresa Kobza, RD/LD Ophelia McDaniel, RN</p> <p>Survey Abbreviations:</p> <p>AD = Activities Director ADL = Activities of Daily Living BG = Blood glucose BIMS = Brief Interview for Mental Status CAA = Care Area Assessment cal/mL = Calories per milliter CNA = Certified Nursing Assistant CP = Care Plan COTA = Certified Occupational Therapy Assistant DNS = Director of Nursing Services LN = Licensed Nurse LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = Milligram(s) mL = MilliLiter(s)</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

12/30/2016

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

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F 000	Continued From page 1 MSDS = Material Safety Data Sheet(s) Nosey cup = Cups that have a cut out on the non-drinking side so that they can be tilted without interference by the nose. This allows the drinker to avoid tilting the head. NCD = National Coverage Determination OOB = Out of bed PO = by mouth P&P = Policy and Procedure PRN = As Needed RD = Registered Dietitian RN = Registered Nurse RNC = Regional Nurse Consultant SDC = Staff Development Coordinator SSS = Social Services Specialist s/sx = Signs and symptoms ST = Speech Therapist TAR = Treatment Administration Record TV = Television x = times w/c = Wheelchair 1:1 = one-to-one	F 000			
F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced	F 248		1/17/17	

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F 248	<p>Continued From page 2</p> <p>by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure 1 of 9 residents (#4) sampled for activities, was offered and provided with activities outlined on the care plan. This created the potential for harm if residents experienced mood changes or behaviors resulting from boredom. Findings include:</p> <p>Resident #4 was admitted to the facility on 12/2/08 with diagnoses which included Huntington's disease, weight loss, and dementia.</p> <p>Resident #4's quarterly MDS assessment, dated 11/15/16, documented she was severely cognitively impaired and could not communicate her needs to the staff.</p> <p>Resident #4's annual MDS assessment, dated 8/15/16, documented Resident #4 and/or her family were not involved in determining her activities preferences. The activities preferences were as follows:</p> <ul style="list-style-type: none"> * Resident #4 wanted her family involved in her care. * Resident #4 liked keeping up with the news. * Resident #4 liked to pick her bathing preferences. * Resident #4 liked to participate in favorite activities. <p>The most recent annual MDS assessment that included Resident #4's participation, was dated 9/16/12. The MDS documented Resident #4's activity preferences as follows:</p>	F 248	<p>Resident Specific The Interdisciplinary (ID) team reviewed resident #4 and adjusted her care plan and activity records to reflect her historic preferences.</p> <p>Other Residents The ID team reviewed other residents who are currently unable to choose activities for themselves to validate that their historic choices are honored. Adjustments have been made as indicated.</p> <p>Facility Systems Staff is educated that resident's activity needs are met even when they no longer can make those decisions independently. Re-education was provided by the Director of Nursing (DNS) and/or the Staff Development Coordinator (SDC) to include but not limited to, validating residents who are no longer able to choose have historical activity preferences honored, that accommodations are made to meet these desires, documentation reflects care provided, activities are age appropriate, and after cares are provided the curtains are returned to a position so that residents can view television/other personal items. The system is amended to include review of activity plans for residents who can no longer express their desires with family and/or historical assessments.</p>		

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F 248	<p>Continued From page 3</p> <ul style="list-style-type: none"> * Resident #4 felt it was very important to her to have her family involved in her care. * Resident #4 felt it was very important to listen to music. * Resident #4 felt it was very important to have pets visit her. * Resident #4 felt it was very important to pick her bathing preferences. * Resident #4 felt it was not important at all to keep up with the news. * Resident #4 felt it was not important at all to participate in favorite activities. <p>The activities identified on Resident #4's 9/16/12 MDS assessment, which included her participation, were inconsistent with her 8/15/16 annual MDS assessment, during which activities were selected for her.</p> <p>Resident #4's CAA worksheet, in the activities sections, dated 8/22/16, documented she would have 1:1 visits when she was not able to attend events/meals out of her room.</p> <p>Resident #4's Activities Care Plan, dated 5/14/14, documented she was dependent on staff for activities, cognitive stimulation, social interaction related to physical limitations, disease process, immobility and cognitive deficits. The goals outlined on the Activities Care Plan included:</p> <ul style="list-style-type: none"> * Resident #4 will maintain involvement in cognitive stimulation, and social activities 3x per week as desired through the review date. The goal was revised 8/24/16, and had a target date of 11/2/16. * Resident #4 will be able to meet her individual 	F 248	<p>Monitor</p> <p>The social service staff and/or designee will audit residents with a new MDS completed to validate resident preferences are instituted for 12 weeks. Clinical rounds will validate age appropriate media is available at the resident bedside 3 times per week for 12 weeks. Starting the week of January 15, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 248	<p>Continued From page 4</p> <p>preferences according to the MDS section F [related to preferred routines and activities]. The goal was revised 8/24/16, and had a target date of 11/2/16.</p> <p>Interventions on the Activities Care Plan included:</p> <ul style="list-style-type: none"> * Staff was to converse with her while providing cares, beginning 5/14/14. * Resident #4 needed assistance with ADL's during activities, revised 8/15/16. * Resident #4 enjoyed taking a bath and should have one several times a week, revised 6/10/16. * Resident #4 had a family member invited to her care conferences, revised 6/10/16. * Resident #4 was able to watch what she enjoys on TV, has DVD movies and music through her TV. Staff was to change her program as needed to prevent repetition, revised 6/10/16. * Staff was to provide Resident #4 with 1:1 bedside/in-room visits 1-3 times per week and activities if she was unable to get out of her room for activities/events/meals, revised 11/4/16. * Resident #4 enjoyed listening to music and watching the news, revised 6/10/16. * When Resident #4 could not participate in organized activities, staff was to turn on the TV or turn music on for sensory stimulation, revised 8/15/16. <p>Resident #4's ADL Activities log from 11/2/16 through 12/1/16, documented;</p> <ul style="list-style-type: none"> * Resident #4 participated in watching TV 45 times out of 51 documented activities. * Resident #4 participated in musical pursuits 2 times out of 51 documented activities. 	F 248			

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F 248	<p>Continued From page 5</p> <ul style="list-style-type: none"> * Resident #4 participated in relaxation 2 times out of 51 documented activities. * Resident #4 participated in social pursuits and special events 2 times out of 51 documented activities. <p>Resident #4's record contained a 1:1 activity participation log, which documented:</p> <ul style="list-style-type: none"> * In October 2016 Resident #4 was provided 1:1 activity from staff on 7 days. The activities provided were reading newspapers and articles, talking to her, and checking on her TV. * In November 2016 Resident #4 was provided 1:1 activities from staff on 3 days. The activities provided were reading newspapers and articles to Resident #4. <p>Resident #4's 1:1 activity participation log documented staff read the newspaper to her. Resident #4's 9/16/12 MDS assessment, which included her participation, stated she felt it was not important at all to keep up with the news.</p> <p>On 11/28/16 at 2:42 pm through 5:21 pm, Resident #4's TV was turned on to a children's station. There was a curtain covering the TV which blocked it from her view. The documentation on the activities log documented she was participating in TV watching during this time frame.</p> <p>On 11/29/16 at 8:09 am, Resident #4 was in bed in her room and the TV was tuned to a children's station.</p> <p>On 11/29/16 at 9:45 am, Resident #4's TV</p>	F 248			

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F 248	Continued From page 6 continued to play children's shows. On 11/29/16 at 10:36 am, Resident #4's TV continued to play children's shows and SDC stated there was only three stations on her TV and if residents wanted cable they had to pay for it. She stated the other channel was a drawing show and she did not think it was as stimulating as the children's show. On 11/30/16 at 12:19 pm, Resident #4's TV was tuned to children's programs. On 12/1/16 at 3:51 pm, the Activities Director stated Resident #4 received 1:1 activities 1-3x per week. She stated the new online charting program did not allow her and her staff to chart that it was completed. She stated with the current documentation it did not appear the 1:1 visits were being completed. She stated when Resident #4 was able to verbalize what she liked; she enjoyed watching old movies and TV, meditation, and music. She agreed the activities log did not document many activities besides TV. She stated the antennas in the facility did not allow all rooms access to all the channels. She stated Resident #4 did not have room for a DVD player in her room but maybe a shelf could be built to house one. She stated she could ask the family for a DVD player.	F 248			
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 281		1/17/17	

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F 281	<p>Continued From page 7</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined the facility failed to ensure LNs performed BG checks consistent with facility policy and accepted standards of practice. This was true for 1 of 3 LNs (#1) and affected 2 of 5 residents (#24 & #25) observed during BG checks. The failure created the potential for inaccurate BG results and for negative effects if Resident #24 and #25 were to receive the wrong amount of insulin. Findings include:</p> <p>The Fundamentals of Nursing, 8th edition, by Potter, Perry, Stockert and Hall, 2013, document the following steps and rationales regarding BG monitoring:</p> <p>* Step 14: "...Wipe away the first droplet of blood...(See manufacturer directions for meter used.) and Rationale: "First drop of blood may contain more serous fluid than blood cells."</p> <p>* Step 15: Lightly squeeze puncture site...until large droplet of blood has formed..." and Rationale: "Adequate size droplet is needed to activate monitor and obtain accurate results..."</p> <p>* Step 16: "Obtain test results," and Rationale: Exposure of blood to test strip for prescribed time ensures proper results."</p> <p>The facility's "Blood Glucose Monitoring Using a NovaStat Strip Glucometer" procedure documented, "...Pierce the skin sharply and quickly...Squeeze...finger to form a drop of</p>	F 281	<p>Resident Specific The clinical management team reviewed resident #24 and 25 for adverse effects from inaccurate technique utilized for blood sugar monitoring. No negative outcomes were identified. The licensed nurse has been re-educated in blood sugar monitoring technique.</p> <p>Other Residents The clinical management team reviewed other insulin dependent residents for blood sugar trending. Licensed nurses have been reeducated in blood sugar monitoring technique.</p> <p>Facility Systems Licensed nurses are educated on-hire and annually to accurate blood sugar monitor technique. Re-education was provided by the DNS and/or SDC to include but not limited to, wiping away the first drop of blood and utilizing the second drop of blood for monitoring the glucose value. The system is amended to include periodic surveillance of blood glucose testing process.</p> <p>Monitor The SDC and/or designee will complete blood sugar monitoring surveillance two times per week for 4 weeks, then once weekly for 8 weeks. Starting the week of January 15, 2017 the review will be</p>		

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F 281	Continued From page 8 blood...Wipe away the first drop of blood and squeeze...to form another drop...Apply the drop of blood to the...test strip...Wait for the...test result..." On 11/29/16 at 11:30 am, RN #1 was observed as she checked Resident #24's BG level. The RN pierced the skin on Resident #24's right pointer finger then applied the first drop of blood to the test strip. Resident #24's BG level was 243. On 11/29/16 at 11:55 am, RN #1 was observed as she checked Resident #25's BG level. The RN pierce the skin on the resident's left fourth finger then applied the first drop of blood to the test strip. Resident #25's BG level was 182. On 12/2/16 at 10:30 am, the DNS said nurses were to wipe away the 1st drop of blood and use the 2nd blood drop when they check a resident's BG level.	F 281	documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 309		1/17/17	

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F 309	<p>Continued From page 9</p> <p>consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>(I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure 1 of 15 sampled residents (Resident #3) was provided with the necessary care and services to address her diagnosis of dysphagia and related diet modifications. This deficient practice placed Resident #3 at risk of aspiration and related complications. Findings include:</p> <p>Resident #3 was admitted to the facility on 9/1/16 with diagnoses which included dysphagia [difficulty swallowing].</p> <p>Resident #3's annual MDS assessment, dated 9/7/16, documented she was cognitively intact. The assessment also stated Resident #3 did not have natural teeth and had dentures.</p> <p>Resident #3's ST Notes, dated 9/5/16, documented Resident #3 was pocketing food, had poor oral intake and was unable to tolerate texture. On 9/29/16, her attending physician ordered a Modified Barium Swallow Study [MBSS] to rule out silent aspiration and to</p>	F 309	<p>Resident Specific The clinical management team reviewed resident #3's orders, notified the physician, and transcribed the orders as indicated.</p> <p>Other Residents The clinical management team reviewed other residents with dysphagia for timely transcription of new orders. No other orders lacked transcription.</p> <p>Facility Systems Licensed nurses are educated to identify orders in need of transcription and process timely. Re-education was provided by the DNS and/or SDC to include but not limited to, process to identify orders in need of transcription, noting of transcription, and accurately coding into the electronic record. The system is amended to include review of orders by medical records and/or clinical management to validate orders are transcribed and accurately coded into the</p>		

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - CALDWELL			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
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F 309	<p>Continued From page 10</p> <p>determine if Resident #3 was a candidate for diet upgrade to thin liquids and soft diet.</p> <p>Resident #3 received a MBSS on 10/19/16, that documented when Resident #3 alternated solids and liquids there was residual food and fluids left in the mouth. The results included, "The significant residual combined with pooling, does place the patient at risk for aspiration [inhale food or liquid into the lungs]."</p> <p>The MBSS recommendations included a "diet of soft solids," and "liquids before meals or 2 hours after meals, but not during meals." "Speech therapy to treat dysphagia issues."</p> <p>On 10/22/16 Resident #3's attending physician ordered, "ST recommendation: Provide thin liquids before meals and 2 hours after meals; no liquids with po solids."</p> <p>Resident #3 was observed to be served water with her meal of a regular diet on 12/1/16 at 12:45 pm during lunch meal and 5:55 pm during dinner meal in the west dining room. CNA #4, interviewed at 5:55 pm, stated, "She drinks water with all her meals. I was not told that the resident could not have water." At 6:30 pm the consultant Registered Dietitian (RD) was requested to observe Resident #3 eating chili and drinking water. Resident #3's dinner meal also included coffee. At 6:40 pm, the physician's order dated 10/22/16, was shown to the consultant RD. She stated she had never seen the order and would talk with the ST.</p> <p>An interview was conducted with the consultant ST on 12/2/16 at 12:00 pm. The ST stated, "I</p>	F 309	<p>electronic record through the clinical meeting.</p> <p>Monitor The medical records clerk and/or designee will review consultation reports, physician hand written orders, and verbal orders for accuracy and correct coding within the electronic record 3 times per week for 12 weeks. Starting the week of January 15, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 309	Continued From page 11 have been working with [Resident #3] using techniques to increase her ability to tolerate water. These trials are not done by staff only the ST. CNAs should not be giving her water with meals." Resident #3 was interviewed on 12/1/16 during her dinner meal and stated she drank water with all of her meals. Resident #3's care plan, dated 9/1/16, did not include interventions to address Resident #3's dysphagia and the texture of Resident #3's diet. The care plan was not updated to include the physician's 10/22/16 order to "provide thin liquids before meals and 2 hours after meals; no liquids with po [by mouth] solids."	F 309			
F 312 SS=E	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) 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 observation, resident and staff interviews, and record review, it was determined the facility failed to ensure 1 of 15 sample residents (#1) received necessary assistance during meals as care planned; and 5 of 13 residents in a Resident Group Interview and 8 of	F 312	Resident Specific The clinical management team reviewed resident #1 and adjusted his assistance with meals plan. The clinical management team reviewed	1/17/17	

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F 312	<p>Continued From page 12</p> <p>15 sample residents (#2, #4, #5, #7, #9-#11, and #13) consistently received baths or showers. These failures placed Resident #1 at risk for hunger and weight loss and Residents #2, #4, #5, #7, #9-#11, and #13, at risk for psychosocial distress and/or medical harm due to lack of hygienic practices. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 3/14/14, with diagnoses that included Lewy body dementia. Resident #1's annual MDS assessment, dated 11/23/16, documented his cognitive skills were severely impaired, he had an altered level of consciousness, and did not respond to others. According to the assessment, the resident was totally dependent upon facility staff for all activities of daily living.</p> <p>Resident #1's care plan documented a Focus entry dated 2/24/16, which stated Resident #1 was at risk for nutritional decline related to: depression, variable intakes, history of significant weight loss, dehydration risk, restlessness, and choking episode 1/27/15. The plan documented staff were to provide Resident #1 feeding/dining assistance as needed.</p> <p>Resident #1's physician's ordered a regular diet, pureed texture and nectar thick consistency for fluids on 2/25/16.</p> <p>Resident #1's attending physician's Nursing Home Visit [document], dated 4/26/16, stated that on 1/4/16 Resident #1 weighed 152.4 pounds and he had experienced a decline due to dementia and dysphagia. The assessment of Resident #1 included, "unavoidable weight loss as a part of decline with dementia."</p>	F 312	<p>resident #2, 4, 5, 7, 9, 10, 11, and 13 bathing schedules and adjusted as indicated.</p> <p>Other Residents The clinical management team reviewed other residents for assistance with meals and bathing schedules. Adjustments have been made as indicated.</p> <p>Facility Systems Care givers are educated to provide hands on assistance for residents who are unable to care for themselves during their certification and upon hire. Re-education was provided by the DNS and/or SDC to include but not limited to, assistance with meals, assistance and consistency of provision of bathing, and documentation into the electronic record. The system is amended to include review of the previous days bathing schedule implementation to validate baths were provided and not documented as "NA" in clinical meeting. Residents will be interviewed periodically on personal bathing choice.</p> <p>Monitor The DNS and/or designee will audit bathing records 3 times per week for 12 weeks. Clinical rounds will validate residents are assisted with meals 3 times per week for 12 weeks. Starting the week of January 15, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The</p>		

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F 312	<p>Continued From page 13</p> <p>On 11/21/16, the consultant Registered Dietitian (RD) documented a progress note which stated Resident #1's "intakes remained low and variable b/t [between] 0-75%."</p> <p>A Weights and Vitals Summary sheet documented Resident #1's weight was 125 pounds on 11/23/16, which was a weight loss of 27.4 pounds since 1/4/16.</p> <p>Resident #1 was observed in the East Dining Room on 11/29/16 as his meal was served at 12:20 pm. Resident #1 sat at the table awake and was provided assistance 10 minutes later at 12:30 pm. At that time, CNA #12 sat at the table on a stool between Resident #1 and another resident. The CNA gave Resident #1 liquids only and assisted the other resident to eat. At 12:50 pm, Resident #1 was sitting at the table awake. CNA #12 and the other CNAs were feeding and assisting other residents. At 1:00 pm, Resident #1 remained sitting at the table while CNAs were collecting meal trays from residents and putting the trays in the meal transport carts. At 1:05 pm, CNA #3 picked up Resident #1's plate and proceeded to throw the contents of the plate in a garbage receptacle. Facility staff was not observed to assist Resident #1 to eat food from his plate during this lunch meal observation.</p> <p>Facility staff did not provide Resident #1 with the dining assistance necessary to promote weight gain or prevent further weight loss.</p> <p>2. Residents did not regularly receive baths and/or showers. Examples include:</p>	F 312	<p>PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. A sample of 10 residents per month will be interviewed on bathing preferences and personal choice for 12 weeks.</p>		

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F 312	<p>Continued From page 14</p> <p>a. During the Resident Group Interview, conducted on 11/29/16 at 2:30 pm, 5 of 13 residents stated they did not get showers on a consistent basis. The residents said they wanted showers at least twice a week. One resident stated s/he had gone for 8 days without a shower or bath.</p> <p>b. Resident #5 was re-admitted to the facility on 2/1/16 with diagnoses which included difficulty in walking, Alzheimer's disease, and convulsions.</p> <p>Resident #5's quarterly MDS assessment, dated 11/22/16, documented she was severely cognitively impaired.</p> <p>Resident #5's ADL Care Plan, revised 5/20/14, documented she would complete bathing tasks for her upper body with the assistance of one staff. Interventions stated Resident #5 was to receive a shower or bath 2 times a week and PRN, revised 6/10/16.</p> <p>Resident #5's September 2016 ADL Shower/Bathing record documented (Monday and Thursday in the AM):</p> <p>* On 9/22/16 in the afternoon, Resident #5 received a bath.</p> <p>Resident #5's October 2016 ADL Shower/Bathing record documented:</p> <p>* On 10/7/16 in the evening, Resident #5 received a bath. This was 15 days between showers or baths.</p> <p>* On 10/13/16 in the morning, Resident #5 received a shower.</p>	F 312			

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F 312	<p>Continued From page 15</p> <ul style="list-style-type: none"> * On 10/22/16 in the evening, Resident #5 received a bath. This was 9 days between showers or baths. * On 10/25/16 in the evening, Resident #5 received a bath. <p>Resident #5's November 2016 ADL Shower/Bathing record documented:</p> <ul style="list-style-type: none"> * On 11/2/16 in the morning, Resident #5 received a shower. This was 8 days between showers or baths. * On 11/6/16 in the afternoon, Resident #5 received a bath. * On 11/13/16 in the afternoon, Resident #5 received a shower. This was 7 days between showers or baths. * On 11/21/16 in the morning, Resident #5 received a shower. * On 11/30/16 in the morning, Resident #5 received a bath. This was 9 days between showers or baths. <p>Resident #5's September - November 2016 Shower/Bathing ADL Flowsheet documented 25 responses with "NA."</p> <p>c. Resident #4 was admitted to the facility on 12/2/08 with diagnoses which included Huntington's disease, weight loss, and dementia.</p> <p>The 11/15/16 quarterly MDS assessment documented Resident #4 had a severe cognitive impairment and was unable to communicate her needs.</p> <p>Resident #4's ADL Care Plan, revised 11/14/16, documented she had ADL self-care deficits</p>	F 312			

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F 312	<p>Continued From page 16 related to her Huntington's. Interventions included; Resident #4 was totally dependent on staff to provide a shower or bath 2x a week and PRN, revised 6/10/16.</p> <p>Resident #4's September 2016 ADL Shower/Bathing record documented (Monday and Thursday in the PM):</p> <p>* On 9/22/16 in the afternoon, Resident #4 received a full bed bath.</p> <p>Resident #4's October 2016 ADL Shower/Bathing record documented:</p> <p>* On 10/1/16 in the evening, Resident #4 received a full bed bath. This was 9 days between showers or baths.</p> <p>* On 10/7/16 in the evening, Resident #4 received a full bed bath. This was 6 days between showers or baths.</p> <p>* On 10/13/16 in the morning, Resident #4 received a full bed bath. This was 6 days between showers or baths.</p> <p>* On 10/22/16 in the evening, Resident #4 received a shower. This was 9 days between showers or baths.</p> <p>Resident #4's November 2016 ADL Shower/Bathing record documented:</p> <p>* On 11/3/16 in the morning, Resident #4 received a full bed bath. This was 12 days between showers or baths.</p> <p>* On 11/6/16 in the afternoon, Resident #4 received a shower.</p> <p>* On 11/13/16 in the afternoon, Resident #4 received a full bed bath. This was 7 days</p>	F 312			

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F 312	<p>Continued From page 17 between showers or baths.</p> <ul style="list-style-type: none"> * On 11/16/16 in the morning, Resident #4 received a full bed bath. * On 11/22/16 in the afternoon, Resident #4 received a shower. This was 6 days between showers or baths. <p>Resident #4's September - November 2016 Shower/Bathing ADL Flowsheet documented 65 responses with "NA."</p> <p>d. Resident #10 was admitted to the facility on 10/19/11 with diagnoses which included Alzheimer's disease, dementia, and history of other diseases of the digestive system.</p> <p>Resident #10's ADL Care Plan, revised 2/3/15, documented he had ADL self-care deficits related to deterioration in ADL's, declining health status and limited mobility. Interventions included; Resident #10 required assistance from 2 staff members with showers or baths, revised 6/10/16.</p> <p>Resident #10's September 2016 ADL Shower/Bathing record documented (Thursday and Sunday in the PM):</p> <ul style="list-style-type: none"> * On 9/7/16 in the afternoon, Resident #10 received a shower. * On 9/14/16 in the afternoon, Resident #10 received a shower. This was 7 days between showers or baths. * On 9/20/16 in the afternoon, Resident #10 received a shower. This was 6 days between showers or baths. * On 9/26/16 in the afternoon, Resident #10 received a shower. This was 6 days between showers or baths. 	F 312			

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F 312	<p>Continued From page 18</p> <p>Resident #10's October 2016 ADL Shower/Bathing record documented:</p> <ul style="list-style-type: none"> * On 10/1/16 in the evening, Resident #10 received a shower. * On 10/8/16 in the evening, Resident #10 received a shower. This was 7 days between showers or baths. * On 10/18/16 in the morning, Resident #10 received a shower. This was 10 days between showers or baths. * On 10/25/16 in the evening, Resident #10 received a shower. This was 7 days between showers or baths. <p>Resident #10's November 2016 ADL Shower/Bathing record documented:</p> <ul style="list-style-type: none"> * On 11/2/16 in the morning, Resident #10 received a shower. This was 8 days between showers or baths. * On 11/5/16 in the afternoon, Resident #10 received a shower. * On 11/10/16 in the afternoon, Resident #10 received a shower. This was 5 days between showers or baths. <p>Resident #10's September - November 2016 Shower/Bathing ADL Flowsheet documented 19 responses with "NA."</p> <p>e. Resident #13 was admitted to the facility on 3/20/14 with diagnoses which included Alzheimer's disease.</p> <p>Resident #13's ADL Care Plan, revised 7/15/14, documented he had ADL self-care deficits related</p>	F 312			

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F 312	<p>Continued From page 19 to Alzheimer's and blindness. Interventions included; Resident #13 required assistance from 1 staff member with showers or baths, revised 6/10/16.</p> <p>Resident #13's September 2016 ADL Shower/Bathing record documented (Wednesday and Saturday in the AM):</p> <ul style="list-style-type: none"> * On 9/3/16 in the afternoon, Resident #13 received a shower. * On 9/9/16 in the morning, Resident #13 received a shower. This was 6 days between showers or baths. * On 9/14/16 in the afternoon, Resident #13 received a shower. This was 5 days between showers or baths. * On 9/20/16 in the afternoon, Resident #13 received a shower. This was 6 days between showers or baths. * On 9/26/16 in the morning, Resident #13 received a shower. This was 6 days between showers or baths. * On 9/30/16 in the morning, Resident #13 received a shower. <p>Resident #13's October 2016 ADL Shower/Bathing record documented:</p> <ul style="list-style-type: none"> * On 10/7/16 in the evening, Resident #13 received a shower. This was 7 days between showers or baths. * On 10/14/16 in the morning, Resident #13 received a shower. This was 7 days between showers or baths. * On 10/22/16 in the evening, Resident #13 received a shower. This was 8 days between showers or baths. 	F 312			

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F 312	<p>Continued From page 20</p> <p>* On 10/27/16 in the morning, Resident #13 received a shower.</p> <p>Resident #13's November 2016 ADL Shower/Bathing record documented:</p> <p>* On 11/3/16 in the afternoon, Resident #13 received a full bed bath. This was 7 days between showers or baths.</p> <p>* On 11/6/16 in the afternoon, Resident #13 received a shower.</p> <p>* On 11/13/16 in the afternoon, Resident #13 received a full bed bath. This was 7 days between showers or baths.</p> <p>* On 11/19/16 in the morning, Resident #13 received a shower.</p> <p>* On 11/30/16 in the afternoon, Resident #13 received a shower. This was 11 days between showers or baths.</p> <p>Resident #13's September - November 2016 Shower/Bathing ADL Flowsheet documented 23 responses with "NA."</p> <p>f. Resident #7 was admitted to the facility in 2014 and readmitted on 6/28/16 with multiple diagnoses including multiple sclerosis and chronic pain.</p> <p>Resident #7's current potential for skin impairment care plan included an intervention for baths twice a week and PRN.</p> <p>Resident #7's ADL bathing records for September 2016 through November 2016 documented the resident was not bathed or showered as follows:</p>	F 312			

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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 312	<p>Continued From page 21</p> <ul style="list-style-type: none"> * 9/1/16 to 9/5/16 = 5 days * 9/7/16 to 9/12/16 = 6 days * 9/14/16 to 9/20/16 = 7 days * 9/22/16 to 9/26/16 = 5 days * 10/7/16 to 10/11/16 = 5 days * 10/13/16 to 10/18/16 = 6 days * 10/20/16 to 11/2/16 = 14 days * 11/8/16 to 11/13/16 = 6 days * 11/15/16 to 11/29/16 = 12 days <p>On 11/29/16 at 10:35 pm, Resident #7 said she received a bath or shower "about every 2 weeks" but she would like to have a bath twice a week.</p> <p>g. There were similar findings for Residents #2, #9, and #11 regarding the facility's failure to consistently provide baths/shower.</p> <p>The key for the facility's ADL Flowsheets included the following:</p> <ul style="list-style-type: none"> * X- Resident Not Available * R- Resident Refused * NA- Not applicable <p>The key specific to bathing included:</p> <ul style="list-style-type: none"> * 1- Bath * 2- Shower * 3- Full bed bath <p>On 12/2/16 at 9:39 am, the DNS stated showers were to be completed, however, the ADL sheet showed this did not happen for the multiple residents listed above. She did not know why "NA" was charted and could not tell from the documentation if residents had received showers on those days. She stated she had been working</p>	F 312			

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F 312	Continued From page 22 on the shower issue with her staff. She stated they were to complete a skin check sheet after every shower and give them to her. She stated she had a list of residents whose showers were to be completed and the staff was to notify her for any reasons of why showers were not completed. She stated she would be in-servicing her staff in regards to the shower issue. On 12/2/16 at 12:11 am, CNA #6 stated when she completed showers she charted them in the charting system. The ADL sheets were reviewed with the CNA and she was asked what "NA" meant in the documentation. She stated "NA" would mean not done. She was not sure why "NA" would be documented.	F 312			
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation.	F 323		1/17/17	

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F 323	<p>Continued From page 23</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review and Material Safety Data Sheet (MSDS) review, it was determined the facility failed to ensure: a) toxic chemicals were secured; and b) residents' neurologic status was assessed after unwitnessed falls. This was true for 3 of 15 sample residents (#6, #9 & #12) and all other independently mobile residents who moved near the West Housekeeping room and the East Spa room; and for 1 of 4 sample residents (#5) reviewed for falls. Failure to secure toxic chemicals created the potential for residents to experience severe skin burns, serious eye damage, headache, GI symptoms, and irritation to the eyes, skin, mucus membranes and respiratory tract if they inhaled, ingested or were exposed to the toxic chemicals. Failure to assess Resident #5's neurological status placed her at risk for more than minimal harm if a change in her neurologic status was undetected. Findings include:</p> <p>1. Unsecured chemicals were in areas accessible to residents as follows:</p> <p>a. On 11/28/16 at 2:25 pm, the door to the Housekeeping room, near the West dining room, was observed to be ajar. The surveyor was in the Housekeeping room for 25 minutes and observed multiple unsecured toxic chemicals in the room.</p>	F 323	<p>Resident Specific The ID team made rounds to validate that door locks latch independently to keep chemicals secured within the center, to include but not limited to the housekeeping and shower rooms.</p> <p>The clinical management team reviewed resident # 5 for adverse affects as a result of incomplete neurological assessments post fall. No adverse affects were identified. The physician was updated as indicated.</p> <p>Other Residents The ID team made rounds to validate that chemicals are secured within the center. Chemicals are secured.</p> <p>The clinical management team reviewed other residents with unwitnessed falls for completed neurological assessment. No adverse affects were identified. The physician was updated as indicated.</p> <p>Facility Systems Staff are educated on prevention of accidents upon hire and annually. Re-education was provided by the DNS and/or SDC to include but not limited to,</p>		

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F 323	<p>Continued From page 24</p> <p>The unsecured chemicals and their associated MSDS precautionary statements were:</p> <ul style="list-style-type: none"> * Virex II 256 in spray bottles and bottles with spouts - "Combustible liquid. Causes severe skin burns and serious eye damage. Harmful if swallowed." * Clorox bleach - "...considered hazardous...Skin corrosion/irritation...Serious eye damage/eye irritation..." * Lime Off descaler - "Eyes: Severe eye irritant. Liquid and mists may burn or injure eyes, causing corneal damage. Inhalation: May be irritating to mucous membranes of the nose, throat, and lungs. Ingestion: Irritating and corrosive to the mouth and throat..." * Liquid Creme Restroom cleaner - "Avoid contact with eyes." * 3 containers of Sani Cloth Bleach Germicidal wipes - "Causes moderate eye irritation. Avoid contact with eyes or clothing..." * Super Concentrate Glass Cleaner in a large dispenser with a spout - "Respiratory Tract Irritation...Mild Skin Irritation...Severe Eye Irritation...Gastrointestinal Irritation..." * Emerald Floor Cleaner #412 in a large dispenser with a spout - "Avoid contact...with eyes and skin." * Deep Kleen Carpet Cleaner in a large dispenser with a spout - "...Slight skin irritant...Eye irritant...Vapors and mist may be irritating to mucous membranes in the nose, throat, and lungs...Irritation to the mouth and throat..." <p>On 11/28/16 at 2:50 pm, CNA #1, who was in the hallway by the West Housekeeping room, said the door to the housekeeping room should "stay"</p>	F 323	<p>neurological assessment for residents with unwitnessed falls, and securing of chemicals, and completion of the work order process as indicated. The system is amended to include post fall review of neurological assessment for 3 days in clinical meeting and clinical rounds to include validation of secured areas with functioning locks.</p> <p>Monitor The DNS and/or designee will audit records of residents with new unwitnessed falls for completion of neurological assessment for 12 weeks. Clinical rounds will validate chemicals are secured 3 times per week for 12 weeks. Starting the week of January 15, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 323	<p>Continued From page 25</p> <p>closed and locked. A moment later, the SW came by and asked "Is it not staying closed?" CNA #1 pushed the housekeeping door closed and checked to ensure it was locked.</p> <p>b. On 11/29/16, the door to the Spa Room, near the East dining room and Restorative dining room, was observed to be ajar from 4:36 am to 5:35 pm (59 minutes) with unsecured chemicals in the upper and lower cabinets and medicated shampoos and a medicated powder in a drawer. There were no locks on the cabinets or the drawer. The unsecured chemicals and their associated MSDS precautionary statements were:</p> <ul style="list-style-type: none"> * Virex II 256 in spray bottles - "Combustible liquid. Causes severe skin burns and serious eye damage. Harmful if swallowed." * 2 containers of Sani Cloth Bleach wipes - "Causes moderate eye irritation. Avoid contact with eyes or clothing..." <p>On 11/29/16 at 5:35 pm, the DNS accompanied the surveyor to the East Spa room. The DNS said the Spa room door should be locked and, "It was a past practice" that she had been trying to change. The DNS said the items would be secured that night.</p> <p>The toxic chemicals were accessible to Residents #6, #9 & #12 and all other independently mobile residents who moved about the West Housekeeping room and the East Spa room.</p> <p>2. Resident #5 was re-admitted to the facility on 2/1/16 with diagnoses which included difficulty in</p>	F 323			

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F 323	<p>Continued From page 26 walking, Alzheimer's disease, and convulsions.</p> <p>The Facility's NCD Fall Response and Management P&P, dated 2/14/16, documented staff was to determine whether residents experienced head trauma, which required further diagnostic evaluation. In addition, staff was to "monitor neurologic assessments per physician orders or monitor every 15 minutes for 1 hour, then every 30 minutes for 1 hour, then every hour for 2 hours or until the condition stabilized."</p> <p>Resident #5's quarterly MDS assessment, dated 11/22/16, documented she was severely cognitively impaired and had experienced 2 falls with no injuries.</p> <p>Resident #5's High Risk for Falls Care Plan, revised 10/29/16, documented she was at high risk for falls related to unsteady gait, spontaneous and unpredictable behaviors, and psychotropic medication use. Interventions included:</p> <ul style="list-style-type: none"> * Staff was to anticipate Resident #5's needs, beginning on 10/29/16. * Staff was to assist Resident #5 with toileting and getting out of bed after her roommate, revised 8/30/16. * Staff was to provide an environment free of clutter and things she needed within reach, revised 9/27/15. * Staff was to provide various activities to keep Resident #5 engaged, revised 6/10/16. * Resident #5 had a chair alarm and a floor alarm while she was in bed, revised 11/4/16. * Staff was to state to Resident #5 when it was time to use the bathroom because she would say 	F 323			

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F 323	<p>Continued From page 27 no when asked, revised 8/9/16.</p> <p>Resident #5's Actual Fall Care Plan, dated 11/1/16, documented she had falls related to unsteady gait. Interventions included:</p> <ul style="list-style-type: none"> * Staff was to monitor Resident #5 PRN for 72 hours after a fall for signs and symptoms of pain, bruises and changes in mental status. The staff was to document and report the results PRN, revised 2/27/16. * Resident #5 required increased supervision in the dining room, revised 8/12/16. * Staff was not to leave Resident #5 unattended in the bathroom, revised 11/1/16. <p>Resident #5's Fall Risk Assessment, dated 11/23/16 documented she was at high risk of falling.</p> <p>Resident #5's clinical record documented she experienced multiple falls since 7/23/16. Three of the falls were unwitnessed. Neurological assessments were not completed after 2 of the 3 unwitnessed falls. These included:</p> <ul style="list-style-type: none"> * Resident #5's Post Fall Investigation records and Incident Investigation Report, dated 8/12/16, documented she experienced an unwitnessed fall and was found on the floor in the dining room. The investigation note documented the RN stated the resident must have stood up from the table and fell between the table and piano. <p>Resident #5's Nurses' Note, dated 8/12/16 at 10:12 am, documented she had a history of</p>	F 323			

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F 323	<p>Continued From page 28</p> <p>unsteady gait with a history of falls and she had experienced tremors prior to the fall.</p> <p>Resident #5's Nurses' Note, dated 8/12/16 at 5:27 pm, documented she fell and had experienced tremors.</p> <p>Resident #5's Nurses' Note, dated 8/12/16 at 9:16 pm, documented she continued to experience tremors/seizure like activity up to dinner. The note documented she was able to eat and talk through the tremors.</p> <p>Resident #5's clinical record did not contain a neurological assessment completed for the unwitnessed fall on 8/12/16.</p> <p>* Resident #5's Post Fall Investigation records and Incident Investigation Report, dated 11/1/16, documented she experienced an unwitnessed fall while in the bathroom. The investigation note additionally documented she had been toileted and the CNA left the room to get the nurse and they heard her fall.</p> <p>Resident #5's Nurses' Note, dated 11/1/16, documented she was assisted to the toilet by her roommate's 1:1 sitter. The sitter went to the door to get assistance from another staff member and they heard the resident fall on the floor.</p> <p>Resident #5's clinical record did not contain a neurological assessment completed for the unwitnessed fall on 11/1/16.</p> <p>On 12/1/16 at 11:45 am, RN #1 stated Resident #5 had a history of falling. She stated she fell in different areas of the facility and different times.</p>	F 323			

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F 323	Continued From page 29 She stated Resident #5 was very impulsive and would jump up very quickly. She stated Resident #5 was not stable and did not have good enough balance to maintain an upright position. RN #1 stated the facility did not complete a neurological assessment if the resident's position after the fall did not indicate the resident hit his/her head, such as a resident found on his/her hands and knees. She stated this was because residents did not have the strength to fall to the floor and then pick themselves up onto their hands and knees. On 12/1/16 at 12:45 pm, CNA #5 stated Resident #5's roommate had 1:1 supervision and Resident #5 spent the majority of the day in the presence of her roommate. She stated if Resident #5 had to go to the bathroom, the roommate's sitter called another CNA to assist the resident. She stated she could not recall Resident #5 falling after the changes were made. On 12/1/16 at 4:39 pm, the DNS stated neurological assessments should be completed for all unwitnessed falls.	F 323			
F 367 SS=K	483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced	F 367		1/17/17	

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F 367	<p>Continued From page 30</p> <p>by: Based on observation, staff interview, record review, policies and recipes, it was determined the facility failed to ensure physician-ordered pureed diets and thickened liquids were the appropriate consistency when served to residents. This was true for 5 of 15 sampled residents (#1, #2, #4, #10, and #13) and 7 random residents (#16 - #22). The facility failed to ensure:</p> <p>a) Resident #4 received food and liquid consistencies as ordered to protect her from aspiration, was positioned appropriately during food and liquid intake, and pureed foods and honey-thick liquids were not combined to avoid a mixed consistency; and</p> <p>b) Residents #1, #2, #4, #10, #13 and #16 - #22 received pureed-consistency food per physician orders.</p> <p>c) Residents #1, #4, #10, #13, #17 and #22, who were on pureed diets and had orders for thickened liquids, received pureed food that was not of a thinner consistency than their liquids.</p> <p>These deficient practices placed the above residents in Immediate Jeopardy of serious harm, impairment, or death due to aspiration of food and/or fluids into their airways. Findings include:</p> <p>The Idaho Diet Manual for Health Care Facilities, 11th edition, 2015, documented the ideal puree consistency should resemble whipped topping or mashed potatoes and occasionally pureed foods may be a thinner consistency to meet an individual's needs. In addition, the idaho Diet</p>	F 367	<p>Resident Specific The clinical management team assessed resident #1, 2, 4, 10, 13, and 16-22 who received a meal tray with pureed food and resident #4 who received a beverage that potentially was less than prescribed by the physician for aspiration. No adverse affects were identified as noted in the CMS-2567. The care plans have been updated with safe swallow strategies and positioning as indicated.</p> <p>Other Residents No other residents receive altered food textures or beverages.</p> <p>Facility Systems Staff is educated to follow physician orders for therapeutic diets. Re-education was provided by the DNS, SDC, and/or DDCO (District Director of Clinical Operations) to include but not limited to,</p> <p>Dietary Staff educated&</p> <p>"To follow pureed and other altered consistency recipes "Tray line staff validate each puree and other altered consistency items are appropriate prior to serving the tray "Registered dietician and food service manager are responsible to correct issues when identified</p> <p>Nursing staff educated&</p> <p>"To validate that pureed and other altered</p>		

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F 367	<p>Continued From page 31</p> <p>Manual documented that foods with high water content must be drained or have additional fluid thickened to the correct consistency. The Idaho Diet Manual referenced the National Dysphagia Diet: Standardization for Optimal Care guidelines.</p> <p>The National Dysphagia Diet: Standardization for Optimal Care 2002, documented a pureed diet was for people who had moderate to severe dysphagia with poor oral phase abilities and reduced ability to protect their airways. A puree diet consists of pureed, homogenous, and cohesive foods and should be "pudding-like."</p> <p>A 12/7/16 InterNet search of The American Speech-Language-Hearing Association at http://www.asha.org/public/speech/swallowing/Swallowing-Disorders-in-Adults, documented a 2004 study that identified signs and symptoms of swallowing disorders included coughing during that or right after eating or drinking, wet or gurgly sounding voice during or after eating or drinking, extra effort or time needed to chew or swallow, and food or liquid leaking from or getting stuck in the mouth. The study noted treatments for those with swallowing disorders included positioning and strategies to help the individual swallow more effectively.</p> <p>The facility's 5/28/16 NCD Thickened Fluid Consistency P&P documented nectar thick fluid "falls slowly from spoon and can be sipped through a straw or cup," honey thick fluid "drop from a spoon, but too thick to be sipped from a straw," and pudding thick fluid "maintains shape, needs to be taken with a spoon, too thick to drink." It documented a physician's order was</p>	F 367	<p>consistency tray items are appropriate or returned to the kitchen</p> <p>"Residents with dysphagia will not be provided variation in texture in a single bite, unless allowed by physician order</p> <p>"When thickening beverages, stir and wait a minimum of 1 minute before providing to the resident</p> <p>"Residents that receive an altered consistency diet, will remain upright for 20 minutes after eating</p> <p>"Care plans to include safe swallow strategies and positioning for residents with dysphagia</p> <p>"Education provided to alert staff of symptoms of potential aspiration</p> <p>Speech therapy staff educated&</p> <p>"After evaluation of dysphagia residents, specific swallowing needs of the resident are determined, these details will be included in the diet order as indicated</p> <p>"If a resident is identified to receive textures that at not compatible with the resident physician orders, the tray and all like trays will be returned to the kitchen</p> <p>"Immediate education to the dietary staff will be provided and the food item validated that it is prepared correctly</p> <p>Monitor</p> <p>The DNS and/or designee will audit altered texture items for appropriate consistency prior to snacks or meal service 5 times per week for 4 weeks, then two times per week for 8 weeks. Residents with new changes in dietary</p>		

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F 367	<p>Continued From page 32</p> <p>needed to alter the fluid consistency. It also documented pre-thickened beverages would be purchased to ensure proper consistency and that beverages not available in a pre-thickened form would be thickened according to the directions for the commercial thickening agent used.</p> <p>The label on the instant food thickener used in the facility directed staff to stir the liquid for 10-20 seconds and allow it to sit for 1-4 minutes until the right consistency was reached.</p> <p>The above standards of practice and facility used products directions, were not followed. Examples include:</p> <ol style="list-style-type: none"> 1. Resident #4 was admitted to the facility on 12/2/08, with diagnoses which included Huntington's disease, weight loss, and dementia. <p>The annual MDS assessment, dated 8/15/16, documented Residents #4 had difficulty swallowing liquids and solids leaking from her mouth.</p> <p>The 8/15/16 Nutritional Status and Dehydration/ fluid maintenance CAA worksheet documented Resident #4 had difficulty swallowing.</p> <p>The 11/15/16 quarterly MDS assessment documented Resident #4 had severe cognitive impairment, was unable to communicate her needs, and required a mechanically-altered diet.</p> <p>Resident #4's Physicians' orders included:</p> <p>* Regular pureed texture diet with honey thick liquids and Nosey cups with meals, initiated</p>	F 367	<p>textures will have their care plan reviewed in clinical meeting to validate safe swallow strategies and positioning is addressed. Starting the week of January 15, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 367	<p>Continued From page 33 11/25/13.</p> <ul style="list-style-type: none"> * Boost Plus 1.5 cal/mL thickened to honey thick during medication passes and documentation of the mL accepted, initiated 11/17/16. * A "full serving" of regular pudding 4 times a day with medications, initiated 6/7/16. <p>Resident #4's 3/13/15 Nutrition Care Plan documented a risk for nutritional decline related to Huntington's Chorea and the need for a pureed diet. Interventions included:</p> <ul style="list-style-type: none"> * Staff to provide all liquids in a coffee cup with lids and "straws," beginning 2/11/15. * Staff to offer between meal food items, revised 6/10/16. * Staff to provide meals per physician diet orders of pureed honey thick liquids, initiated 8/14/14, and revised 6/10/16. * Staff to provide Resident #4 with total assistance during meals, revised 6/10/16. * Staff to provide Nosey cups, revised 6/10/16. <p>A Chewing Difficulty Care Plan goals, dated 1/30/15, documented Resident #4 would have no episodes of choking when eating. Interventions included:</p> <ul style="list-style-type: none"> * Staff to monitor and evaluate food and beverage intake via observations and meal intake records, beginning 1/30/15. * Staff to refer for a speech therapy evaluation and follow-up as indicated, beginning 1/30/15. <p>Resident #4's care plan did not include her history of swallowing difficulty and safe</p>	F 367			

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F 367	<p>Continued From page 34 swallowing practices.</p> <p>A 4/23/15 ST note documented Resident #4 met the goal, "...exhibiting less than 15% s/sx of swallow impairment given full assistance from trained staff or caregivers following safe swallow procedures." The note documented facility staff were trained on the safest, least restrictive diet of pureed foods and safe feeding practices to decrease signs and symptoms of aspiration. The note did not document the safe swallowing procedures staff were to follow or position for Resident #4 during food or beverage intake.</p> <p>On 11/29/16 at 10:36 am, the SDC was observed giving 2 sips of water to Resident #4, who was in bed. The bed was raised approximately 20-degrees and Resident #4 was turned slightly to the left with her head positioned down and near her left shoulder.</p> <p>On 11/29/16 at 11:18 am, RN #1 was observed administering several oral medications that had been crushed and mixed in a pudding-like substance to Resident #4. Resident #4 was observed double swallowing after each bite of the pudding-medication mixture, which was administered with a spoon. The head of the bed was raised approximately 40-degrees and her head was hyperextended back which may increase the risk for aspiration according to the ST on 11/30/16 at 2:25 pm.</p> <p>On 11/29/16 at 12:20 pm, CNA #2 was observed preparing Resident #4's lunch at the bedside. The meal consisted of pureed mashed potatoes, brussel sprouts and chicken; and to drink honey thickened milk, boost, and juice. CNA #2 placed</p>	F 367			

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F 367	<p>Continued From page 35</p> <p>a couple spoonfuls of mashed potatoes into a Nosey cup and poured a small amount of honey thickened milk into the cup. She stirred the mixture a couple times and proceeded to give the potato and milk mixture to Resident #4. Immediately after the first sip, Resident #4 started to cough. The cough had a wet vocal quality to it. The mixture came out of the corners of her mouth. CNA #2 added more honey thickened liquids to the mixture and stirred a couple times and gave it to the resident. The food and honey-thick liquids were not mixed together completely and came out of the cup at different consistencies. Resident #4 immediately coughed again. The cough had a wet vocal quality to it. Initially, the head of the bed was raised approximately 40 degrees. After the second coughing episode, CNA #2 stopped the feeding, raised the head of the bed to approximately 65 degrees, repositioned Resident #4 and placed a pillow behind her head. CNA #2 resumed the feeding. At 12:36 pm, Resident #4 slid down in the bed, began to double swallow after each bite and coughed intermittently. At 12:40 pm, Resident #4 clamped her mouth and would not accept food. At that time, CNA #2 lowered the head of the bed to approximately 40 degrees and stopped feeding the resident.</p> <p>On 11/29/16 at 5:28 pm, CNA #11 brought a dinner tray into Resident #4's room, where the resident was slouched down in her bed. CNA #11 donned gloves and repositioned Resident #4 higher on her bed to an angle of approximately 60-degrees. CNA #11 stated she was not sure Resident #4's care plan addressed how to best help Resident #4 eat her meals. She stated Resident #4 began choking when eating meals.</p>	F 367			

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F 367	<p>Continued From page 36</p> <p>CNA #11 began assisting Resident #4 with her meal without first washing her hands or removing her gloves after assisting the resident reposition and adjust her clothing. CNA #11 stated she forgot to wash her hands and then used the safety-coated spoon to feed Resident #4 the mashed potatoes. CNA #11 gave Resident #4 five spoonfuls of food before the resident began to cough. Resident #4 clamped her mouth shut and would not accept another bite of food. CNA #11 put a cup of juice up to Resident #4's mouth and tipped the thickened fluids into her mouth. Resident #4 then accepted more juice and additional bites of food, which caused Resident #4 to cough intermittently throughout the meal observation. After CNA #11 finished assisting Resident #4 with her meal, she lowered the bed to approximately a 30-degree angle.</p> <p>On 11/30/16 at 11:06 am, Resident #4 was observed in the dining room sitting in a Broda chair. Her head was hyperextended and the chair was tilted back approximately 20-degrees. RN #1 gave Resident #4 her medications. There was also a serving of pudding to be given to Resident #4 by a CNA. CNA #5 prepared a cup of water for Resident #4 using a pre-filled/ pre-measured coffee cup, which contained the facility's thickening powder measured in the kitchen. (The coffee cup was to be used for hot beverages such as hot cocoa per the DM.) CNA #5 filled a coffee cup mug with water, stirred it with a spoon to dissolve the thickener and gave it immediately to Resident #4, placing the cup to her mouth and tipping it up. The water sprayed out of Resident #4's mouth and she coughed a couple of times after continuing to drink the water. CNA #5 placed the water cup on the table and left the</p>	F 367			

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F 367	<p>Continued From page 37</p> <p>room. CNA #10 then began to feed pudding to Resident #4. Resident #4 clamped her mouth shut after 2 bites of pudding.</p> <p>On 11/30/16 at 11:49 am, CNA #5 stated the cup of water she prepared had pre-measured/filled thickening powder already in it from the kitchen and labeled with an "N," that meant "nectar" thick, or an "H," which meant "honey" thick. She stated the cup was then filled with 8 ounces of water, which CNA #5 speculated squirted from the resident's mouth because of the way the resident "moves her tongue."</p> <p>According to the label on the thickening powder, the mixture must set for 1-4 minutes to reach the right consistency. (If not allowed to set the right amount of time the mixture may be too thin.)</p> <p>On 11/30/16 at 12:00 pm, the Dietary Manager stated pre-filled coffee cups with thickener were for hot beverages but not cold fluids; and the facility used pre-thickened honey-and-nectar-thick water, juice, and milk for residents. She stated staff was educated in orientation on thickened liquids, all of which were provided by the kitchen. The Dietary Manager stated the Thickened Fluid Consistency policy and procedure provided to staff during orientation did not specify how long the thickener needed to sit before being given to residents.</p> <p>On 11/30/16 at 12:40 pm, CNA #2 brought in Resident #4's lunch tray containing pureed mashed potatoes, corn, rice and enchiladas. The corn, rice and enchilada had not held their forms and were running together on the plate. In addition, the tray also contained honey thick</p>	F 367			

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F 367	<p>Continued From page 38</p> <p>water, Boost, milk and juice. CNA #2 repositioned Resident #4 up in bed to approximately a 60 degree angle. CNA #2 filled a Nosey cup with a couple scoops of corn and poured honey thick water into the cup. She stirred the mixed items briefly then gave it to Resident #4. At 12:46 pm, CNA #2 added more corn and more honey thick liquids to the cup, stirred it twice and immediately gave it to the resident. The corn and water mixture were not thoroughly mixed together and came out of the cup at different consistencies into Resident #4's mouth. Resident #4 immediately started to cough after a sip. The cough had a wet vocal quality to it. CNA #2 stirred the cup of corn again then put the cup down. At 12:49 pm, CNA #2 placed a couple spoonfuls of rice into a Nosey cup and added thickened milk to the cup, stirred it briefly and gave Resident #4 a sip of the mixture. The rice and milk were not thoroughly mixed together and they came out of the cup at different consistencies into Resident #4's mouth. Resident #4 immediately started coughing after the sip. The cough had a wet vocal quality to it. CNA #2 added more rice and milk to the cup, stirred it a couple more times and gave it to Resident #4. CNA #2 stated Resident #4 had started coughing last week and appeared to have an increased swallowing issue. The CNA said she asked an RN what to do about the residents increased difficulty in swallowing and the RN told her to try mixing the pureed food and liquids.</p> <p>On 11/30/16 at 2:25 pm, ST #1 stated pureed food consistency should be like pudding and not spread out on the plate. He stated he had not looked at the pureed food provided on the lunch plate closely for its consistency, but stated he would check the food to see if the consistency</p>	F 367			

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F 367	<p>Continued From page 39</p> <p>was correct. The ST stated pureed food and liquids should not be mixed together because it would produce two different consistencies in one food item if not mixed completely. ST #1 stated positioning of residents was important and he would evaluate Resident #4 that afternoon for increased swallowing difficulties. The ST stated that in general, 90 degrees was appropriate for intake, but positioning would vary depending on individual circumstances. He stated he would evaluate Resident #4 for proper positioning and recommend what was appropriate in her case. He stated residents at risk for aspiration should remain upright for 20-30 minutes after intake of food or drink.</p> <p>On 11/30/16 at 4:09 pm, ST #1 was observed testing the consistency of 2 pureed food items prepared for the evening meal service that night. The food items included a turkey sandwich on wheat bread, a pea green colored food item with a "mashed potato" like consistency, and a light brown food item (turkey sandwich on wheat) that poured easily when the ST tipped the cup. The pureed turkey sandwich spread out onto the plate and readily dripped off a spoon. ST #1 said the turkey sandwich was "thin" and "poured easily," which it was not the correct consistency for pureed. He said he was "not sure if it was even honey thick or nectar thick" consistency and that he would talk to the dietary staff the next day about the incorrect consistency of the turkey sandwich.</p> <p>On 11/30/16 at 4:16 pm, ST #1 stated staff should not give mixed consistencies to residents at the same time. The pureed food he looked at was not the correct consistency, but noted</p>	F 367			

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F 367	<p>Continued From page 40</p> <p>Resident #4 was evaluated and deemed safe to consume a pureed diet with honey thick liquids. He stated his recommendations would consist of positioning and educating staff on safe feeding practices.</p> <p>On 11/30/16 at 4:36 pm, RD #1 said pureed foods should be like pudding in consistency and, for the sake of safety, consistencies should not be mixed together.</p> <p>On 12/2/16, the facility provided the ST evaluation, dated 11/30/16, which documented Resident #4 was referred for swallowing difficulties during meals during the previous week. The note documented skilled ST was necessary to educate the caregivers and without therapy Resident #4 was at risk for possible aspiration. The note documented Resident #4 should be at an angle of no less than 60-degrees during intake and for 20 minutes after oral intake. Resident #4 was not to receive thin liquids, but was to receive pureed foods with honey thick liquids.</p> <p>2. On 11/30/16 at 4:09 pm, ST #1 was observed testing the consistency of two pureed food items prepared for the evening meal service that night. The food items included a turkey sandwich on wheat bread, a pea green colored food item with a "mashed potato" like consistency, and a light brown food item (turkey sandwich on wheat) that poured easily when the ST tipped the cup. The pureed turkey sandwich spread out onto the plate and readily dripped off a spoon. ST #1 said the turkey sandwich was "thin" and "poured easily," which it was not the correct consistency for pureed. He said he was "not sure if it was even</p>	F 367			

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F 367	<p>Continued From page 41</p> <p>honey thick or nectar thick" consistency and that he would talk to the dietary staff the next day about the incorrect consistency of the turkey sandwich.</p> <p>On 11/30/16 at 4:36 pm, RD #1 said pureed foods should be like pudding in consistency. The RD was informed of the earlier observation with the ST regarding the incorrect consistency of pureed turkey sandwich on wheat bread.</p> <p>On 11/30/16 at 5:35 pm, RD #1 was observed in the kitchen informing the Dietary Manager that the turkey sandwich was not the correct consistency for pureed.</p> <p>The facility's turkey sandwich on wheat bread recipe instructions were to arrange 1 slice of bread on a sheet pan with 2 slices of turkey on the bread and another slice of bread on top.</p> <p>The pureed turkey sandwich instructions directed staff to prepare the sandwich per the regular recipe. The instructions directed further for staff to prepare a slurry of water/stock and thickener, and lastly add 3 oz of slurry per portion. The "recipe notes" documented the amount of thickener required may vary relative to the liquid content of the cooked product, alternate processing and thickener for best results and check consistency of the food item periodically.</p> <p>On 11/30/16 at 5:40 pm, a test tray containing pea-green food item was of "mashed potato" consistency and maintained its shape. A thin light brown item, which the Dietary Manager identified as pureed turkey sandwich on wheat bread, was spread out on the plate and readily dripped from</p>	F 367			

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F 367	<p>Continued From page 42</p> <p>a spoon. When asked if the pureed turkey sandwich was to be served to residents, the Dietary Manager stated "yes." The Dietary Manager initially said the pureed turkey sandwich "looks a little thin," then said "It looks alright to me" when asked again if she was intended to serve the pureed turkey sandwich to residents. When asked to describe the consistency a pureed food should be, the Dietary Manager said pureed foods should be "mashed potato" or "pudding like" consistency. When asked if the turkey sandwich was the consistency of mashed potato or pudding like, the Dietary Manager stated "No." The Dietary Manager then said she would not serve the pureed turkey sandwich to residents and then instructed staff to remove all meal trays with the pureed turkey sandwich.</p> <p>On 11/30/16 at 5:52 pm, the Dietary Manager delivered new pureed foods for the residents of "mashed potato" like consistency turkey sandwiches.</p> <p>On 11/30/16 at 7:00 pm, the DNS stated the first turkey sandwich was not the correct consistency.</p> <p>There were 14 residents in the facility with orders for pureed diets, seven of whom also had orders for thickened liquids, and one resident who requested pureed foods.</p> <p>a. Residents with orders for a pureed diet and thickened liquids included:</p> <p>i. Resident #1 was admitted to the facility on 3/14/14 with diagnoses that included Lewy body dementia.</p>	F 367			

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F 367	<p>Continued From page 43</p> <p>Resident #1's annual MDS, dated 11/23/16, documented his cognitive skills were severely impaired.</p> <p>Resident #1's Nutrition care plan, dated 2/24/16, documented he was at risk for nutritional decline related to a choking episode on 1/27/15.</p> <p>Resident #1's physician's orders included a regular diet, pureed texture and nectar thick fluids on 2/25/16.</p> <p>ii. Resident #4 was admitted to the facility on 12/2/08 with diagnoses which included Huntington's disease, weight loss, and dementia.</p> <p>Resident #4's Nutrition Care Plan, dated 3/13/15, documented the risk for nutritional decline related to Huntington's chorea and the need for a pureed diet. Interventions included meals per physician diet orders of pureed honey thick liquids, initiated 8/14/14, and revised 6/10/16.</p> <p>Resident #4's Physicians' orders included a pureed texture diet with honey thick liquids and Nosey cups with meals, started 11/25/2013.</p> <p>iii. Resident #10 was admitted to the facility on 10/19/11 with diagnoses which included Alzheimer's disease, dementia, and history of other diseases of the digestive system.</p> <p>A 8/7/14 Nutrition Care Plan documented Resident #10 was at risk for nutritional decline related to swallowing difficulty, no teeth or dentures and a mechanically altered diet. Interventions included meals per physician diet orders with regular pureed and nectar thick</p>	F 367			

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F 367	<p>Continued From page 44 liquids, revised 6/10/16.</p> <p>Resident #10's December 2016 recapitulation of Physicians' orders included a regular pureed texture diet with nectar thick liquids, beginning 9/01/2015.</p> <p>iv. Resident #13 was admitted to the facility on 3/20/14 with diagnoses which included Alzheimer's disease.</p> <p>A 3/9/16 Nutrition Care Plan documented Resident #13 was at risk for nutritional decline related to altered texture for Alzheimer's. Interventions included meals per physician order with a regular pureed diet and nectar thick liquids, revised 6/10/16.</p> <p>* Resident #13 was on swallowing precautions and was to be out of bed in his wheelchair to eat/drink. Staff was to have him elevated 90 degrees using pillows, as needed, and for 30 minutes after eating.</p> <p>Resident #13's December 2016 Recapitulation of Physicians' orders included a regular pureed texture diet with nectar thick liquids, beginning 9/1/15.</p> <p>v. Resident #17 was admitted to the facility on 7/17/12 with diagnoses which included Huntington's disease, feeding difficulties and Alzheimer's disease.</p> <p>Resident #17's December 2016 Recapitulation Physicians' orders included a regular pureed texture diet with nectar thick liquids, beginning 11/03/15.</p>	F 367			

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F 367	<p>Continued From page 45</p> <p>vi. Resident #22 was admitted to the facility on 8/28/14 with diagnoses which included Alzheimer's disease.</p> <p>Resident #22's December 2016 Recapitulation Physicians' orders included a regular pureed texture diet with nectar thick liquids, beginning 9/01/15.</p> <p>b. Residents with orders for a pureed diet included:</p> <p>i. Resident #2 was admitted to the facility in 2012 and readmitted on 4/11/16 with multiple diagnoses including Alzheimer's dementia.</p> <p>A 4/18/16 Nutritional Care plan documented Resident #2 was at risk for nutritional decline. Interventions included meals per the physician's orders for regular pureed foods.</p> <p>Resident #2's recapitulation of Physicians' orders included a regular diet, pureed texture, starting on 4/19/16.</p> <p>ii. Resident #16 was admitted to the facility on 8/15/14 with diagnoses which included dysphagia of the oropharyngeal phase.</p> <p>Resident #16's December 2016 Recapitulation Physicians' orders documented Resident #16 was on a regular pureed texture diet, beginning 11/03/15.</p> <p>iii. Resident #18 was admitted to the facility on 8/29/2011, with diagnoses which included Parkinson's disease.</p>	F 367			

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F 367	<p>Continued From page 46</p> <p>Resident #18's December 2016 Recapitulation Physicians' orders documented Resident #18 was on a regular pureed texture diet, beginning 9/01/15.</p> <p>iv. Resident #19 was admitted to the facility on 3/20/15, with diagnoses which included dysphagia oral phase.</p> <p>Resident #19's December 2016 Recapitulation Physicians' orders documented Resident #19 was on a regular pureed texture diet with 1:1 assistance for cueing Resident #19 to slow down while eating and alternate liquids and solids, beginning 9/01/15.</p> <p>v. Resident #20 was admitted to the facility on 11/28/16, with diagnoses which included dysphagia of the oral phase.</p> <p>Resident #20's December 2016 Recapitulation Physicians' orders documented Resident #20 was on a regular pureed texture diet for difficulty chewing and swallowing, beginning 11/09/16.</p> <p>vi. Resident #21 was admitted to the facility on 2/04/15, with diagnoses which included Alzheimer's disease.</p> <p>Resident #21's December 2016 Recapitulation Physicians' orders documented Resident #21 was on a limited concentrated sweet pureed texture diet for dysphagia, beginning 10/25/16.</p> <p>The facility failed to ensure the health and safety of residents whose nourishment included pureed foods and/or thickened liquids, were not placed</p>	F 367			

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F 367	<p>Continued From page 47 at imminent risk of serious risk of harm, impairment, or death.</p> <p>NOTIFICATION AND REMOVAL OF IMMEDIATE JEOPARDY:</p> <p>On 11/30/16 at 7:05 pm, the facility Administrator and DNS were notified verbally and in writing regarding the Immediate Jeopardy situations, and of the need to formulate and implement a plan of removal.</p> <p>On 12/1/16 at 11:55 am, the facility provided evidence that an acceptable plan to remove the immediacy had been developed and implemented. Resident #4 was evaluated by the ST. A seating evaluation was ordered for proper positioning during meals and other times of intake and modifications to Resident #4's Broda chair were in process. All residents with orders for a pureed diet and/or thickened liquids were assessed and evaluated for signs and symptoms of aspiration. The removal plan also included re-education of dietary staff on following recipes and ensuring pureed foods were of pudding like consistencies. The nursing staff were also educated to return incorrect consistency foods to the kitchen; use pre-packaged nectar, honey and pudding thickened fluids; follow outlined directions to thicken hot beverages (except coffee to be thickened by kitchen staff); residents to remain upright for 20 minutes after eating; and not to alter the consistency of food or fluids by combining them unless specifically ordered by the physician.</p> <p>The above actions were verified and the Immediate Jeopardy removed prior to the survey</p>	F 367			

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F 367	Continued From page 48 exit conference completed on December 2, 2016.	F 367			
F 368 SS=E	483.60(f)(1)-(3) FREQUENCY OF MEALS/SNACKS AT BEDTIME (f) Frequency of Meals (f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. (f)(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. (f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on the resident and staff interview and record review, it was determined the facility failed to ensure bedtime snacks were offered to all residents. This was true for 5 of 13 residents in a Resident Group Interview and 5 of 15 sample residents (#2, #5, #7, #10 and #11). The failure created the potential for more than minimal harm if residents experienced hunger between dinner and breakfast and/or did not receive adequate nutrition to support healing or prevent weight loss. Findings include:	F 368	Resident Specific The clinical management team reviewed resident #2, 5, 7, 10, and 11 for HS snacks and validated they are offered room to room. Other Residents The clinical management team reviewed other residents for HS snack and validated they are offered room to room.	1/17/17	

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F 368	<p>Continued From page 49</p> <p>The key for facility ADL Flowsheets included:</p> <ul style="list-style-type: none"> * X- Resident Not Available * R- Resident Refused * NA- Not applicable <p>The key specific to bedtime snacks included:</p> <ul style="list-style-type: none"> * 1 - HS Snack Offered: hs - yes accepted, or hs - No [not accepted] * 2 - Percent of HS snack consumed. Staff were to document consumption as: "0" for 0 - 25%, "1" for 26% - 50%, "2" for 51% - 75%, "3" for 76% - 100%, or "4" for Resident Unavailable <p>On 12/1/16 at 12:45 pm, the RNC stated that "hs" with a number meant a snack was provided and the amount consumed. The RNC also stated that "hs" without a number for the amount consumed and "NA" both meant a snack was not offered.</p> <p>On 12/1/16 at 12:55 pm, the DNS stated that all residents should get an HS snack.</p> <p>On 12/1/16 at 5:01 pm, the RD #2 stated that all residents should be offered an HS snack.</p> <p>On 12/2/16 at 9:39 am, The DNS stated HS snacks should be documented in the ADL Flowsheet.</p> <p>On 12/2/16 at 12:11 am, CNA #6 stated "NA" would mean not done. She said she was not sure why "NA" would be documented.</p> <p>1. On 11/29/16 at 2:30 pm, during the Resident Group interview with 13 residents, 5 residents said they were not offered bedtime snacks. The</p>	F 368	<p>Facility Systems</p> <p>Clinical staff are educated to offer HS snack by the DNS and/or SDC to include but not limited to, taking the cart room to room and documentation of acceptance. The system is amended to include, review of the previous evenings HS snack consumption to snacks were provided and not documented as NA in clinical meeting.</p> <p>Monitor</p> <p>The DNS and/or designee will audit HS snack records 3 times per week for 12 weeks. Clinical rounds will validate residents are offered and assisted with snacks at the bedside 3 times per week for 12 weeks. Starting the week of January 15, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 368	<p>Continued From page 50</p> <p>residents said bedtime snacks were taken to the dining rooms and residents had to go to the dining room to get a snack. They said if they did not go to the dining room they did not get a snack.</p> <p>2. Resident #2 was admitted to the facility in 2012 and readmitted on 4/11/16 with multiple diagnoses including Alzheimer's disease, general anxiety disorder, and chronic pain.</p> <p>Resident #2's September 2016 HS snack record documented:</p> <ul style="list-style-type: none"> * "hs" 8 times * "NA" 4 times. <p>Resident #2's October 2016 HS snack record documented:</p> <ul style="list-style-type: none"> * "hs" 18 times * "NA" 3 times. <p>Resident #2's November 2016 HS snack record documented:</p> <ul style="list-style-type: none"> * "hs" 9 times * "NA" 3 times <p>3. Resident #7 was admitted to the facility in 2014 and readmitted on 6/28/16 with multiple diagnoses, including diabetes mellitus.</p> <p>On 11/29/16 at 10:35 am, Resident #7 said the facility staff did not always offer her a snack at bedtime.</p> <p>Resident #7's September 2016 ADL HS Snack</p>	F 368			

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F 368	<p>Continued From page 51 record documented</p> <p>*"hs" 13 times * "NA" 1 time</p> <p>Resident #7's October 2016 HS snack record documented:</p> <p>* "hs" 19 times * "NA" 3 times</p> <p>Resident #7's November 2016 HS snack record documented:</p> <p>* "hs" 19 times * "NA" 1 time</p> <p>4. Resident #11 was admitted to the facility on 11/21/16 with multiple diagnoses including ESRD.</p> <p>On 12/2/16 at 10:05 am, Resident #11 said the facility did not consistently offer her a bedtime snack.</p> <p>Resident #11's November 2016 HS snack record documented</p> <p>* "hs" 3 times * "NA" 3 times * "X" was documented on 11/21/16</p> <p>4. Resident #10 was admitted to the facility on 10/19/11 with diagnoses which included Alzheimer's disease, dementia, and history of other diseases of the digestive system.</p> <p>Resident #10's September 2016 ADL HS Snack</p>	F 368			

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F 368	Continued From page 52 record documented: * "hs" 13 times. * "NA" 7 times Resident #10's October 2016 ADL HS Snack record documented: * "hs" 11 times * "NA" 8 times Resident #10's November 2016 ADL HS Snack record documented: * "hs" 10 times * "NA" 6 times 5. There were similar findings for Residents #5 and #11 regarding the facility's failure to consistently offer HS snacks.	F 368			
F 373 SS=D	483.60(h)(1)-(3), 483.95(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT 483.60 (h) Paid feeding assistants- (h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if- (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law.	F 373		1/17/17	

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F 373	<p>Continued From page 53</p> <p>(h)(2) Supervision.</p> <p>(i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).</p> <p>(ii) In an emergency, a feeding assistant must call a supervisory nurse for help.</p> <p>(h)(3) Resident selection criteria.</p> <p>(i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems.</p> <p>(ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.</p> <p>(iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan.</p> <p>483.95</p> <p>(h) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.60 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff who</p>	F 373	Resident Specific The DNS provided performance		

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F 373	<p>Continued From page 54</p> <p>provided feeding assistance had successfully completed a State-approved training course before feeding residents. This was true for 1 random resident (#26). The failure created the potential for Resident #26 to experience discomfort and/or not reach his/her highest practicable level of well-being. Findings include:</p> <p>On 11/30/16 at 12:30 pm, the SSS was observed as she fed bites of food to Resident #26 during the lunch meal service in the East dining room.</p> <p>Resident #26's clinical record documented the resident required extensive assistance with eating. The record also documented Resident #26 did not have a swallowing disorder or require a mechanically altered diet.</p> <p>On 12/1/16 at 11:55 am, the SSS said she had fed Resident #26 a "couple bites" of food on 11/30/16 during the lunch meal service and that the DNS stopped her a few minutes later. The SSS said she had received feeding assistance training "about 20 years ago in another state" but not in Idaho. The SSS added that she was not a CNA.</p>	F 373	<p>improvement counseling regarding keeping within the scope of practice for a social service specialist. No staff without appropriate license/certification or successful completion of the State-approved training course for feeding assistance will assist residents with meal consumption.</p> <p>Other Residents No other residents were assisted with meal consumption by untrained feeding assistants.</p> <p>Facility Systems Staff is educated by the DNS and/or SDC that only RNs, LPNs, CNAs, or certified paid feeding assistance are permitted to assist residents with feeding. Currently no paid feeding assistant is utilized at the center.</p> <p>Monitor The DNS and/or designee will complete clinical rounds to validate residents are assisted with meals only by trained/certified personnel 3 times per week for 12 weeks. Starting the week of January 15, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		1/17/17	

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F 431	<p>Continued From page 55</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) 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) Procedures. 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>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--</p> <p>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>(g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>(h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature</p>	F 431			

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F 431	<p>Continued From page 56 controls, and permit only authorized personnel to have access to the keys.</p> <p>(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure residents' medications were available; medications were securely stored; and expired medications were not available for resident use. The failures created the potential for more than minimal harm for: a) 3 random residents (#21, #25 & #27) to experience uncontrolled BG levels if their quick acting insulin had been borrowed and was not available; b) 3 of 15 sample residents (#6, #9 & #12) and all other independently mobile residents if they were exposed to or ingested medicated shampoos or medicated powder in the East Spa room; and c) 3 of 15 sample residents (#7, #8 & #13) and 1 random resident (#22) to experience subtherapeutic benefit from expired medications. Findings include:</p> <p>1. On 11/29/16 at 12:00 pm, RN #1 was observed as she prepared to administer Resident #25's quick acting insulin. The RN removed a gallon Ziploc like bag from the medication cart. This bag had Resident #25's name on it and it</p>	F 431	<p>Resident Specific Resident #25 received the proper insulin as noted in the CMS-2567. The DNS provided performance improvement counseling regarding medications are not to be borrowed, alternative methods were reviewed with the licensed nurse.</p> <p>Other Residents No other residents received borrowed medications.</p> <p>Facility Systems Licensed nurses are educated on licensure, upon hire, and annually regarding the use of drugs and biologicals. Re-education was provided by the DNS and/or SDC to include but not limited to, do not borrow <input type="checkbox"/> order timely and utilize the E-kit, secure medications, remove discharged resident medication from the storage area, and do not utilize expired medications. The system is</p>		

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - CALDWELL			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
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F 431	<p>Continued From page 57</p> <p>contained Resident #25's long acting insulin pen and a Humalog solution cartridge pen labeled for Resident #27. The date 11/29/16 and initials were handwritten on Resident #27's Humalog solution cartridge pen. RN #1 recognized the initials as the night nurse's initials and said the night nurse must have put Resident #27's Humalog cartridge pen in Resident #25's bag by mistake. RN #1 said, however, that she used Resident #27's Humalog cartridge pen to administer Resident #25's Humalog insulin that morning. The RN removed Resident #27's Humalog cartridge pen from Resident #25's bag and said she would destroy it. The RN took Resident #27's Humalog solution cartridge pen to the medication room and returned to the medication cart empty handed a few moments later. At 12:04 pm, RN #1 looked for Resident #25's Humalog KwikPen but did not find it in the medication cart. The RN went back to the medication room and returned with a Humalog KwikPen labeled for Resident #21 which she said was new and that she "borrowed" for Resident #25 because there were no more Humalog KwikPens for Resident #25. At 12:08 pm, RN #1 used Resident #21's Humalog KwikPen to administer Humalog 4 units to Resident #25. After the administration, RN #1 placed the Humalog KwikPen in Resident #25's bag and said she would "keep" it in the bag and tell the DNS and the next shift what she had done.</p> <p>On 11/29/16 at 12:30 pm, the DNS said Resident #21's Humalog KwikPen was removed from Resident #25's bag and discarded. The DNS added that a "Stat" order was sent to the pharmacy for new insulin pens for Resident #21, #25, and #27.</p>	F 431	<p>amended to include periodic surveillance of medication administration and review of the refrigerated class medications monthly.</p> <p>Monitor The SDC and/or designee will complete medication pass surveillance two times per week for 4 weeks, then once weekly for 8 weeks. The medication storage is monitored on clinical rounds three times per week with expiration date review once monthly. Starting the week of January 15, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 431	<p>Continued From page 58</p> <p>2. On 11/29/16 from 4:36 am to 5:35 pm (59 minutes), the door to the Spa Room near the East dining room was observed to be ajar. Medicated shampoos and a medicated powder were observed in an unlocked drawer in the unsecured room as follows:</p> <ul style="list-style-type: none"> * Ketoconazole 2%: 4 containers for Resident #1; 2 containers for Resident #28; 3 containers for Resident #18; 2 containers for Resident #22; and 1 container without a pharmacy label; * Selenium sulfide 2.25% shampoo: 1 container for Resident #6; and * Nystop powder: 1 container for Resident #29. <p>On 11/29/16 at 5:35 pm, the DNS accompanied the surveyor to the Spa Room on the East hall. The DNS said the medicated shampoos and powder should be in a locked area and that the items would be secured that night. The DNS said it was a past practice that she had been trying to change.</p> <p>3. On 12/2/16 at 9:45 am, the medication room was inspected with LPN #2 and the SDC in attendance initially. During the inspection, the SDC was replaced by the RNC. The following medications were observed to be expired:</p> <ul style="list-style-type: none"> * Resident #7's Promethazine 25 mg tablets - 29 tablets expired 7/12/16 * Resident #8's injectable Ativan 2 mg/mL - 1 vial expired 6/2016 and 3 vials expired 8/2016 * Resident #13's hydrocodone-acetaminophen 5/325 mg tablets - 60 tablets expired 4/13/16 * Resident #22's injectable Ativan 2 mg/mL - 4 vials expired 6/2016 and 10 vials expired 8/2016 	F 431			

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F 431	Continued From page 59	F 431			
F 441 SS=D	<p>Two LNs immediately disposed of the expired medications.</p> <p>483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>(a) Infection prevention and control program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);</p> <p>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p>	F 441		1/17/17	

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F 441	<p>Continued From page 60</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which 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; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined the facility failed to ensure staff consistently performed standard hand hygiene measures to reduce the risk for infection. This was true for 1 LPN (#5) and 2</p>	F 441	<p>Resident Specific The clinical management team reviewed resident #4 and #31; they do not have evidence of infection based on lack of following the hand washing and glove use</p>		

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F 441	<p>Continued From page 61</p> <p>CNAs (#9 and #11) during observations of direct care for 1 of 15 sample residents (#4) and administration of eye drops for 1 of 11 residents (#31) observed during medication pass. The failure created the potential for the residents to develop infection from cross-contamination. Findings include:</p> <p>The facility's Hand Hygiene/Handwashing policy documented, "Handwashing is the single most important procedure for preventing the spread of infection. If soap and water are not available and hands are not visibly soiled, an alcohol-based hand rub (ABHR) may be used for routine decontamination of hands in clinical situations...Hand hygiene is to be performed:</p> <p>*After touching ...contaminated items, whether or not gloves are worn...*After removal of medical/surgical or utility gloves... *After contact with a patient's intact skin..."</p> <p>This policy was not followed. Examples include:</p> <p>1. On 12/1/16 at 3:35 pm, LPN #5 was observed as she prepared 7 oral medications and 1 eye drop medication (Restasis) for Resident #31. The LPN touched the computer screen, touched papers on top of the medication cart, closed medication cart drawers, and locked the medication cart with her bare hands. The LPN did not perform any type of hand hygiene before she applied exam gloves and went the resident's room. The LPN knocked on Resident #31's door then she administered 1 drop of Restasis in each eye while wearing the same gloves. After the eye drop administration, the LPN removed the gloves, administered the oral medications, then</p>	F 441	<p>policy.</p> <p>Other Residents Rounds reveal staff utilizing good hand washing and glove use techniques.</p> <p>Facility Systems Clinical staff are educated to infection control practices upon hire and annually. Re-education was provided by the DNS and/or SDC to include but not limited to, hand washing before and after glove use. The system is amended to include periodic surveillance of hand washing and glove use with personal cares, repositioning during meal time, and medication administration.</p> <p>Monitor The SDC and/or designee will complete hand washing surveillance three times per week for 4 weeks, then two times per week for 8 weeks. Starting the week of January 15, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 441	Continued From page 62 left the room. The LPN did not perform any type of hand hygiene prior to administering the eye drops or after the glove removal. On 12/2/16 at 3:40 pm, LPN #5 said nothing and simply nodded her head up and down when informed of the observations. 2. On 11/29/16 at 10:48 am, CNA #9 and CNA #10 entered Resident #4's room. CNA #10 stated Resident #4's attends needed changed. CNA #10 washed her hands and proceeded to place gloves on. CNA #9 placed gloves on her hand without washing her hands. They proceeded to change Resident #4's attends. 3. On 11/29/16 at 5:28 pm, CNA #11 brought Resident #4's dinner tray into her room. Resident #4 was slouched down in her bed and CNA #11 put on gloves and repositioned Resident #4 up higher on her bed at approximately a 60 degree angle. CNA #11 sat down to start assisting Resident #4 with her meal and did not wash her hands or remove her gloves after direct contact with the resident. She stated she forgot to wash her hands. She set down the silverware and washed her hands.	F 441			
F 458 SS=E	483.90(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT (d)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, it was determined the facility failed to ensure rooms with multiple	F 458	Resident Specific IDT reviewed residents in rooms 111, 112, and 114 regarding space for personal	1/17/17	

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F 458	<p>Continued From page 63</p> <p>residents had at least 80 square feet of living space per resident. This was true for 3 of 32 resident rooms (rooms 111, 112 and 114) which did not meet the minimum requirement of 80 square feet per resident. The failure created the potential for a negative effect for 1 of 15 sample residents (#9) and 5 random residents to experience a loss of well-being. Findings included:</p> <ul style="list-style-type: none"> - 2 residents were in room 111, which had 78.6 square feet per resident. - 2 residents were in room 112, which had 79 square feet per resident. - 2 residents were in room 114, which had 79.5 square feet per resident. <p>From 11/28/16 to 12/2/16, the residents in rooms 111, 112, and 114 said their rooms were satisfactory, including #9 who resided in room 112. The furniture in the rooms was arranged in a manner that provided for ease of access to the beds and closets.</p> <p>The facility had a room size requirement waiver for rooms 111, 112 and 114 which was granted on 10/29/15 and was in effect until the next on-site survey.</p> <p>On 11/29/16, the Administrator said the facility wanted to renew its room size requirement waiver.</p>	F 458	<p>belongings. Adequate space is provided for resident needs. The center has requested a room waiver for rooms 111, 112, and 114.</p> <p>Other Residents Other resident rooms observed by the IDT offer adequate space, ensuring that proper square footage is maintained.</p> <p>Facility Systems Social services director/designee will observe and interview residents in rooms with a waiver to validate needs continue to be met.</p> <p>Monitor The Executive Director (ED) and/or designee will review with social services director and observe rooms with waivers to monitor for needs met during the resident's care plan review process at least quarterly. Any concerns will be addressed immediately and discussed with the PI. The PI committee may adjust the frequency of monitoring after 12 weeks, as it deems appropriate.</p>		

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - C	STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State licensure survey conducted at the facility November 28, 2016 to December 2, 2016</p> <p>The survey team included:</p> <p>Linda Kelly, RN, Team Coordinator Teresa Kobza, RD/LD Ophelia McDaniels, RN</p>	C 000		
C 422	<p>02.120,05,p,vii Capacity Requirments for Toilets/Bath Areas</p> <p>vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water.</p> <p>This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to maintain the minimum number of tubs or showers for licensed beds. This affected 13 of 15 (#1-#13) sampled residents residing in the facility, and had the potential to affect all residents who resided in the facility. Findings include:</p> <p>The facility was licensed for 71 beds and had 63 residents who lived in the facility.</p> <p>State guidance at C-422 indicates, in part, "...there shall be at least one (1) tub or shower for</p>	C 422	<p>Resident Specific No specific residents were indicated.</p> <p>Other Residents All residents in the center are affected.</p> <p>Facility Systems The portable bathing tub is requested as a waiver. The units can be taken to patient rooms for those do not want to and/or are unable to leave their rooms, or those requiring and/or requesting the whirlpool unit for their comfort and relaxation. For</p>	1/17/17

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 12/30/16
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C 422	<p>Continued From page 1</p> <p>every twelve (12) licensed beds..." Seventy-one licensed bed divided by 12 licensed beds equaled 5.916 or 6 tubs or showers.</p> <p>On 11/29/16, the Administrator said the facility wanted to renew their waiver for the tub and shower requirement.</p> <p>Three bathing areas were identified during the "General Observations of the Facility" on 12/2/16 at 11:10 am with the Maintenance Director. They were: the East tub room with 1 tub, the Spa room with 1 shower, and the West Bath with 1 shower.</p> <p>During the survey, there were no concerns voiced and there were no written concerns identified regarding the number of bathing facilities.</p>	C 422	<p>those residents preferring or requiring showering/bathing rooms there is a spa room with a tub and two shower rooms as indicated in the CMS-2567.</p> <p>Monitoring The Executive Director is responsible to oversee that the center has adequate bathing units to meet the needs of the residents who reside in the center. Any concerns will be addressed immediately and discussed with the PI committee.</p>	