



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P. O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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December 22, 2016

Bradley Hruza, Administrator
Valley Vista Care Center Of St Maries
820 Elm Street,
St Maries, ID 83861-2119

Provider #: 135075

Dear Mr. Hruza:

On **December 5, 2016**, a survey was conducted at Valley Vista Care Center Of St Maries 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 a widespread deficiency 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(s) in writing on **December 1, 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. 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 **January 3, 2017**. Failure to submit an acceptable PoC by **January 3, 2017**, may result in the imposition of additional civil monetary penalties by **January 15, 2017**.

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

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

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

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

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

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Based on the immediate jeopardy cited during this survey:

F0225 -- S/S: J -- 483.12(a)(3)(4)(c)(1)-(4) -- Investigate/report Allegations/individuals
F0226 -- S/S: L -- 483.12(b)(1)-(3), 483.95(c)(1)-(3) -- Develop/implment Abuse/neglect, Etc Policies

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

Civil money penalty

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 5, 2017**, if substantial compliance is not achieved by that time.

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

Your facility's noncompliance with the following:

F0225 -- S/S: J -- 483.12(a)(3)(4)(c)(1)-(4) -- Investigate/report Allegations/individuals;
F0226 -- S/S: L -- 483.12(b)(1)-(3), 483.95(c)(1)-(3) -- Develop/implment Abuse/neglect, Etc Policies

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents # # **1, #4, & #16** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

If you believe the deficiencies have been corrected, you may contact David Scott, R.N. or Nina

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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>

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 **January 3, 2017**. If your request for informal dispute resolution is received after **January 3, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Debby Ransom, RN, RHIT, Supervisor
Long Term Care

dr/pt
Enclosures

cc: Chairman, Board of Examiners - Nursing Home Administrators

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2016
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES		STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 from November 28, 2016 to December 5, 2016.</p> <p>Immediate Jeopardy was identified at:</p> <p>F0225 -- S/S: J -- 483.12(a)(3)(4)(c)(1)-(4) -- Investigate/report Allegations/individuals F0226 -- S/S: L -- 483.12(b)(1)-(3), 483.95(c)(1)-(3) -- Develop/implement Abuse/neglect, Etc Policies</p> <p>The Immediate Jeopardy at F225 and F226 was removed on December 1, 2016.</p> <p>The surveyors conducting the survey were:</p> <p>Brad Perry, BSW, LSW, Team Coordinator David Scott, RN Nina Sanderson, BSW, LSW Susan Costa, RN Edith Cecil, RN Marci Clare, RN</p> <p>Survey Definitions: ADL = Activities of Daily Living AROM = Active Range of Motion BCP = Behavioral Care Program BID = Twice daily BIMS = Brief Interview for Mental Status BMI = Body Mass Index CDM = Certified Dietary Manager cm = Centimeters CNA = Certified Nursing Assistant</p>	F 000		

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

TITLE

(X6) DATE

Electronically Signed

01/03/2017

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 DC = Discontinue DON = Director of Nursing FTT = Failure to Thrive H = Hour hs = Hour of sleep IDT = Interdisciplinary Team IM = Intramuscular K2 = high calorie supplement, 2 calories per cc LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = milligram ML = Milliliter NTE = Not To Exceed PCP = Personal Care Physician PO = by mouth PR = per rectum PRN = As Needed PROM = Passive Range of Motion PU = Pressure Ulcer Q or q = Every RA = Restorative Aide Res = Resident R/T = Related to TIA = Transient Ischemia Attack, "mini strokes" TAR = Treatment Administration Record TID = Three times daily W/C = Wheelchair X = times	F 000			
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-	F 157		1/19/17	

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F 157	Continued From page 2 (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically	F 157			

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F 157	<p>Continued From page 3</p> <p>update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident, family member, and staff interview, observation, and record review, it was determined the facility failed to ensure physicians and family members were notified of significant changes in residents' clinical conditions. This was true for 2 of 9 (#3 and #4) sampled residents. This deficient practice had the potential to result in missed opportunities for medical intervention and family involvement. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 11/9/16. His diagnoses included dementia, FTT, and PU on his left buttock. Resident #3's record documented falls on 2 occasions, however, his record did not include documentation that his physician was notified of the falls. Examples include:</p> <p>a. Interdisciplinary Progress Notes, dated 11/10/16 at 4:30 am, documented Resident #3 was found on the floor at 3:45 am. The progress note stated he was found on his left side, with skin tears to his first and second knuckles of his left hand, as well as, a large elevated contusion to his left forehead. The progress note did not include documentation his physician was notified of the fall and injuries.</p> <p>b. "Interdisciplinary Progress Notes," dated 11/18/16 at 12:00 am, included documentation Resident #3 was being assisted with cares by 2 staff members at 8:55 pm on 11/17/16. The progress note stated he slid out of bed onto the</p>	F 157	<p>This Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because the provisions of the federal and state law require it. This provider maintains that the alleged deficiencies do not individually, or collectively, jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of long term care facilities, and this Plan of Correction, in its entirety, constitutes this providers allegation of compliance.</p> <p>Completion dates are provided for the procedural procession purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in compliance with requirements of participation or that corrective action was necessary.</p> <p>F157:</p>		

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F 157	<p>Continued From page 4 floor. The progress note did not include documentation his physician was notified of the fall to the floor.</p> <p>During an interview on 12/1/16 beginning at 10:45 am, the Behavioral Unit Manager reviewed Resident #3's record and stated his record did not include documentation that his physician was contacted after the fall or when he slid out of bed.</p> <p>2. Resident #4 was admitted to the facility on 7/21/15. Her diagnoses included depression and Alzheimer's Disease.</p> <p>A Resident Incident Report, dated 11/23/16 at 9:30 pm, documented Resident #4 was found lying on the floor at her bedside with a 1 cm laceration to the bridge of her nose. The incident report documented the physician was notified at 9:30 pm. The incident report did not document family notification.</p> <p>On 11/29/16 at 3:00 pm, Resident #4's family member approached the nurse's station and asked the nurse, "What happened to Resident #4's face?"</p> <p>On 11/29/16 at 3:45 pm, Resident #4's family member stated she was not notified of the fall with injury to the resident's face.</p>	F 157	<p>Corrective Action:</p> <p>On 11/29/2016, Resident #4's family was notified of resident #4's fall on 11/23/2016. Resident #3's physician was notified of the events on 11/10/2016 and 11/18/2016 on the days that the events occurred. However, the documentation for notification of the physician was provided on Resident #3's Accident and Incident reports and not in the interdisciplinary progress note. Upon notification of the deficient practice the nursing staff was educated on the requirements to notify family and physicians at the time of a change in resident status, accident, or other required events, and the importance of thoroughly documenting notifications as required.</p> <p>Potential Residents:</p> <p>All residents have the potential to be affected by this cited deficient practice. All of the resident accident and incident reports are being audited from 12/01/2016 forward, starting 12/30/2016, to ensure that family or physician notifications were completed when required.</p> <p>Facility Systems:</p> <p>Staff were in-serviced beginning on 12/27/2016 and continuing through 12/30/2016 on the federal citation, the cited deficient practice, and the</p>		

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F 157	Continued From page 5	F 157	importance of physician and family notification when a resident experiences a change in status, an accident, or other required event. Starting January 5th, all residents Accident and Incidents, physician's orders, and changes in clinical status will be reviewed and audited by the IDT in daily morning meetings to ensure that resident's physicians and families have been notified when required. Monitoring: Required family and physician notifications will be reviewed and audited at the daily stand-up meeting Monday through Friday by the IDT and by the RN manager on the weekends. Beginning in January, the audits will be reviewed by the QAA Committee to ensure substantial compliance and will continue for five months, at which time the need for continued audits will be re-evaluated.		
F 221 SS=D	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F 221		1/19/17	

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F 221	<p>Continued From page 6</p> <p>42 CFR §482.12, 483.12(a)(2)</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms.</p> <p>(a) The facility must-</p> <p>(1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record and policy review, and staff interviews, it was determined the facility failed to ensure a resident was free from restraints. The facility failed to identify the medical need for the restraint, ensure the least restrictive restraint was used, and re-evaluate the ongoing need for the restraint. This was true for 1 of 2 (#1) residents sampled for restraints. This had the potential for physical harm if restraints were improperly used, and the potential for psychosocial harm if the resident experienced a psychological decline to due feelings of being restricted in movement. Findings include:</p> <p>The facility's December 2007 Use of Restraints policy documented:</p>	F 221	<p>Corrective Action:</p> <p>On 12/28/2016 a comprehensive restraint reduction assessment was completed by an occupational therapist for Resident #1 and it was determined that the residents leg straps were the residents least restrictive device. Resident #1 was interviewed on 12/28/2016 by the Resident Services department and a mood and depression screen was conducted. The resident's depression screen continued to show minimal depression. Resident #1 was asked how she felt about the leg straps in her chair and she stated that she feels safer with</p>		

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F 221	Continued From page 7 * Restraints would only be used for the safety and well-being of the resident and only after alternatives had been tried unsuccessfully. * Restraints would only be used to treat the resident's medical symptoms and never for staff convenience, or for the prevention of falls. * Restraints would only be used if the resident had a specific medical symptom that could not be addressed by another less restrictive intervention. * Prior to placing a resident in restraints a pre-restraining assessment and review to determine the need for restraints would need to be completed. * Individuals restrained would be reviewed quarterly to determine whether they were candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination. * Documentation regarding how the restraint benefited the resident and addressed the medical symptoms. Resident #1 was admitted to the facility on 4/18/14 with multiple diagnoses, including Huntington's Chorea, dementia and anxiety. Resident #1's 8/5/16 quarterly MDS assessment documented she: * Did not have a physical restraint, * Had modified independence for daily decision	F 221	them and that it makes it easier for her to eat. Resident was interviewed a second time on 12/30/2016 by the Resident Services department and the facilities consultant LCSW, who participated via telephone conference. Resident #1's fall care plan was reviewed and revised on 12/19/2016. Resident #1's care plan was updated to reflect the use of the leg straps as an enabling device to improve residents safety with sitting and her ability to eat as a result of her involuntary choreic movements. A clarification order was also obtained from the resident's physician instructing the use of the leg straps PRN to improve postural stability due to choreic movements. Other Residents: This deficient practice has the potential to affect all residents within the facility that require restraining devices. However, at this time there are no other residents within the facility utilizing restraining devices. Facility Systems: Staff were in-serviced beginning on 12/27/2016 and continuing through 12/30/2016 regarding the regulatory requirement of F221, Valley Vistas policy and procedure regarding the use of restraints, and the deficient practice. Effective 12/28/2016, no restraints will be initiated without an evaluation and/or input from a physical or occupational		

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F 221	<p>Continued From page 8 making, and * Required extensive assistance for bed mobility and transfers.</p> <p>Resident #1's Occurrence Reports for July and August 2016 documented the following:</p> <p>* 7/28/16 - "Throwing herself out of bed and chair." The unsuccessful interventions included: "Assess needs, Explain safety, Change Staff, Change Environment."</p> <p>* 7/31/16 - "Resident attempted to throw herself out of her chair several times." The unsuccessful interventions included "Explain care, change staff, reassure, change environment." The successful intervention documented, "Able to redirect [without] further incident."</p> <p>* 8/2/16 - "She said she wanted to go outside. Then she tried to slide out of chair." The unsuccessful interventions included "Re-assure, validate concerns, change staff, change environment, offer to go back outside." The immediate interventions section documented, "Res[ident] cont[inued] to try to throw self out of chair despite repeated attempts to explain why she shouldn't do that."</p> <p>* 8/10/16 - "Resident was trying to throw herself to the floor from her chair. So I asked her what she was trying to do then she stated she was trying to hurt herself." The unsuccessful interventions included "1 [on] 1 for safety, assess needs, reassure." The Revised Plan section documented, "Assess for leg strap while in Broda chair."</p>	F 221	<p>therapist to determine if less restrictive measures are available or appropriate. Licensed nurses were in-serviced on the F221 regulatory requirements, Valley Vistas policy and procedure, and the deficient practice found during the facilities 2016 recertification survey, and this protocol change during a licensed nurse meeting held on 12/30/2016. Furthermore, nurses were instructed by the DNS to obtain orders for therapy to evaluate and treat residents prior to requesting orders for the use of a restraint from the physician. Only after a therapist has assessed the resident and deemed the restraint safe, appropriate and necessary will the nurse request orders for the restraint device. Effective immediately, all restraints will be assessed for removal or reduction quarterly and PRN by a therapist with the use of the comprehensive restraint reduction assessment.</p> <p>Monitoring:</p> <p>Beginning January 18th 2017, an audit will be conducted weekly by the DNS or her designee to ensure compliance with Valley Vista policy and regulatory requirements regarding restraint usage and attempts to avoid, reduce, or eliminate the use of restraints. The results of these audits will be reviewed at the monthly Quality Assurance meetings. This audit will be conducted weekly for four weeks, followed by bi-monthly audits for two months, and then monthly for two</p>		

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F 221	<p>Continued From page 9</p> <p>Resident #1's 8/10/16 Device Decision Guide: Restraint, Enabler, and Safety Hazard, signed by the Behavior Unit Manager, did not document the need for the restraint, what other least restrictive measures were taken or attempted, or how the restraint was to be fitted.</p> <p>Resident #1's 8/10/16 Physical Restraint Informed Consent form documented "alternative non-restraint approaches have proven to be ineffective: Talking [with] resident about dangers of falling out of w/c."</p> <p>Resident #1's 8/10/16 physician's telephone orders documented, "Leg strap while in Broda to keep from potential harm when attempting to throw self out of chair. Release Q2 [hours] [and] at meals."</p> <p>Resident #1's 8/10/16 restraint note documented:</p> <p>"We have explained the risks to [Resident #1] in regards to throwing herself out of her chair, but she continues to attempt it. We are placing the leg strap for [Resident #1]'s safety. If [Resident #1] gets too weak and her attempts to throw herself out of the chair are no longer occurring, the strap will be discontinued. The restraint will be evaluated at intervals not to exceed 3 month."</p> <p>Resident #1's Fall care plan on 8/10/16 documented, "Leg strap while in Broda chair. Release Q2[hours] [and] PRN."</p> <p>Resident #1's progress notes from 8/11/16 to 11/29/16 did not document further attempts by her to "throw herself out of her wheelchair."</p>	F 221	<p>months at which time the need for continued audits will be re-evaluated.</p>		

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F 221	<p>Continued From page 10</p> <p>Resident #1's 8/29/16 physician's telephone orders documented, "OK to leave leg strap on [at] meals due to progression of Hunnington's [sic]."</p> <p>Resident #1's Fall care plan, on 8/29/16, documented, "Leg strap may be placed on [at] meals if needed."</p> <p>Resident #1's current Fall care plan documented, "Leg strap while up in Broda chair. Release Q2H, All meals and PRN."</p> <p>On 11/29/16 from 11:39 am to 12:17 pm, Resident #1 was observed in her Broda wheelchair at a table in the dining room. The wheelchair's back was angled at approximately 65 to 70 degrees. Resident #1 had bilateral padded leg straps, which extended from beneath the wheelchair seat, securing the medial and anterior thighs and buckled at the back of the wheelchair. Resident #1 was observed several times rocking back and forth in her wheelchair. CNA #6 assisted Resident #1 with her meal and did not release the leg strap during that time. During the meal, LN #1 sat down opposite of Resident #1 for several minutes to observe CNA #6 assist the resident and did not release the strap. At 12:15 pm, CNA #2 was observed assisting Resident #1 with her ice cream and did not release the strap.</p> <p>On 11/29/16 from 5:32 pm to 5:47 pm, Resident #1 was observed in her Broda wheelchair at a dining room table. The bilateral leg straps were secured on her thighs. CNA #7 assisted Resident 1 with her meal and did not release the leg strap.</p> <p>On 12/1/16 at 9:05 am, LN #2 said Resident #1's</p>	F 221			

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F 221	<p>Continued From page 11</p> <p>leg strap should be released during meals per the care plan.</p> <p>On 12/1/16 at 2:15 pm, CNA #2 said Resident #1's leg strap was to be used during meals due to her decline.</p> <p>On 12/1/16 at 2:30 pm, the Behavior Unit Manager said Resident #1's leg strap was used to keep her from throwing herself out of the wheelchair and to keep her safe. She said the 8/10/16 Device Decision Guide was the assessment for Resident #1 and there had not been another evaluation since placement of the leg strap. She said there was no other assessment in the clinical record and she did not think that therapy had completed an evaluation. The Behavior Unit Manager said in the past, Resident #1 received 1-on-1 supervision, but that was not attempted as an option prior to the leg strap placement and no other least restrictive alternatives had been tried. She said the facility had not consulted with a neurologist prior to the leg strap placement. She said the strap could be left on during meals. When she reviewed the physician's orders and the care plan, she said she did not know why the care plan had not been updated to reflect the physician's orders. The Behavior Unit Manager said Resident #1 tended to attempt to throw herself out of her wheelchair at meal times, but said she could not find that documentation in the clinical record. She said Resident #1's 8/29/16 Physician's order did not clarify the criteria for staff to use when applying the strap during meals.</p> <p>On 12/1/16 at 5:30 pm, the Director of Therapy said the Therapy Department had not been</p>	F 221			

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F 221	Continued From page 12 involved in re-assessing Resident #1's leg strap because she was on Hospice at the time. The facility failed to establish a medical need for Resident #1's restraint, attempt alternative least restrictive interventions prior to placing the restraint, adequately assess the resident for the restraint, assess for proper fitting of the restraint, provide staff with consistent direction of its use, and re-evaluate the restraint within 3 months of its placement.	F 221			
F 225 SS=J	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a	F 225		1/19/17	

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F 225	<p>Continued From page 13 nurse aide or other facility staff.</p> <p>(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p>	F 225			

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F 225	<p>Continued From page 14</p> <p>Based on observation, resident and staff interview, facility policy/procedure review, and record review, it was determined the facility failed to thoroughly investigate allegations of abuse and/or neglect, and injuries of unknown origin. This was true for 2 of 8 sampled residents (#1 and #4) reviewed for accidents and supervision and for one random resident (#16) who filed a grievance with the facility alleging a staff member had verbally abused and intentionally intimidated her. Specifically:</p> <p>a) Resident #16 filed a grievance with the facility on 9/27/16 that alleged a specific staff member had verbally abused and intimidated her. The staff member was reassigned and continued to care for other residents; an investigation into the allegation was not conducted and the allegation was not reported to the State Agency. The identified staff member was observed on duty in the facility on 12/1/16. The resident who filed the 9/27/16 grievance stated she continued to be fearful of the staff member and still felt she had been verbally abused and intimidated.</p> <p>b) Resident #4 was assessed on 11/1/16 with bruises to her right forearm that were depicted by the facility as arranged in a pattern consistent with fingerprint bruising. The staff member who reported the bruising surmised the resident's arms had been held by staff while cares were provided. There was no evidence the facility investigated this statement further to eliminate abuse as the possible cause of the bruising. The facility concluded the injury was self-inflicted.</p> <p>c) Resident #1, who was equipped with a restraint belt to her wheelchair, was assessed on</p>	F 225	<p>Corrective Action:</p> <p>The CNA that was alleged to have verbally abused resident #16 was immediately suspended pending investigation. A full investigation was conducted and reported to the Bureau of Facility Standards. The injuries of unknown origin on Resident #1 and Resident #4 were fully investigated and the investigations were reported to the Bureau of Facility Standards. All staff members working on the evening of the discovery of the deficient practice were in-serviced immediately on the facilities grievances and abuse and neglect policy and procedures. The IDT staff was immediately in-serviced and retrained on properly identifying abuse allegations and examining the contents of abuse allegation reports, accident/incident reports, occurrence reports, and grievances on 12/01/2016. No abuse was substantiated in any of the incidents.</p> <p>Other Residents:</p> <p>All residents have the potential to be affected by this deficient practice. All staff members were in-serviced on the facilities abuse and neglect policies and procedures prior to them working with residents after the discovery of deficient practice. All accident and incident reports and ancillary documents 60 days prior to the finding of the deficient practice were reviewed by the administrator and Corporate Compliance Nurse to</p>		

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F 225	<p>Continued From page 15</p> <p>9/14/16 with a large hematoma on her outer thigh. The facility failed to provide evidence the injury was investigated. The facility attributed the hematoma to an injection Resident #1 received six days prior to the appearance of the injury.</p> <p>The failure of the facility to identify and thoroughly investigate the above incidents placed Residents #1, #4, and #16, and other residents with injuries of unknown origin, and residents who came in contact with the staff member accused of verbal abuse and intimidation, in immediate jeopardy of serious harm, impairment, or death.</p> <p>Findings include:</p> <p>The facility's Abuse & Neglect Prevention Training Program, dated 11/19/16, documented protocols and procedures for all staff related to "Prevention, Identification, Investigation, Protection, [and] Reporting" of abuse, neglect, and misappropriation of resident property. Training Program materials were determined to be compliant and consistent with related federal regulations.</p> <p>1. Resident #16 was admitted to the facility on 9/16/16, with diagnoses of bipolar disorder, histrionic personality disorder, narcissistic personality disorder, dependent personality disorder, major depression, and anxiety disorder.</p> <p>Resident #16's Mood/Behavioral Alteration Care Plan, dated 9/21/16, documented:</p> <p>* "Resident's behaviors and attempts to manipulate will not interfere with care delivery."</p>	F 225	<p>determine if any other injuries of unknown origin went unreported or any allegations of abuse went uninvestigated. All residents and/or representatives were interviewed to identify any concerns regarding care or potential abuse allegations. The resident and family interviews were completed on 12/30/2016. No additional incidents or unaddressed care concerns were discovered.</p> <p>Facility Systems:</p> <p>All policies and operational implementation procedures related to grievance reports and follow up investigations, accident and incident reports and investigations, and abuse investigations and reporting protocols were reviewed by the Administrator, Corporate Compliance Nurse, and the Corporate Compliance Director. All accident and incident reports and associated ancillary documents and grievances submitted are now audited daily by members of the IDT and Corporate Compliance Director or designee, to identify any potential injuries of unknown origin or any potential incidents of abuse. Action plans are now implemented for each accident and incident report, grievance, and allegation of abuse that requires additional follow up investigations. Copies of all abuse allegations, accident and incident reports, occurrence reports, and grievance reports, along with IDT action plans are</p>		

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F 225	<p>Continued From page 16</p> <ul style="list-style-type: none"> * "Resident will experience a stable and comfortable environment." * "Be alert for attempts to manipulate that are really bids for additional attention." * "Do not accept resident accounts of others' statements, behaviors; deal directly with individual." <p>A September 2016 Monthly Behavior Summary documented Resident #16 exhibited 28 episodes of anxiety with distress that month, 6 episodes of delusions with distress, 8 episodes of delusions without distress, 9 incidents of verbal aggression, 2 incidents of physical aggression, 12 episodes of socially inappropriate behavior, 5 episodes of resistance to care, 2 incidents of hallucinations with distress, 5 incidents of hallucinations without distress, and 15 incidents of paranoia.</p> <p>The September 2016 Monthly Behavior Summary documented Resident #16 on 9/26/16 experienced two episodes of anxiety with distress and a single episode each of socially inappropriate behavior and paranoia. On 9/27/16, the Monthly Summary documented Resident #16 experienced 1 episode each of anxiety with distress and delusions without distress.</p> <p>A Physician's Telephone Order, dated 9/26/16, documented Resident #16 was admitted to the facility's Behavior Program "per IDT assessment."</p> <p>On 9/27/16, Resident #16 filed a Grievance/Complaint Report with the facility alleging CNA #4 was "verbal[ly] abusive" and "intimidated" her during cares. The Grievance/Complaint Report did not include</p>	F 225	<p>now submitted to the Corporate Compliance Director or designee for review.</p> <p>Monitoring:</p> <p>Beginning the week of January 2nd 2017, the Corporate Compliance Director will meet with the Nursing Home Administrator once a week to review all action plans and findings of abuse, accidents and incidents, grievances, and occurrences. The Nursing Home Administrator will present and review all action plans and findings on abuse allegations, accident and incidents, grievances, and occurrences at monthly QA meetings for any further follow up and for ongoing training purposes. The meeting between the Corporate Compliance Officer and the Nursing Home Administrator will be conducted weekly for four weeks, followed by bi-monthly meetings for two months, and then monthly meetings for two months, at which time the need for continued audits will be re-evaluated.</p>		

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F 225	<p>Continued From page 17</p> <p>evidence of an investigation. The Report documented CNA #4 was relocated to another area of the facility where she would not come into contact with Resident #16.</p> <p>A Care Conference Report, dated 9/27/16, documented Resident #16 was admitted to the Behavior Care Program "due to her socially inappropriate behaviors" and that she continued to exhibit "behaviors that require a significant amount of 1:1 [staff] time and attention."</p> <p>On 12/1/16 at 8:25 am, CNA #4 identified how to recognize, respond to, and report suspected abuse and/or neglect and stated she and all facility staff received abuse prevention training annually.</p> <p>On 12/1/16 at 9:50 am, the Administrator, who also served as the facility's Abuse Prevention Coordinator, stated both he and Resident #16 remembered and had recently discussed the 9/27/16 incident. The Administrator stated Resident #16's report of "verbal abuse" and intimidation by CNA #4 was not processed according to the facility's policy or "normal procedure" because he had not been shown Resident #16's written statement. The Administrator stated he also did not personally initiate an investigation into the allegation of verbal abuse and intimidation as the Grievance/Complaint Report documented Resident #16 was "satisfied" with CNA #4's reassignment to another area of the facility.</p> <p>On 12/1/16 at 10:45 am, the DON stated she did not recall seeing Resident #16's written statement regarding the 9/27/16 incident either,</p>	F 225			

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F 225	<p>Continued From page 18</p> <p>but spoke with both Resident #16 and CNA #4 at the time and considered the matter resolved to Resident #16's satisfaction.</p> <p>On 12/1/16 at 10:50 am, Resident #16 stated she remembered the 9/27/16 incident with CNA #4, still considered CNA's behavior that day as verbally abusive and intimidating. She said, "I'm just actually afraid of her. I wouldn't want anyone else to go through what I've been through with her [CNA #4]."</p> <p>An investigation into Resident #16's allegation was not conducted and the allegation was not reported to the State Agency.</p> <p>2. Resident #4 was admitted to the facility on 7/21/15, with diagnoses that included Alzheimer's disease, dementia with behavioral disturbance, anxiety, and pain.</p> <p>Resident #4's quarterly MDS assessment, dated 9/9/16, documented her cognition was severely impaired, she rarely/never made decisions, she was verbally aggressive, rejected cares, and exhibited behaviors of hitting and scratching herself.</p> <p>A Resident Incident Report for Resident #4, dated 11/1/16 at 2:30 am, documented, "Found 4 bruises. Bruise to inner right forearm 3 x 2.25 cm. Bruises to outer right forearm approx 1 x 1 cm, 1.5 x 1 cm, 1.25 x 1 cm.</p> <p>A staff statement, dated 11/1/16 at 2:30 am, documented: "It looked like fingerprints from someone's hand. I went and got [Nurse] to come take a look. I believe these may have happened</p>	F 225			

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F 225	<p>Continued From page 19</p> <p>from someone giving cares and holding on to [Resident #4's] arm." The facility's incident report body diagram illustrated the bruises were arranged in a pattern consistent with fingerprint bruising.</p> <p>An undated "Follow up Incident Report Impaired Skin" documented Resident #4 was combative and resistive to cares. A Behavior Monitor for 10/31/16 documented the resident exhibited striking out, pinching, kicking, and pushing, and had been known to squeeze her own forearms "hard" when upset. It was determined the bruising was "reasonably related to event." The report was signed by RN UM #1 and the Administrator. There was no documentation the facility investigated further to rule out abuse.</p> <p>On 12/1/16 at 8:10 am, RN UM #1 stated she interviewed and assessed Resident #4 and did not think the bruising looked like fingerprints. RN UM #1 produced a document that noted staff were interviewed, however, no other individual staff statements were provided.</p> <p>On 12/1/16 at 9:45 am, the Administrator stated he reviewed the accident/incident reports and allegations of abuse reports prior to signing them. Referring to the 11/1/16 Resident Incident Report, he stated he had not signed it because he had not reviewed it. The Administrator stated "If I had read this, I would have investigated it to rule out abuse. Should have caught that statement regarding the fingerprints."</p> <p>3. Resident #1 was admitted to the facility on 4/18/14 with multiple diagnoses, including Huntington's Chorea, dementia, and anxiety.</p>	F 225			

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F 225	<p>Continued From page 20</p> <p>The 8/5/16 quarterly MDS assessment documented Resident #1 had modified independence for daily decision making.</p> <p>Resident #1's September 2016 MAR documented an order on 9/10/15 for 75 mg IM every 2 weeks Haldol Docanoate for Huntington's Chorea.</p> <p>Resident #1's September 2016 Physician Order Report documented an order on 8/10/16 for a leg strap while in her Broda chair to keep from potential harm when attempting to "throw herself out of the chair" and to remove the strap every two hours. The padded leg strap was observed throughout the survey attached around Resident #1's upper legs, and underneath and behind her wheelchair.</p> <p>The September 2016 MAR documented the IM Haldol Docanoate was administered to Resident #1's right hip on 9/8/16.</p> <p>Resident #1's 9/14/16 Progress Note documented, "Res[ident] noted to have 10 cm [by] 7 cm reddened area to R[ight] outer thigh [with] firm round center appears non tender to touch [no] bruising or open areas; [Physician] here to eval[uate] [Family Member] also present, states hematoma that should resolve n[o] n[ew] o[r]ders] re[ceive]d..."</p> <p>Resident #1's Incident Report, dated 9/14/16, documented: "On 9/14/16 Nurse noted a 10 cm [by] 7 cm oval area of redness with a firm lump in center on [Resident #1's] right upper thigh. [Resident #1] had no idea what had happened.</p>	F 225			

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

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F 225	<p>Continued From page 21</p> <p>[Resident #1] does not move around a lot at times due to her Huntington's chorea. MAR revealed that [Resident #1] was given her Haldol injection 9/12/16 on right hip...[Nurse] was a traveling nurse and has finished her contract with us. I was unable to contact her regarding the injection. Family and Hospice were notified. Hospice ordered warm packs to area. Area is resolving." The documentation did not include information ruling out Resident #1's leg restraint as a source of the injury.</p> <p>An undated and unsigned document provided by the facility on 12/1/16, documented, "Interviewed [2 CNAs] regarding bump on thigh. They thought it could be from her attempting to throw herself out of her w/c or roll up to mat. Talked to [Nurse] who came in to assess res[ident]. She thought it was an encapsulate from haldol IM..."</p> <p>The facility's completed abuse investigations from June 2016 to November 2016 did not include documentation related to the above issue.</p> <p>On 12/1/16 at 8:35 am and 9:10 am, the Behavior Unit Manager said she interviewed two CNAs and a nurse, but did not have witness statements for them. She said Resident #1's leg restraint was ruled out as a source of the injury due to the location of the hematoma, which said was likely caused by the Haldol injection. She reviewed the MAR and said the IM Haldol was given to the right hip on 9/8/16, and not on 9/12/16, as the report documented. She said had she realized the discrepancies at the time of the investigation she would have investigated the incident as an injury of unknown origin to rule out abuse.</p>	F 225			

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F 225	<p>Continued From page 22</p> <p>On 12/1/16 at 9:25 am, the Administrator reviewed the investigation and said based on the information in the report, he could not determine the cause of the hematoma and it should have been investigated more thoroughly to rule out abuse.</p> <p>NOTIFICATION AND REMOVAL OF IMMEDIATE JEOPARDY:</p> <p>On 12/1/16 at 12:25 pm, the facility's Administrator was informed the deficient practices placed the identified residents, and other residents with injuries of unknown origin or who came into contact with the staff member accused of verbal abuse and intimidation, in Immediate Jeopardy of serious harm, impairment, or death.</p> <p>On 12/1/16 at 7:35 pm, the facility provided an acceptable immediate jeopardy removal plan to address findings at F225 and F226. Key elements of the plan included:</p> <ul style="list-style-type: none"> * Thorough investigation of the incidents above related to Residents #1, #4, and #16. * Administrator and Corporate Compliance Nurse to begin review of grievance reports, accident and incident reports, and all other ancillary documents submitted over the last 60 days, with ongoing review during week-day IDT meeting, to identify any other potentially affected residents. * Individual and immediate in-service of all staff on the floor to assure they understood operation expectations to identify, report, investigate, and 	F 225			

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F 225	Continued From page 23 take corrective actions on all potential abuse, and conduct training with all staff prior to start of next shift. * Re-train all IDT staff members regarding properly identifying abuse allegations and examining contents of abuse allegation reports, accident/incident reports, occurrence reports, and grievances to determine what additional investigation is required and what state reporting requirements must be fulfilled. Implementation of the above actions was verified on-site and the facility informed on 12/1/16 at 8:20 pm, that the immediate jeopardy was removed.	F 225			
F 226 SS=L	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also	F 226		1/19/17	

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F 226	<p>Continued From page 24</p> <p>provide training to their staff that at a minimum educates staff on-</p> <p>(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.</p> <p>(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property</p> <p>(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, facility policy/procedure review, and record review, it was determined the facility failed to thoroughly investigate allegations of abuse and/or neglect, and injuries of unknown origin. This was true for 2 of 8 sampled residents (#1 and #4) reviewed for accidents and supervision and for one random resident (#16) who filed a grievance with the facility alleging a staff member had verbally abused and intentionally intimidated her. Specifically:</p> <p>a) Resident #16 filed a grievance with the facility on 9/27/16 that alleged a specific staff member had verbally abused and intimidated her. The staff member was reassigned and continued to care for other residents; an investigation into the allegation was not conducted and the allegation was not reported to the State Agency. The identified staff member was observed on duty in the facility on 12/1/16. The resident who filed the 9/27/16 grievance stated she continued to be fearful of the staff member and still felt she had</p>	F 226	<p>Corrective Action:</p> <p>The CNA that was alleged to have verbally abused resident #16 was immediately suspended pending investigation. A full investigation was conducted and turned into the Bureau of Facility Standards. The injuries of unknown origin on Resident #1 and Resident #4 were investigated and the investigations were reported to the Bureau of Facility Standards. All staff members working on the evening of the discovery of the deficient practice were in-serviced immediately on the facilities grievances and abuse and neglect policy and procedures. The IDT staff was immediately in-serviced and retrained on properly identifying abuse allegations and examining the contents of abuse allegation reports, accident/incident reports, occurrence reports, and grievances on 12/01/2016. No abuse was</p>		

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F 226	<p>Continued From page 25 been verbally abused and intimidated.</p> <p>b) Resident #4 was assessed on 11/1/16 with bruises to her right forearm that were depicted by the facility as arranged in a pattern consistent with fingerprint bruising. The staff member who reported the bruising surmised the resident's arms had been held by staff while cares were provided. There was no evidence the facility investigated this statement further to eliminate abuse as the possible cause of the bruising. The facility concluded the injury was self-inflicted.</p> <p>c) Resident #1, who was equipped with a restraint belt to her wheelchair, was assessed on 9/14/16 with a large hematoma on her outer thigh. The facility failed to provide evidence the injury was investigated. The facility attributed the hematoma to an injection Resident #1 received six days prior to the appearance of the injury.</p> <p>The failure of the facility to identify and thoroughly investigate the above incidents placed Residents #1, #4, and #16, and other residents with injuries of unknown origin, and residents who came in contact with the staff member accused of verbal abuse and intimidation, in immediate jeopardy of serious harm, impairment, or death.</p> <p>Findings include:</p> <p>The facility's Abuse & Neglect Prevention Training Program, dated 11/19/16, documented protocols and procedures for all staff related to "Prevention, Identification, Investigation, Protection, [and] Reporting" of abuse, neglect, and misappropriation of property. Training</p>	F 226	<p>substantiated in any of the incidents</p> <p>Other Residents:</p> <p>All residents have the potential to be affected by this deficient practice. All staff members were in-serviced on the facilities abuse and neglect policies and procedures prior to working with residents after the discovery of deficient practice. All accident and incident reports and ancillary documents 60 days prior to the finding of the deficient practice were audited by the administrator and Corporate Compliance Nurse to determine if any other injuries of unknown origin went unreported or any allegations of abuse went uninvestigated. All residents and/or representatives were interviewed to identify any concerns regarding care or potential abuse allegations. The resident and family interviews were completed on 12/30/2016. No additional incidents or additional unaddressed concerns were discovered.</p> <p>Facility Systems:</p> <p>All policies and procedures and operational implementation related to grievance reports and follow up investigations, accident and incident reports and follow up investigations, and abuse investigations and reporting protocol were reviewed by the Administrator, Corporate Compliance Nurse, and the Corporate Compliance</p>		

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F 226	<p>Continued From page 26</p> <p>Program materials were determined to be compliant and consistent with related federal regulations and included the following:</p> <ul style="list-style-type: none"> * Indicators of Abuse and Neglect * Abuse Definitions * Predicting Abusive Behavior * Understanding Stress and Abusive Behavior * Catastrophic Reactions * Behavioral Causes and Interventions * Reporting Abuse to Facility Management * Abuse Prohibition * Videotaping, Photographing, and Other Imaging of Residents * Resident-to-Resident Altercations * Abuse and Neglect - Clinical Protocol * Abuse Investigations * Abuse Prevention Program * Preventing Resident Abuse <p>1. Resident #16 was admitted to the facility on 9/16/16, with diagnoses of bipolar disorder, histrionic personality disorder, narcissistic personality disorder, dependent personality disorder, major depression, and anxiety disorder.</p> <p>Resident #16's Mood/Behavioral Alteration Care Plan, dated 9/21/16, documented:</p> <ul style="list-style-type: none"> * "Resident's behaviors and attempts to manipulate will not interfere with care delivery." * "Resident will experience a stable and comfortable environment." * "Be alert for attempts to manipulate that are really bids for additional attention." * "Do not accept resident accounts of others' statements, behaviors; deal directly with individual." 	F 226	<p>Director or designee. All accident and incident reports and all other ancillary documents and grievances submitted are now audited daily by members of the IDT, and overseen daily by the administrator and corporate compliance officer, to identify any potential injuries of unknown origin or any potential incidents of abuse. Action plans are now implemented for each accident and incident report, grievance, and allegation of abuse that requires additional follow up investigations. Copies of all abuse allegations, accident and incident reports, occurrence reports, and grievance reports, along with IDT action plans are now submitted to the Corporate Compliance Director or designee for review.</p> <p>Monitoring:</p> <p>Beginning the week of January 2nd 2017, the Corporate Compliance Director will meet with the Nursing Home Administrator once a week to review all action plans and findings of abuse, accidents and incidents, grievances, and occurrences. The Nursing Home Administrator will present and review all action plans and findings on abuse allegations, accident and incidents, grievances, and occurrences at monthly QA meetings for any further follow up and for ongoing training purposes. The meeting between the Corporate Compliance Director and the Nursing Home Administrator will be conducted</p>		

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F 226	<p>Continued From page 27</p> <p>A September 2016 Monthly Behavior Summary documented Resident #16 exhibited 28 episodes of anxiety with distress that month, 6 episodes of delusions with distress, 8 episodes of delusions without distress, 9 incidents of verbal aggression, 2 incidents of physical aggression, 12 episodes of socially inappropriate behavior, 5 episodes of resistance to care, 2 incidents of hallucinations with distress, 5 incidents of hallucinations without distress, and 15 incidents of paranoia.</p> <p>The September 2016 Monthly Behavior Summary documented Resident #16 on 9/26/16 experienced two episodes of anxiety with distress and a single episode each of socially inappropriate behavior and paranoia. On 9/27/16, the Monthly Summary documented Resident #16 experienced 1 episode each of anxiety with distress and delusions without distress.</p> <p>A Physician's Telephone Order, dated 9/26/16, documented Resident #16 was admitted to the facility's Behavior Program "per IDT assessment."</p> <p>On 9/27/16, Resident #16 filed a Grievance/Complaint Report with the facility alleging CNA #4 was "verbal[ly] abusive" and "intimidated" her during cares. The Grievance/Complaint Report did not include evidence of an investigation. The Report documented CNA #4 was relocated to another area of the facility where she would not come into contact with Resident #16.</p> <p>A Care Conference Report, dated 9/27/16, documented Resident #16 was admitted to the</p>	F 226	<p>weekly for four weeks, followed by bi-monthly meetings for two months, and then monthly meetings for two months, at which time the need for continued audits will be re-evaluated.</p>		

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F 226	<p>Continued From page 28</p> <p>Behavior Care Program "due to her socially inappropriate behaviors" and that she continued to exhibit "behaviors that require a significant amount of 1:1 [staff] time and attention."</p> <p>On 12/1/16 at 8:25 am, CNA #4 identified how to recognize, respond to, and report suspected abuse and/or neglect and stated she and all facility staff received abuse prevention training annually.</p> <p>On 12/1/16 at 9:50 am, the Administrator, who also served as the facility's Abuse Prevention Coordinator, stated both he and Resident #16 remembered and had recently discussed the 9/27/16 incident. The Administrator stated Resident #16's report of "verbal abuse" and intimidation by CNA #4 was not processed according to the facility's policy or "normal procedure" because he had not been shown Resident #16's written statement. The Administrator stated he also did not personally initiate an investigation into the allegation of verbal abuse and intimidation as the Grievance/Complaint Report documented Resident #16 was "satisfied" with CNA #4's reassignment to another area of the facility.</p> <p>On 12/1/16 at 10:45 am, the DON stated she did not recall seeing Resident #16's written statement regarding the 9/27/16 incident either, but spoke with both Resident #16 and CNA #4 at the time and considered the matter resolved to Resident #16's satisfaction.</p> <p>On 12/1/16 at 10:50 am, Resident #16 stated she remembered the 9/27/16 incident with CNA #4, still considered CNA's behavior that day as</p>	F 226			

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F 226	<p>Continued From page 29</p> <p>verbally abusive and intimidating. She said, "I'm just actually afraid of her. I wouldn't want anyone else to go through what I've been through with her [CNA #4]."</p> <p>An investigation into Resident #16's allegation was not conducted and the allegation was not reported to the State Agency. The facility failed to operationalize its abuse and neglect policy and procedures.</p> <p>2. Resident #4 was admitted to the facility on 7/21/15, with diagnoses that included Alzheimer's disease, dementia with behavioral disturbance, anxiety, and pain.</p> <p>Resident #4's quarterly MDS assessment, dated 9/9/16, documented her cognition was severely impaired, she rarely/never made decisions, she was verbally aggressive, rejected cares, and exhibited behaviors of hitting and scratching herself.</p> <p>A Resident Incident Report for Resident #4, dated 11/1/16 at 2:30 am, documented, "Found 4 bruises. Bruise to inner right forearm 3 x 2.25 cm. Bruises to outer right forearm approx 1 x 1 cm, 1.5 x 1 cm, 1.25 x 1 cm.</p> <p>A staff statement, dated 11/1/16 at 2:30 am, documented: "It looked like fingerprints from someone's hand. I went and got [Nurse] to come take a look. I believe these may have happened from someone giving cares and holding on to [Resident #4's] arm." The facility's incident report body diagram illustrated the bruises were arranged in a pattern consistent with fingerprint bruising.</p>	F 226			

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F 226	<p>Continued From page 30</p> <p>An undated "Follow up Incident Report Impaired Skin" documented Resident #4 was combative and resistive to cares. A Behavior Monitor for 10/31/16 documented the resident exhibited striking out, pinching, kicking, and pushing, and had been known to squeeze her own forearms "hard" when upset. It was determined the bruising was "reasonably related to event." The report was signed by RN UM #1 and the Administrator. There was no documentation the facility investigated further to rule out abuse.</p> <p>On 12/1/16 at 8:10 am, RN UM #1 stated she interviewed and assessed Resident #4 and did not think the bruising looked like fingerprints. RN UM #1 produced a document that noted staff were interviewed, however, no other individual staff statements were provided.</p> <p>On 12/1/16 at 9:45 am, the Administrator stated he reviewed the accident/incident reports and allegations of abuse reports prior to signing them. Referring to the 11/1/16 Resident Incident Report, he stated he had not signed it because he had not reviewed it. The Administrator stated "If I had read this, I would have investigated it to rule out abuse. Should have caught that statement regarding the fingerprints." The facility failed to follow its Abuse Prevention policy.</p> <p>3. Resident #1 was admitted to the facility on 4/18/14 with multiple diagnoses, including Huntington's Chorea, dementia, and anxiety.</p> <p>The 8/5/16 quarterly MDS assessment documented Resident #1 had modified independence for daily decision making.</p>	F 226			

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F 226	<p>Continued From page 31</p> <p>Resident #1's September 2016 MAR documented an order on 9/10/15 for 75 mg IM every 2 weeks Haldol Docanoate for Huntington's Chorea.</p> <p>Resident #1's September 2016 Physician Order Report documented an order on 8/10/16 for a leg strap while in her Broda chair to keep from potential harm when attempting to "throw herself out of the chair" and to remove the strap every two hours. The padded leg strap was observed throughout the survey attached around Resident #1's upper legs, and underneath and behind her wheelchair.</p> <p>The September 2016 MAR documented the IM Haldol Docanoate was administered to Resident #1's right hip on 9/8/16.</p> <p>Resident #1's 9/14/16 Progress Note documented, "Res[ident] noted to have 10 cm [by] 7 cm reddened area to R[ight] outer thigh [with] firm round center appears non tender to touch [no] bruising or open areas; [Physician] here to eval[uate] [Family Member] also present, states hematoma that should resolve n[o] n[ew] o[r]ders] re[ceive]d..."</p> <p>Resident #1's Incident Report, dated 9/14/16, documented: "On 9/14/16 Nurse noted a 10 cm [by] 7 cm oval area of redness with a firm lump in center on [Resident #1's] right upper thigh. [Resident #1] had no idea what had happened. [Resident #1] does move around a lot at times due to her Huntington's chorea. MAR revealed that [Resident #1] was given her Haldol injection 9/12/16 on right hip...[Nurse] was a traveling</p>	F 226			

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F 226	<p>Continued From page 32</p> <p>nurse and has finished her contract with us. I was unable to contact her regarding the injection. Family and Hospice were notified. Hospice ordered warm packs to area. Area is resolving." The documentation did not include information ruling out Resident #1's leg restraint as a source of the injury.</p> <p>An undated and unsigned document provided by the facility on 12/1/16, documented, "Interviewed [2 CNAs] regarding bump on thigh. They thought it could be from her attempting to throw herself out of her w/c or roll up to mat. Talked to [Nurse] who came in to assess res[ident]. She thought it was an encapsulate from haldol IM..."</p> <p>The facility's completed abuse investigations from June 2016 to November 2016 did not include documentation related to the above issue.</p> <p>On 12/1/16 at 8:35 am and 9:10 am, the Behavior Unit Manager said she interviewed two CNAs and a nurse, but did not have witness statements for them. She said Resident #1's leg restraint was ruled out as a source of the injury due to the location of the hematoma, which said was likely caused by the Haldol injection. She reviewed the MAR and said the IM Haldol was given to the right hip on 9/8/16, and not on 9/12/16, as the report documented. She said had she realized the discrepancies at the time of the investigation she would have investigated the incident as an injury of unknown origin and followed the facility's abuse policy and procedures.</p> <p>On 12/1/16 at 9:25 am, the Administrator reviewed the investigation and said based on the</p>	F 226			

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F 226	Continued From page 33 information in the report, he could not determine the cause of the hematoma and it should have been investigated more thoroughly to rule out abuse. He said there were not witness statements or other investigative materials attached as required by the facility's abuse policy. NOTIFICATION AND REMOVAL OF IMMEDIATE JEOPARDY: On 12/1/16 at 12:25 pm, the facility's Administrator was informed the deficient practices placed the identified residents, and other residents with injuries of unknown origin or who came into contact with the staff member accused of verbal abuse and intimidation, in Immediate Jeopardy of serious harm, impairment, or death. On 12/1/16 at 7:35 pm, the facility provided an acceptable immediate jeopardy removal plan to address findings at F225 and F226. Please refer to F225 for key elements of the plan. Implementation of the plan was verified on-site and the facility informed on 12/1/16 at 8:20 pm, that the immediate jeopardy was removed.	F 226			
F 241 SS=E	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced	F 241		1/19/17	

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F 241	<p>Continued From page 34</p> <p>by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure staff demonstrated respect for residents' privacy by knocking on their doors before entering their rooms and offering choices of clothing protectors during meals. This was true for 1 of 13 (#5) sampled residents and 4 (#17 - #20) random residents and the potential to adversely affect residents' psychosocial well-being. Findings include:</p> <p>1. On 11/28/16 from 1:13 pm to 1:25 pm, Laundry Aide #1 was observed walking into six resident rooms without knocking or announcing herself prior to entering the rooms. Residents #17, #18, #19, and #20 were in their rooms when Laundry Aide #1 entered.</p> <p>On 11/28/16 at 1:27 pm, Laundry Aide #1 said she only needed to knock when the doors were closed and could just enter rooms if the doors were opened.</p> <p>On 12/1/16 at 3:45 pm, the DON said staff were to knock on residents' doors or announce themselves prior to entering rooms.</p> <p>2. Resident #5 was admitted to the facility on 1/2/15, with diagnoses that included dementia with abnormal weight loss, and anxiety. Resident #5 was not offered the use of a cloth napkin during each meal, and clothing protectors were placed around his neck.</p> <p>During the mid-day meal observation on 11/29/16 at 11:05 am, 8 residents were observed in the behavioral care program dining room. CNAs and</p>	F 241	<p>Corrective Action:</p> <p>Staff education was provided to Laundry Aide #1 on 11/28/2016 regarding the facilities policy of knocking and awaiting permission to enter all residents' room to protect their dignity. Resident #5 no longer resides at this facility.</p> <p>Other Residents:</p> <p>As this deficiency has the potential to affect all residents, a resident council meeting was held on 12/29/2016 and the council's decision was to discontinue the use of clothing protectors.</p> <p>Facility Systems:</p> <p>All staff were educated starting on 12/27/2016 and continuing through 12/30/2016 regarding the regulatory requirements of F241 and the deficient practices found during the facilities recertification survey the week of 11/28/2016. All Housekeeping staff were educated on 12/28/2016 regarding F241 and respecting resident privacy. Per the resident council meeting clothing protectors are longer offered at this facility. No further facility system changes are needed.</p> <p>Monitoring:</p> <p>Beginning the week of January 2nd 2017, an audit will be conducted bi-weekly by</p>	

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F 241	Continued From page 35 LNs were observed assisting the residents with putting on clothing protectors. Resident #5 received a clothing protector from CNA #2, who did not speak to him as she placed it. Resident #5 was not offered a choice of a cloth napkin or clothing protector. On 11/29/16 at 4:40 pm, CNA #3 spoke to Resident #5, and pointed to a CNA and stated, "She's going to bring you a clothing protector." After the clothing protector was placed, CNA #3 started to feed Resident #5 without offering a choice to use a cloth napkin or clothing protector. Resident #5's Care Plan did not include the use of clothing protectors. On 12/1/16 at 9:50 am, the Behavioral Unit Manager stated Resident #5's care plan should have included the use of clothing protectors, as Resident #5 was not always cognitively able to choose a napkin or clothing protector. The facility did not ensure Resident #5's dignity was protected by allowing him to choose between a napkin or clothing protector at meals.	F 241	NHA or designee to ensure resident's dignity is protected while in their rooms and that staff are knocking and awaiting permission to enter resident rooms prior to entering. Beginning January 18th 2017 a bi-weekly audit will be conducted by the NHA or designee to ensure residents dignity is protected during meal times. The results of the audits will be reviewed at the monthly QA meeting. These audits will be conducted bi-weekly for four weeks, followed by weekly audits for four weeks, and then monthly audits for three months after that, at which time the need for continued audits will be re-evaluated.		
F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a resident received medically-related	F 250	Corrective Action: Resident #1 was interviewed on	1/19/17	

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F 250	<p>Continued From page 36</p> <p>social services prior to or after the placement of a restraint. This was true for 1 of 13 (#1) sampled residents and had the potential for psychosocial harm if the resident experienced a psychological decline to due feelings of being restricted in movement. Findings include:</p> <p>Resident #1 was admitted to the facility on 4/18/14, with multiple diagnoses, including Huntington's Chorea, dementia and anxiety.</p> <p>Resident #1's 8/5/16 quarterly MDS assessment documented the resident: * Did not have a physical restraint, * Had modified independence for daily decision making, and * Had minimal depression.</p> <p>Resident #1's Mood care plan dated 5/24/16 documented, "Continue to work with consulting psychiatrist along with primary care provider to manage medications and behaviors..."</p> <p>Resident #1's 8/10/16 Occurrence Report, signed by the Behavior Program Manager and the Resident Services Coordinator, documented, "Resident was trying to throw herself to the floor from her chair. So I asked her what she was trying to do then she stated she was trying to hurt herself." The "Unsuccessful" interventions included "1 [on] 1 for safety, assess needs, reassure." The Revised Plan section documented, "Assess for leg strap while in Broda chair."</p> <p>Resident #1's clinical record did not include social service progress notes regarding alternative options prior to the restraint</p>	F 250	<p>12/28/2016 by the Resident Services department and a mood and depression screen was conducted. The resident's depression screen continued to show minimal depression. Resident #1 was asked how she felt about the leg straps in her chair and she stated that she feels safer and that it makes it easier for her to eat. Resident was interviewed a second time on 12/30/2016 by the Resident Services department and the facilities consultant LCSW, who participated via telephone conference.</p> <p>Other Residents:</p> <p>All residents requiring the use of restraints have the potential to be affected by this deficient practice. All residents were reviewed and there were no other residents in the facility using any restraint devices.</p> <p>Facility Systems:</p> <p>Staff were educated starting on 12/27/2016 and continuing through 12/30/2016 regarding the regulatory requirements of F250 and the deficient practices found during the facilities recertification survey the week of 11/28/2016. The LCSW re-educated staff on 12/30/2016 regarding the importance of medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident and the necessary assessments and resident</p>		

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F 250	<p>Continued From page 37</p> <p>placement and did not document a psychosocial evaluation was completed prior to, or after, the restraint was placed.</p> <p>Resident #1's 8/10/16 physician's telephone orders documented, "Leg strap while in Broda to keep from potential harm when attempting to throw self out of chair. Release Q2 [hours] [and] at meals."</p> <p>Resident #1's 8/10/16 restraint note signed by the Behavior Unit Manager, documented: "We have explained the risks to [Resident #1] in regards to throwing herself out of her chair, but she continues to attempt it. We are placing the leg strap for [Resident #1]'s safety. If [Resident #1] gets too weak and her attempts to throw herself out of the chair are no longer occurring, the strap will be discontinued. The restraint will be evaluated at intervals not to exceed 3 months."</p> <p>Resident #1's fall care plan documented on 8/10/16, "Leg strap while in Broda chair. Release Q2 [hours] [and] PRN."</p> <p>Resident #1's current fall care plan documented, "Leg strap while up in Broda chair, release Q2H [hours], all meals and PRN."</p> <p>On 11/29/16 from 11:39 am to 12:17 pm, Resident #1 was observed in her Broda wheelchair at a table in the dining room. The wheelchair's back was angled at approximately 65 to 70 degrees. Resident #1 had bilateral padded leg straps, which extended from beneath the wheelchair seat, securing the medial and anterior thighs and buckled at the back of the</p>	F 250	<p>monitoring required in the event that a restraint is placed. A restraint device audit tool was implemented on January 4th to ensure all restraint devices in the facility have the appropriate documentation to ensure that medically related social services is included and that the devices are determined to be the least restrictive devices for the residents by a physical or occupational therapist.</p> <p>Monitoring:</p> <p>Beginning in January 2017, an audit will be conducted monthly by the DNS or her designee to ensure restraint usage documentation is compliant to ensure that residents receive medically-related social services prior to and after the placement of a restraint. The results of these audits will be reviewed monthly at the Quality Assurance meetings for the next five months, at which time the need for continued audits will be re-evaluated.</p>		

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F 250	<p>Continued From page 38</p> <p>wheelchair. Resident #1 was observed several times rocking back and forth in her wheelchair. CNA #6 assisted Resident #1 with her meal and did not release the leg strap during that time. During the meal, LN #1 sat down opposite of Resident #1 for several minutes to observe CNA #6 assist her and did not release the strap. At 12:15 pm, CNA #2 was observed assisting Resident #1 with her ice cream and did not release the strap.</p> <p>On 11/29/16 from 5:32 pm to 5:47 pm, Resident #1 was observed in her Broda wheelchair at a dining room table. The bilateral leg straps were secured on her thighs. CNA #7 assisted Resident #1 with her meal and did not release the leg strap.</p> <p>On 12/1/16 at 4:45 pm, the Behavior Program Manager said she was out of the facility on leave when the leg restraint was initially placed and the Resident Service Coordinator would have been involved. The Behavior Program Manager said she was aware the restraint was to be placed and had agreed with the decision. She said she did not advocate for a least restrictive option. The Behavior Program Manager said she talked with Resident #1 regarding the restraint placement, but could not find documentation to support that conversation. She said she did not complete or arrange for a psychological assessment prior to or after the restraint placement and did not consult with a neurologist or other psychiatric expert.</p> <p>On 12/1/16 at 5:00 pm, the Resident Service Coordinator said she was not involved with Resident #1's leg restraint placement.</p>	F 250			

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F 252 SS=E	<p>483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.</p> <p>(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure a clean and homelike environment when resident meals were provided on trays and napkin holders that were soiled with food and drink residue. This was true for 7 of 9 (Residents #1, #2, #4, #6, #7, #8, and #9) sampled residents and all other residents who utilized the facility's dining rooms. This deficient practice created the potential for harm if the residents were embarassed by meals served cafeteria style on trays and/or felt the lack of cleanliness of dining items was unacceptable, disrespectful, or undignified. Findings include:</p> <p>1. On 11/28/16 at 2:00 pm, 10 of 10 napkin</p>	F 252	<p>Corrective Action:</p> <p>Housekeeping and Kitchen managers were educated on 11/30/2016 of the deficient practice and corrective action was taken immediately. The kitchen staff deep cleaned all of the napkin holders on 11/30/2016. Resident #1's care plan was updated and the intervention to leave meal items to stay on tray due to behaviors may occur was discontinued on 12/28/2016.</p> <p>Other Residents:</p>	1/19/17	

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F 252	<p>Continued From page 40</p> <p>holders in the dining room were observed to be soiled with food and/or drink residue.</p> <p>On 11/29/16 at 2:00 pm, the dining room tables appeared to have been cleaned. Ten of 10 napkin holders were observed to be soiled with food and/or drink residue.</p> <p>Residents #1, #2, #4, #6, #7, #8, and #9, ate meals in the facility's dining room</p> <p>On 11/30/16 at 3:45 pm, CNA #5 stated the housekeeping department was responsible for cleaning the dining room after each meal. Staff responsible for cleaning the dining room were not available for interview.</p> <p>2. Resident #1 was admitted to the facility on 4/18/14 with multiple diagnoses, including Huntington's Chorea, dementia, and multiple contractures.</p> <p>The 11/18/16 significant change MDS assessment documented Resident #1 was moderately cognitively impaired and required extensive one person assistance with eating.</p> <p>Resident #1's current care plan documented, "[Meal] Items to stay on trays due to behaviors may occur."</p> <p>On 11/29/16 at 11:39 and 5:32 pm, Resident #1 was observed in her Broda wheelchair at a dining room table. Her meals were served on a tray. Staff were observed assisting her with her meals. Resident #1 was not asked if she wanted to keep the items on the trays.</p>	F 252	<p>As this deficiency has the potential to affect all residents, all residents dietary care plans were reviewed by the dietary manager on 12/30/2016. All residents within the facility that had the intervention to leave meal items to stay on tray due to behaviors may occur, had their care plans updated and the intervention was discontinued.</p> <p>Facility Systems:</p> <p>The housekeeping manager added the napkin holders to the daily cleaning schedule three times a day, after each meal on 11/30/2016. The dietary manager added the napkin holders to her kitchen staffs weekly cleaning schedule to be deep cleaned in the dishwasher every Friday. Dietary and CNA staff were in-serviced on 12/14/2016 regarding the requirement of not leaving food on trays unless by resident choice per federal regulation F252. Effective immediately, residents will no longer be care planned to keep food items on their trays due to behaviors that may occur. Facility practice will be to remove food items from trays. Residents expressing their desire for leaving food items on their trays will be accommodated and their care plans will be updated accordingly. Dietary staff were educated on 12/26/2016 and Housekeeping staff were in-serviced on 12/16/2016 regarding F252 and maintaining a safe, clean, comfortable and homelike environment. All staff were educated beginning on 12/27/2016 and</p>		

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F 252	Continued From page 41	F 252	<p>continuing through 12/30/2016 regarding the regulatory requirement of F281 and the deficient practice.</p> <p>Monitoring:</p> <p>Beginning January 2017, an audit will be conducted by the Housekeeping Manager or designee to ensure that napkin holders are being cleaned daily. The Housekeeping Managers audit will be conducted bi-weekly for four weeks, followed by weekly audits for four weeks, and then monthly audits for three months after that. Additionally, the Dietary Manager will conduct an audit to ensure that the napkin holders are being deep cleaned as scheduled by the kitchen staff. The Dietary Managers audits will be conducted weekly for four weeks, followed by monthly audits for four months. Beginning January 18th 2017, an audit will be conducted by the NHA or designee to ensure residents food is not left on their trays unless specified by resident choice. This audit will be conducted bi-weekly for four weeks, followed by weekly for four weeks, and then monthly for three months. The results of the audits will be reviewed at the monthly QA meeting beginning with the January 2017 meeting. Upon completion of this audit schedule the need for continued audits will be re-evaluated.</p>		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		1/19/17	

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F 280	<p>Continued From page 42 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:</p> <p>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.</p> <p>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.</p> <p>(iv) The right to receive the services and/or items included in the plan of care.</p> <p>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.</p> <p>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--</p> <p>(i) Facilitate the inclusion of the resident and/or resident representative.</p> <p>(ii) Include an assessment of the resident's strengths and needs.</p> <p>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.</p>	F 280			

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F 280	Continued From page 43 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 280			

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F 280	<p>Continued From page 44</p> <p>by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents' care plans were reviewed and/or revised to reflect their current needs. This was true for 2 of 9 (#1 and #5) sampled residents. The deficient practice had the potential to cause harm if residents did not receive appropriate care and interventions due to inaccurate information on their care plans. Findings include:</p> <p>1. Resident #5 was admitted to the facility on 1/2/15 with diagnoses that included dementia, abnormal weight loss, and anxiety.</p> <p>Resident #5's nutritional care plan, dated 1/2/15, included interventions that did not include implementation or revision dates.</p> <p>One of the care plan's undated interventions, directed staff to provide high calorie ice cream with all meals. Resident #5's meal record did not include intake documentation for the high calorie ice cream.</p> <p>On 11/29/16 at 10:00 am, Resident #5 was observed eating toast and jelly. A hot beverage was in a cup. He did not receive high calorie ice cream.</p> <p>On 11/29/16 at 11:05 am, Resident #5 was observed eating his midday meal of squash, potatoes, and chicken. There were 4 beverages and a dessert in a bowl with cherries. He did not receive high calorie ice cream.</p> <p>On 11/30/16 at 9:00 am, Resident #5's meal</p>	F 280	<p>Corrective Action:</p> <p>Resident #1 <input type="checkbox"/>s fall care plan was reviewed and revised on 12/19/2016. Resident #5 no longer resides at this facility.</p> <p>Other Residents:</p> <p>As this deficiency has the potential to affect all residents, a review of all residents <input type="checkbox"/> care plans was completed by the DNS on 12/30/2016. Any care plans found out of compliance were updated at the time of review.</p> <p>Facility Systems:</p> <p>Staff were educated beginning on 12/27/2016 and continuing through 12/30/2016 regarding the regulatory requirement of F280 and the deficient practice. A care plan audit form was implemented on January 3rd and will be completed no less than monthly by the Corporate Compliance Nurse to ensure ongoing compliance with appropriate and timely care plan revisions.</p> <p>Monitoring:</p> <p>In addition to the monthly care plan audit completed by the Corporate Compliance Nurse, beginning the week of January 2nd 2017, the DNS or designee will conduct weekly care plan audits for eight weeks, followed by monthly audits for</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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F 280	<p>Continued From page 45 included 2 waffles, syrup, butter and 4 beverages. High calorie ice cream was not included and he was not offered high calorie ice cream with the meal.</p> <p>Resident #5's care plan, undated, documented "Monitor food and fluid intake with meals, see meal monitor."</p> <p>The meal monitor flow sheet for November 2016, documented consumption amounts of each meal, as well as, the fluid and supplement amounts consumed.</p> <p>The meal monitor documented Resident #5 refused 21 breakfasts, 9 midday meals and 10 dinners. The meal monitor documented Resident #5 refused all 3 meals on 11/27/16, as well as, breakfast on 11/28/16.</p> <p>Resident #5's care plan included an undated intervention, that documented "TID snack requested per resident. % consumed, if refused, write why on back of sheet. [6 oz supplement]."</p> <p>The November 2016 snack monitor documented Resident #5 refused snacks 33 of the 90 opportunities.</p> <p>An "Interdisciplinary Progress Note," dated 9/9/16, documented nursing was to notify Resident #5's family and physician regarding his one month weight loss. It documented all interventions were in place, and Resident #5 would continue to be monitored, and was signed by the dietary manager.</p> <p>An Interdisciplinary Progress Note, dated</p>	F 280	<p>three months to ensure that resident care plans meet resident's needs and that care plans are implemented effectively. After five months of audits the need for continued audits will be re-evaluated. The results of the audits will be reviewed at the monthly QA meeting.</p>		

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F 280	<p>Continued From page 46</p> <p>9/15/16, written and signed by the dietician, documented Resident #5 continued to have poor intake and weight loss. It documented his physician and family were aware of the weight loss, which stated "May be unavoidable." The note documented "Will continue to implement/offer nutritional interventions."</p> <p>In an Interdisciplinary Progress Note, dated 10/10/16, documented Resident #5 was being monitored for weight loss and received a soft mechanical diet, with 1-2 finger foods, snacks TID, high calorie ice cream with each meal and K2 120 cc TID with medications. The Progress Note did not address Resident #5's refusals of meals, snacks, or supplement consumption.</p> <p>An Interdisciplinary Progress Note, dated 10/10/16, documented Resident #5 had a Stage II pressure ulcer, and his meal intake was poor. Resident #5's weight loss was documented as possibly unavoidable, however, staff were directed to continue nutritional interventions.</p> <p>On 11/30/16 at 9:40 am, the Dietary Manager stated each residents' diet card was reviewed with each meal. She stated the diet card included supplements, which for Resident #5 included the high calorie ice cream. She stated if a resident was asleep for a meal, or requested a certain item for that meal, then a new meal tray that did not include supplements or high calorie ice cream would be provided. She stated the Behavioral Care Program should maintain a supply of high calorie ice cream for Resident #5.</p> <p>On 12/1/16 at 9:50 am, the Behavioral Unit Manager stated the care plan for Resident #5</p>	F 280			

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F 280	<p>Continued From page 47</p> <p>should have been revised and updated to include interventions related to his refusals of meals. She stated the care plan should include dates when each intervention was initiated, and revisions. The Behavioral Unit Manager stated care plans were reviewed and revised by the interdisciplinary team, not the nursing staff of the BCP.</p> <p>Additional information was provided by the facility on 12/7/16. It included documentation by the Dietary Manager on personal stationary, dated 12/6/16. It stated "Reviewed resident's care plan twice in the month of his wt. loss. No updates were necessary due to everything already in place on care plan."</p> <p>Resident #5's weight on 8/17/16 was documented as 114 pounds, and his weight on 11/17/16, was documented as 104 pounds, a loss of 10 pounds, or 8.77% over a 3 month period. His care plan was not revised to include interventions for his meal and supplement refusals, and interventions were not fully implemented.</p> <p>2. Resident #1 was admitted to the facility on 4/18/14 with multiple diagnoses, including Huntington's Chorea, dementia, and anxiety.</p> <p>Resident #1's 8/10/16 physician's telephone orders documented, "Leg strap while in Broda to keep from potential harm when attempting to throw self out of chair. Release Q2 [hours] [and] at meals."</p> <p>Resident #1's fall care plan documented on 8/10/16, "Leg strap while in Broda chair. Release</p>	F 280			

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F 280	<p>Continued From page 48 Q2[hours] [and] PRN."</p> <p>Resident #1's 8/29/16 physician's telephone orders documented, "OK to leave leg strap on [at] meals due to progression of Hunnington's [sic]."</p> <p>Resident #1's fall care plan documented on 8/29/16, "Leg strap may be placed on [at] meals if needed."</p> <p>Resident #1's current fall care plan documented, "Leg strap while up in Broda chair, Release Q2H, All meals and PRN."</p> <p>On 11/29/16 from 11:39 am to 12:17 pm, Resident #1 was observed in her Broda wheelchair at a table in the dining room. The wheelchair's back was angled at approximately 65 to 70 degrees. Resident #1 had bilateral padded leg straps, which extended from beneath the wheelchair seat, securing the medial and anterior thighs and buckled at the back of the wheelchair. Resident #1 was observed several times rocking back and forth in her wheelchair. CNA #6 assisted Resident #1 with her meal and did not release the leg strap during that time. During the meal, LN #1 sat down opposite of Resident #1 for several minutes to observe CNA #6 assist her and did not release the strap. At 12:15 pm, CNA #2 was observed assisting Resident #1 with her ice cream and did not release the strap.</p> <p>On 11/29/16 from 5:32 pm to 5:47 pm, Resident #1 was observed in her Broda wheelchair at a dining room table. The bilateral leg straps were secured on her thighs. CNA #7 assisted Resident #1 with her meal and did not release the leg</p>	F 280			

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F 280	Continued From page 49 strap. On 12/1/16 at 9:05 am, LN #2 said Resident #1's leg strap should be released during meals per the care plan. On 12/1/16 at 2:15 pm, CNA #2 said Resident #1's leg strap was to be used during meals due to her decline. On 12/1/16 at 2:30 pm, the Behavior Unit Manager said Resident #1's leg strap could be left on during meals. When she reviewed the physician's orders and the current care plan, she said she did not know why the care plan had not been updated to reflect the physician's orders.	F 280			
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- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure meet professional standards of quality were met when order changes were not implemented when a resident was no longer on hospice and when a PRN catheter order did not document a medical justification for its use. This was true for 1 of 13 (#1) sampled residents and had the potential to harm Resident #1 if treatment was based on incomplete orders. Findings include:	F 281	Corrective Action: Staff were educated regarding the need for timely discharge orders from hospice services. Resident #1's catheter order was discontinued on 12/01/2016. Other Residents: As this deficiency has the potential to	1/19/17	

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F 281	<p>Continued From page 50</p> <p>Resident #1 was admitted to the facility on 4/18/14, with multiple diagnoses, including Huntington's Chorea.</p> <p>Resident #1's November 2016 Physician Order Report documented on 4/21/16, "Catheter insertion PRN for comfort measure for end of life care if clinically indicated by bladder distension or pain w[ith] suprapubic palpation."</p> <p>Resident #1's August 2016 to November 2016 TARs documented she did not have a catheter.</p> <p>On 12/1/16 at 2:30 pm, the Behavior Unit Manager said the catheter order should have been discontinued as the resident was no longer on hospice. She said the order should have also documented the type of catheter to be used.</p> <p>Resident #1's 11/10/16 progress notes documented, "Care conference. Res[ident] has stabilized [and] is being D/C'd from hospice care...notified [Physician]."</p> <p>Resident #1's 11/11/16 Hospice progress documented, "...discussed her discharge from hospice with [Resident #1]..."</p> <p>Resident #1's 11/22/16 Physician's Telephone Order documented, "d/c from Hospice."</p> <p>On 12/1/16 at 2:30 pm, the Behavior Unit Manager said she did not realize the facility required an order to discharge Resident #1 from hospice care. She said hospice stopped caring for Resident #1 on 11/10/16 or 11/11/16.</p>	F 281	<p>affect all residents, an audit was completed by the DNS by 12/30/2016 and all residents within the facility that were care planned for catheter use were identified and reviewed for the proper medical justification. There were no other residents transferring on to or off of hospice at the time of review.</p> <p>Facility Systems:</p> <p>Staff were educated beginning on 12/27/2016 and continuing through 12/30/2016 regarding the regulatory requirement of F281 and the cited deficient practice. Effective immediately, all planned discharges from or transfers to hospice will be reviewed in the daily IDT meeting to assure orders or implemented timely, all new catheter orders will also be reviewed in daily IDT meetings for proper medical justification.</p> <p>Monitoring:</p> <p>Beginning the week of 01/02/2017, an audit will be conducted weekly by the DNS or designee to ensure that any new catheter orders for residents have the proper medical justification and that any resident discharging from or transitioning to hospice services receive timely orders and implementation. The results of the audits will be reviewed at the monthly QA meeting. This audit will be conducted weekly for four weeks, and then monthly audits for four months after that, at which time the need for continued audits will be</p>		

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F 281	Continued From page 51	F 281	re-evaluated.		
F 309 SS=D	<p>483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>(l) 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. This REQUIREMENT is not met as evidenced by: Based on review of the facility's bowel protocol, staff interview, and record review, it was determined the facility failed to ensure residents were provided with bowel care consistent with their needs. This was true for 3 of 9 sampled resident (#3, #4, and #6). This deficient practice created the potential for residents to experience</p>	F 309	<p>Corrective Action:</p> <p>Residents #3, #4, and #6 bowel patterns were reviewed on 12/28/2016 and appropriate bowel protocols were initiated as warranted.</p>	1/19/17	

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F 309	<p>Continued From page 52</p> <p>discomfort, pain, and/or medical complications when they did not have a bowel movement for multi-day periods. Findings include:</p> <p>1. Resident #4 was admitted to the facility on 7/21/15 with diagnoses that included Alzheimer's disease, chronic kidney disease stage III, dementia with behavioral disturbance, pain, and constipation.</p> <p>Resident #4's care plan did not address constipation or provide staff with direction regarding how often she should have a bowel movement or interventions to manage constipation.</p> <p>Resident #4's October 2016 bowel record documented she did not experience a bowel movement 10/3 through 10/6 (4 days) and from 10/23 through 10/26 (4 days). The October 2016 MAR documented routine, scheduled bowel medications which included Lactulose 30 mls daily and Miralax 17 gms daily. Resident #4 refused 9 days of the 31 days that month.</p> <p>The facility's bowel care protocol documented one of the following could be used prn x 2 doses if no stool on:</p> <p>Day 2 - MOM 30 cc. If ineffective may give one additional dose after 6 hours with no stool. Day 3 - Dulcolax suppository 10 mg Day 4 - Fleets enema Day 4 - If resident refused all interventions day 2-4, the MD was to be notified and the resident was to be placed on alert charting each shift, and assessed for obstruction.</p>	F 309	<p>Other Residents:</p> <p>As this deficiency has the potential to affect all residents, an audit was completed by the RNA RN on 12/20/2016. All residents within the facility that were care planned for the use of the bowel protocol were identified and reviewed for appropriate utilization. Nursing staff were in-serviced on 12/30/2016 regarding the correct implementation of the facility bowel protocol, F309, and the cited deficient practice.</p> <p>Facility Systems:</p> <p>Staff were educated beginning on 12/27/2016 and continuing through 12/30/2016 regarding the regulatory requirement of F309 and the deficient practice. Effective January 5th 2017, A bowel protocol audit tool will be implemented for a daily audit of a randomly selected group of residents to ensure that the facility does not fail to follow the bowel care protocol.</p> <p>Monitoring:</p> <p>Beginning January 5th 2017, an audit will be conducted daily by the DNS or designee to ensure that the facility does not fail to follow the bowel care protocol. The results of the audits will be reviewed at the monthly QA meeting beginning with the January meeting. This audit will be conducted daily for two weeks, followed by weekly audits for six weeks, and then</p>		

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NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
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F 309	<p>Continued From page 53</p> <p>The October 2016 Bowel Monitoring Form and PRN Bowel Med Sheet documented the following:</p> <ul style="list-style-type: none"> * On 10/5/16, the 2nd day without a bowel movement, staff provided Resident #4 with MOM 30 mls. * On 10/22/16, the 3rd day without a bowel movement, staff provided Resident #4 with a Dulcolax suppository 10 mg. * On 10/27/16, the 4th day without a bowel movement, staff provided Resident #4 with a Dulcolax suppository 10 mg. <p>Although Resident #4 was on a scheduled bowel/constipation regimen, she experienced two 4 day periods without a bowel movement. The facility failed to follow its bowel care protocol during these periods which placed Resident #4 at risk for complication related to constipation.</p> <p>2. Resident #6 was admitted to the facility on 12/16/13, with diagnoses that included Lewy Body dementia, Parkinson's Disease, shoulder pain, and constipation.</p> <p>Resident #6's care plan did not specify how often he should experience a bowel movement or interventions to manage constipation.</p> <p>Resident #6 received medications for management of constipation. Physician orders included Lactulose 30 mls daily, Miralax 17 gms twice daily, and Colace 100 mg twice daily.</p> <p>The facility's bowel care protocol documented</p>	F 309	<p>monthly audits for three months after that, at which time the need for continued audits will be re-evaluated.</p>		

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

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

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F 309	<p>Continued From page 54</p> <p>one of the following could be used prn x 2 doses if no stool on:</p> <p>Day 2 - MOM 30 cc. If ineffective may give one additional dose after 6 hours with no stool.</p> <p>Day 3 - Dulcolax suppository 10 mg</p> <p>Day 4 - Fleets enema</p> <p>Day 4 - If resident refused all interventions day 2-4, the MD was to be notified and the resident was to be placed on alert charting each shift, and assessed for obstruction.</p> <p>The September 2016 bowel record documented Resident #6 did not experience a bowel movement 9/1 through 9/5 (5 days), 9/10 through 9/13 (4 days), and 9/15 through 9/18 (4 days).</p> <p>The September 2016 MAR documented there were no medications provided to Resident #6 for the documented episodes of constipation.</p> <p>The October 2016 bowel record documented Resident #6 did not experience a bowel movement 10/18 through 10/21 (4 days), 10/23 through 10/25 (3 days), and 10/29 through 10/31 (3 days).</p> <p>The October 2016 MAR documented a Dulcolax suppository was provided to Resident #6 on 10/12.</p> <p>The November 2016 bowel record documented Resident #6 did not experience a bowel movement 11/21 through 11/23 (3 days), and 11/25 through 11/27 (3 days).</p> <p>The November 2016 MAR documented MOM was provided on 11/27/16.</p>	F 309			

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F 309	<p>Continued From page 55</p> <p>Although on a scheduled bowel/constipation regimen, Resident #6 experienced episodes of constipation. The facility did not follow its bowel care protocol during these periods, which placed him at risk for complications related to constipation.</p> <p>3. Resident #3 was admitted to the facility on 11/9/16, with diagnoses of dementia, FTT, and PU on the left buttock.</p> <p>His Care Plan Flow Sheet, for November 2016, directed staff to monitor the frequency and consistency of Resident #3's BM's. Resident #3 's Nursing Assessment, dated 11/9/16, documented he was dependent with ADL's and incontinent of bowel and bladder.</p> <p>Resident #3's standing orders for prevention of constipation, documented the orders were to be implemented after 2 days without a BM. The order directed the staff to administer Milk of Magnesia on the second day of no BM. If Resident #3 had no BM by the third day, his orders directed the staff to administer a suppository. On the fourth day without a BM, Resident #3's orders directed he was to have an enema, his physician was to be notified, and the nursing staff was to assess for obstruction and implement alert charting every shift .</p> <p>Resident #3's BM monitor documented he had a BM on the day shift 11/21/16. His next BM did not occur until 11/25/16 on the day shift, 4 days, or 11 shifts later.</p> <p>Resident #3's MAR documented Milk of</p>	F 309			

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F 309	Continued From page 56 Magnesia was administered at 9:00 am 11/24/16, with results on 11/25/16 at 6:30 am. Resident #3 was not monitored for constipation. On 12/1/16 at 2:13 pm, the Behavioral Unit Manager reviewed Resident #3's record and stated "He should not have had to go 4 days without a bowel movement."	F 309			
F 312 SS=D	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 record review, policy review, observation, and staff interview, it was determined the facility failed to ensure 2 of 9 (#3 and #5) sampled residents were bathed regularly. This deficient practice resulted in both residents going without baths/showers for extended periods of time, placing them at risk of psychosocial and/or medical harm due to lack of clinical hygienic practices. Findings include: A facility policy titled Shower/Tub Bath, revised October 2010, did not include the frequency of resident bathing. Review of Resident #3 and Resident #5's care plans, orders, and admission information did not include resident preference for bathing frequency.	F 312	Corrective Action On 12/28/2016, Resident #3's wife (responsible party) was queried regarding Resident #3's historical bathing preferences. His care plan was updated to reflect this preference and an audit was conducted to ensure his bathing schedule was in accordance with this preference. Resident #5 no longer resides at this facility. Other Residents All residents have the potential to be effected by this deficient practice. The	1/19/17	

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F 312	<p>Continued From page 57</p> <p>1. Resident #3 was admitted to the facility on 11/9/16, with the diagnoses of dementia, FTT, and PU on the left buttock.</p> <p>His 11/9/16 admission nursing assessment documented abrasions to both knees, his right wrist and chest, a rash on his right shoulder and back, scratches to his ankle, scabbed areas on his left great toe and left wrist. Additionally, the admitting LN documented he had an unstageable pressure ulcer to his left buttocks.</p> <p>Resident #3's Self Care Deficit care plan, dated 11/9/16, documented he was to receive a bath and nail care once weekly.</p> <p>Resident #3's TARs documented bathing was provided twice in the 21 days since he was admitted, on 11/14/16 and 11/22/16. His TARs documented Resident #3 did not refuse bathing during this period.</p> <p>Resident #3's Interdisciplinary Progress Notes, dated 11/19/16 and 11/21/16, described him picking at scabbed areas on arms and legs.</p> <p>An observation of Resident #3's PU and skin was performed on 12/1/16 at 10:30 am. Resident #3 was observed with multiple areas of bruising and scabbed skin, his fingernails on both hands were long with a dark substance under all nails. CNA #1, who was present during the observation, stated Resident #3 picked at his scabs.</p> <p>On 12/1/16 at 2:15 pm, the Behavioral Unit Manager reviewed Resident #3's record and did not know the reason Resident #3 was not bathed more frequently, as it was not documented that</p>	F 312	<p>bath team was in-serviced on 12/30/2016 on the importance of honoring resident preference in bathing and the risk of psychosocial and/or medical harm due to lack of clinical hygienic practice. On 12/29/2016, an audit was conducted to ensure that all current residents' bathing schedule preferences were appropriately care planned and bathing was being offered in accordance with each resident's preference.</p> <p>Facility Systems</p> <p>Staff were educated beginning on 12/27/2016 and continuing through 12/30/2016 regarding the regulatory requirement of F312 and the deficient practice. Beginning 12/29/2016, all residents and/or their responsible parties will be queried regarding bathing preferences upon admission, at care conferences and no less than annually, in conjunction with their MDS schedule. Care plans and bathing schedules will be updated accordingly.</p> <p>Monitoring</p> <p>The DNS or designee will audit bathing schedules and care plans to ensure ongoing compliance with honoring of resident preferences and clinical hygienic practices weekly for four weeks beginning the week of 1/02/2017. Audits will then continue bimonthly for one month, and monthly for three months. Findings of these audits will be discussed monthly</p>		

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F 312	Continued From page 58 he refused. 2. Resident #5 was admitted to the facility on 1/2/15, with diagnoses that included dementia, abnormal weight loss, and anxiety. Resident #5's care plan for Self Care deficit, dated 1/2/15, documented bathing and nail care was to be provided once weekly. Resident #5's TARs documented bathing was provided on 11/2/16 and 11/17/16, a period of 15 days without bathing. 11/29/16 at 4:30 pm, CNA #3 was asked about a bathing schedule for Resident #5. She stated she did not know whether Resident #5 had a specific bathing schedule.	F 312	with the QA committee beginning with the next planned meeting, tentatively scheduled for 01/11/2017. After five months, the QA committee will determine the need for and frequency of ongoing auditing.		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure an RNA program to prevent a functional	F 318	Corrective Action Resident #1 was assessed by the	1/19/17	

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F 318	<p>Continued From page 59</p> <p>decline in ROM was provided for 1 of 4 (#1) residents sampled for ROM. This deficient practice had the potential to cause harm if Resident #1 experienced a decline in ROM. Findings include:</p> <p>Resident #1 was admitted to the facility on 4/18/14, with multiple diagnoses including Huntington's Chorea and multiple contractures.</p> <p>Resident #1's 11/18/16 significant change MDS assessment documented she:</p> <p>* Had bilateral upper and lower extremity ROM limitations to both sides</p> <p>* Required extensive one or two staff assistance with bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing.</p> <p>Resident #1's ROM care plan, discontinued on 8/14/15, documented, "Resident will participate in RA-AROM program 7 days/week...to include knee extension...hip flexion...trunk flexion..."</p> <p>Resident #1's current pain care plan documented, "Contractures of muscle, multiple sites."</p> <p>Resident #1's current care plan documented she did not participate in an ROM program.</p> <p>On 11/29/16 at 8:15 am, 8:40 am, and 9:40 am, Resident #1 was observed on her bed either asleep, or with her eyes open, and both knees slightly bent and contracted. At 11:39 am, Resident #1 was observed in a Broda wheelchair with leg restraints and at the dining room table</p>	F 318	<p>restorative nurse and a Passive Range of Motion Restorative Program initiated on 12/06/2016.</p> <p>Other Residents</p> <p>All residents with limitations in range of motion have the potential to be affected by this deficient practice. All residents within the facility who have been identified to have limitations in range of motion will be assessed by the restorative nurse for the appropriateness of a restorative Range of Motion Program. Those residents assessed as appropriate, who are not already on a restorative program, will have a program initiated by 01/16/2017.</p> <p>Facility Systems</p> <p>Staff were educated beginning on 12/27/2016 and continuing through 12/30/2016 regarding the regulatory requirement of F318 and the deficient practice. All residents will be screened for restorative needs upon admission, quarterly, and with significant changes of status. Beginning 01/03/2017, the MDS nurses will complete a restorative screening form in conjunction with completion of the MDS. This screening form will be forwarded to the restorative nurse for assessment of appropriateness of restorative program initiation. The restorative nurse will document her assessment and will initiate programs deemed appropriate. The nursing</p>		

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F 318	Continued From page 60 using Kennedy [lightweight, spill proof] cups extended with handles to the side. She was observed with contractures to both hands. On 11/30/16 at 4:00 pm, the Director of Therapy said Resident #1 was not in therapy and not in a restorative program. She said Resident #1 could benefit from a restorative program, but had just been discontinued from hospice. She said the therapy department had not yet received a request for a therapy services evaluation. On 12/1/16 at 2:30 pm, the Behavior Unit Manager said Resident #1 had contractures to her hands, knees, and ankles. She said Resident #1 was not on a restorative program and said Resident #1 had not been on a restorative program since August 2015.	F 318	administration team will be in-serviced on this procedure by 01/03/2017. Monitoring The DNS or designee will audit for completion of restorative assessments weekly for four weeks beginning the week of 1/02/2017. Audits will then continue bimonthly for one month, and monthly for three months. Findings of these audits will be discussed monthly with the QA committee beginning with the next planned meeting, tentatively scheduled for 01/11/2017. After five months, the QA committee will determine the need for and frequency of ongoing auditing.		
F 323 SS=D	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	F 323		1/19/17	

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F 323	<p>Continued From page 61 from bed rails prior to installation.</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 interview, and review of residents' records and incident and accident reports, it was determined the facility failed to ensure residents received sufficient supervision and a safe environment necessary to prevent falls. This was true for 3 of 3 residents (#3, #5 and #6) sampled for falls. The deficient practice had the potential for harm if the falls resulted in injury. Findings include:</p> <p>1. Resident #5 was admitted to the facility on 1/2/15, with diagnoses of dementia, abnormal weight loss, and anxiety.</p> <p>Resident #5's clinical record documented 5 falls over a 3 month period. Three of the falls occurred in 2 days - 11/9/16 and 11/10/16. The incident reports for the falls documented they occurred on day and evening shift. His MDS, dated 9/9/16, documented Resident #5 required extensive assistance with transfers, ambulation, bed mobility and toileting.</p> <p>Resident #5's care plan documented he was to be equipped with a motion alarm while in bed, a wheelchair with anti-lock brakes, a pull tab alarm, and non skid socks. He was to request assistance with cares and was to have his bed in</p>	F 323	<p>Corrective Action:</p> <p>Resident #3's care plan was reviewed and revised on 12/30/2016. Resident has had no other falls in the facility since the fall on 11/17/2016 noted in this survey. Resident #5 no longer resides at this facility. Resident #6's fall prevention interventions were again reviewed on 12/30/2016.</p> <p>Other Residents:</p> <p>All residents have the potential to be affected by this deficient practice. The DNS reviewed all resident care plans on 12/30/2016 to ensure that all current care planned interventions were appropriate for resident condition and relevant for fall and accident prevention. Care plans were updated as indicated.</p> <p>Facility Systems:</p> <p>The facility's falls assessment policy was updated 12/30/2016 to include directive for promptly obtaining a blood glucose level for all residents with a diagnosis of</p>		

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F 323	<p>Continued From page 62</p> <p>the low position and ambulate with assistance. The most recent intervention for Resident #5's care plan, dated 1/19/16, was for a wheelchair with anti-lock brakes.</p> <p>Resident #5's ADL Care Plan, dated 11/10/16, documented he was to have a concave mattress with bolsters, and on 11/11/16, a mat on the floor at his bedside to prevent/lessen injury if a fall occurred.</p> <p>A fall investigation report documented Resident #5 fell on 11/9/16, at 1:10 pm, when he landed on the floor. Interventions included larger wedges to his bed.</p> <p>Resident #5's fall on 11/10/16, occurred at 12:25 pm. An investigation report of the incident documented he was found lying on his right side with his right arm bent behind him. Resident #5 was assessed with a 6 cm laceration above his right eye, complained of right hip pain, and was sent to the ER for evaluation. Interventions following the fall included removing the air mattress from the bed.</p> <p>On 12/1/16 at 9:50 am, the Behavioral Unit Manager stated the air mattress was removed after the 11/10/16 fall, as it appeared to be a hindrance to his ability to move in bed. She stated that the staff performed checks every 15 to 30 minutes for those residents who were a fall risk.</p> <p>2. Resident #3 was admitted to the facility on 11/9/16, with diagnoses that included dementia, FTT, Type II DM, history of syncopal episodes, and TIAs with left sided weakness.</p>	F 323	<p>diabetes. LP were in-serviced on 12/30/2016 on F323 and the cited deficient practice. LP were also in-serviced regarding the update to the facility's fall assessment policy. Starting January 5th, managers will randomly select resident care plans and perform rounds on staff while they are providing cares for those residents to ensure that staff are following resident care plans correctly and that care plans contain appropriate accident prevention interventions.</p> <p>Monitoring:</p> <p>Assigned members of the administration team will conduct Manager's Rounds audits for staff compliance in following resident care plans and implementing appropriate accident prevention interventions. The managers rounds will be completed no less than bi-weekly for four weeks, followed by weekly for four weeks, and then bi-monthly for three months to ensure compliance. Additionally, all Accident and Incident reports related to falls will be audited to ensure ongoing compliance with assessment of blood glucose levels for residents with a diagnosis of diabetes. Audits will occur weekly for four weeks beginning the week of 1/02/2017. Audits will then continue bi-monthly for one month, and monthly for three months. Findings of these audits will be discussed monthly with the QA committee beginning with the next planned meeting, tentatively</p>		

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F 323	<p>Continued From page 63</p> <p>A fall investigation report documented Resident #3 had an unattended fall during his first night at the facility. The fall investigation report documented he was found on the floor at 3:45 am. The fall investigation report noted LN #3 was called to the bedside, and 2 skin tears were noted on his left hand, as well as, a large contusion on his left forehead.</p> <p>The Fall Scene Investigation Report, included documentation that Resident #3 was unable to sit or stand after the fall. Additionally, the report included a section asking "Was resident's Blood Sugar significant?" The LN documented "Not Applicable," however, Resident #3 had a diagnosis of DM.</p> <p>The LN documented interventions put into place to prevent future falls, included alarms to his bed and chair.</p> <p>A Fall Scene Investigation Report, dated 11/17/16 at 8:55 pm, documented Resident #3 had an assisted fall to the floor. The unsigned Fall Scene Investigation Report, documented Resident #3 fell while two staff members were providing care. Resident #3 was assisted to the floor by CNA #8, who used her body to support his fall. No injuries were documented. A Memorandum for Record, dated 11/17/16, documented, "All interventions were in place at the time of the incident." The report did not include what interventions were in place at the time of Resident #3's fall on 11/17/16.</p> <p>On 12/1/16 at 10:45 am, the Behavioral Unit Manager stated interventions to prevent Resident</p>	F 323	<p>scheduled for 01/11/2017. After five months, the QA committee will determine the need for and frequency of ongoing auditing.</p>		

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F 323	Continued From page 64 #3 from falls included bed and chair alarms. She stated the alarm would not prevent a fall, but would alert staff to respond before Resident #3 actually got out of bed. 3. Resident #6 was admitted to the facility on 12/16/13, with diagnoses that included depression, Parkinson's disease, Lewy Body Dementia, hemiplegia affecting the left side, and muscle weakness. Resident #6 had a care plan for Potential for Falls, dated 12/16/13, with an intervention for a motion alarm at bedside. Resident #6's quarterly MDS assessment, dated 3/25/16, documented he had severely impaired decision making skills, required extensive assistance of 2 staff for transfers, and had impaired range of motion in his upper and lower extremities There were no changes documented in these areas on the 6/14/16 MDS assessment. An incident report dated 6/10/16 documented Resident #6 was found lying on the floor in front of an arm chair with a tight grip on the transfer pole. The motion alarm was in place, however, the alarm was in the off position.	F 323			
F 325 SS=G	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 325		1/19/17	

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F 325	Continued From page 65 (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. 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 received nutritional interventions to prevent unplanned weight loss. This was true for 2 of 4 residents (#3 and #5) sampled for weight loss. As a result: a) Resident #5 was harmed when he experienced a severe unplanned weight loss without review and/or revision of nutritional and medication interventions, and b) Resident #3 had the potential for harm should he experience weight loss or hypoglycemia related to missed dining opportunities. Findings include: 1. Resident #5 was admitted to the facility on 1/2/15 with diagnoses that included dementia, abnormal weight loss, and anxiety. Resident #5's weight on 8/17/16 was documented as 114 pounds, and his weight on 11/17/16, was documented as 104 pounds, a loss of 10 pounds, or 8.77% over a 3 month period. a. Resident #5's Nutritional Evaluation, dated 2/1/16, documented an ideal ideal body weight of 128-156 pounds. His weight at that time was 118	F 325	Corrective Action: Resident #5 no longer resides in this facility. Resident #3's care plan was reviewed after survey and revised again with additional interventions put in place on 01/02/2017. Other Residents: All residents have the potential to be affected by this deficient practice. All residents' weights and dietary care plans were reviewed on 01/02/2017 to ensure that they are maintaining acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. Facility Systems: Staff were educated beginning on		

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F 325	<p>Continued From page 66</p> <p>pounds, or a BMI of 19. Resident #5's weight dropped 11 pounds over the previous 30 days. The evaluation included a single recommendation of "Smaller portions if regular portions are overwhelming."</p> <p>Weekly Nutritional Risk Review progress notes, from 8/2/16 to 11/22/16, were unclear as to what interventions were evaluated and whether new interventions were implemented. The "Recommendations and New Interventions" were unchanged from 9/12/16 to 11/22/16, and documented weekly weights and weekly reviews were to continue.</p> <p>Resident #5's nutritional care plan called for, "High cal [calorie] ice cream with all meals." Resident #5's clinical record did not include documented intakes of high calorie ice cream.</p> <p>On 11/29/16 at 10:00 am, Resident #5 was observed eating toast and jelly. High calorie ice cream was not on his tray, and he was not offered high calorie ice cream with the meal.</p> <p>On 11/29/16 at 11:05 am, Resident #5 was observed with his midday meal of squash, potatoes and chicken. There were 4 beverages and a dessert in a bowl with cherries. High calorie ice cream was not on his tray, and he was not offered high calorie ice cream with the meal.</p> <p>On 11/30/16 at 9:00 am, Resident #5 was observed with 2 waffles, syrup, butter, and 4 beverages for breakfast. High calorie ice cream was not on his tray, and he was not offered high calorie ice cream with the meal.</p>	F 325	<p>12/27/2016 and continuing through 12/30/2016 regarding the regulatory requirement of F325 and the deficient practice. On 12/23/2016 a dietary supplement list was created, identifying all residents utilizing hi calorie supplements. The list was implemented into the kitchens individual resident meal tray preparation. Starting January 3rd, the Dietary Manger will bring the dietary care plans of residents experiencing weight loss to the weekly IDT resident at risk meeting. Effective immediately, any resident experiencing weight loss will have their medication regiment reviewed thoroughly to determine if any medications are contributing to the resident's weight loss. Any identified residents will be reviewed in the weekly IDT meeting. See Facility Systems POC for F280 regarding care plan revisions.</p> <p>Monitoring:</p> <p>Beginning the week of January 2nd, an audit will be conducted weekly by the DNS or designee to ensure that the facility does not fail to follow the care plan and put residents at risk for significant weight loss. This audit will be conducted weekly for eight weeks, followed by bimonthly audits for 1 month, and then monthly audits for two months after that, at which time the need for continued audits will be re-evaluated. The dietary manager will conduct an audit of the supplements weekly for four weeks, bi-monthly for one month, and then</p>		

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OMB NO. 0938-0391

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F 325	<p>Continued From page 67</p> <p>Resident #5's updated care plan documented, "120 cc K2 [supplement] with med pass TID." The MAR did not include documentation if Resident #5's entire supplement or partial amounts were consumed three times daily.</p> <p>The November 2016 MAR documented Resident #5 refused the supplement 27 times, which represented a loss of 6,480 potential calories for the month.</p> <p>Resident #5's care plan directed staff to, "monitor food and fluid intake with meals."</p> <p>The meal monitor for November 2016 documented Resident #5 refused 40 meals - 21 breakfasts, 9 midday meals and 10 dinners. On 11/27/16, Resident #5 "refused" all 3 meals, in addition to breakfast on 11/28/16.</p> <p>Resident #5's undated care plan documented, "TID snack requested per resident, % consumed, if refused, write why on back of sheet. [6 oz supplement]."</p> <p>The November 2016 snack monitor documented Resident #5 refused snacks 33 of the 90 opportunities offered.</p> <p>Resident #5's physician-ordered medications with the potential to have an adverse impact on appetite included:</p> <p>Hydrocodone Isosorbide Aricept Ativan Fentanyl patch</p>	F 325	<p>monthly for three months to ensure residents are receiving their supplements with their meals. The results of the audits will be reviewed at the monthly QA meeting beginning with the January 11th 2017 meeting.</p>		

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F 325	<p>Continued From page 68</p> <p>Klonopin Remeron</p> <p>The nutrition care plan did not include documentation medications were considered as contributing to Resident #5's continued weight loss.</p> <p>Resident #5's Interdisciplinary Progress Notes, dated 9/9/16, documented his family and physician were to be notified monthly of weight losses and that Resident #5 would continue to be monitored.</p> <p>An Interdisciplinary Progress Note, dated 9/15/16, documented Resident #5 continued to have poor intake and weight loss. The note documented his physician and family were aware the weight loss "may be unavoidable."</p> <p>An Interdisciplinary Progress Note, dated 10/10/16, documented Resident #5 had a Stage II pressure ulcer, and his meal intake was poor. Resident #5's weight loss was documented as possibly "unavoidable." No new interventions were noted, and the Care Plan was not revised.</p> <p>An Interdisciplinary Progress Note, dated 11/9/16, documented Resident #5 was monitored for weight loss, and received a mechanical soft diet, with 1-2 finger foods, snacks TID, high calorie ice cream with each meal and K2 120 cc TID with medications. The care plan did not address Resident #5's noted refusals of meals, snacks, or supplements.</p> <p>On 11/30/16 at 9:40 am, the Dietary Manager stated each resident's diet card was reviewed</p>	F 325			

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F 325	<p>Continued From page 69</p> <p>with each meal. She stated diet cards included supplements, which for Resident #5 included high calorie ice cream. The Dietary Manager stated each meal was prepared according to the resident's diet card. She stated if a resident was asleep for a meal, or requested a certain item for that meal, then the new meal tray would be set up and would not include supplements or high calorie ice cream. She stated the BCP had a refrigerator/freezer, and should maintain a supply of high calorie ice cream for those occasions.</p> <p>On 12/1/16 at 9:50 am, the Behavioral Unit Manager stated Resident #5's care plan should have been revised and updated to include interventions related to his refusals of meals, include dates when each intervention was initiated, and revision dates. The Behavioral Unit Manager stated care plans were reviewed and revised by the interdisciplinary team, not the nursing staff of the BCP, and that she did not see documentation medications were assessed as a factor with Resident #5's weight loss.</p> <p>Additional information provided by the facility on 12/7/16, documented "Reviewed resident's care plan twice in the month of his wt [weight] loss. No updates were necessary due to everything already in place on care plan."</p> <p>Resident #5 experienced weight loss of greater than 8.7% over a period of 3 months. The care plan did not address medications that may have contributed to his weight loss. Additionally, his care plan was not revised to include interventions for refusals, and interventions were not fully implemented as ordered.</p>	F 325			

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F 325	Continued From page 70 2. Resident #3 was admitted to the facility on 11/9/16, with diagnoses that included dementia, FTT, Type II DM, and PU on the left buttock. Resident #3's weight on admission was documented as 156 pounds. Resident #3's Care Plan Flow Sheet documented he did not receive 18 meals over the 21 day period since his admission, which indicated 28% of meals. On 12/1/16 at 2:13 pm, the Behavioral Unit Manager reviewed Resident #3's record and stated she was not aware of the frequency of his missed meals.	F 325			
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329		1/19/17	

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F 329	<p>Continued From page 71</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents' medications:</p> <ul style="list-style-type: none"> *Were not excessive; *Did not result in an adverse consequence due to the route administered; *Had adequate indications for use; *Were adequately monitored. <p>This was true for 2 of 13 (#1 and #3) sampled residents. These failures created the potential for harm if residents received excessive medications, unnecessary medications, experienced adverse consequences related to improper medication administration, and/or were given medication without adequate monitors. Findings include:</p> <ol style="list-style-type: none"> 1. Resident #1 was admitted to the facility on 4/18/14 with multiple diagnoses, including Huntington's Chorea disease and anxiety. <p>Resident #1's November 2016 Physician Order Report documented an order on 7/8/14 for Lorazepam 2 mg by mouth or IM every 2-4 hours PRN for Anxiety/Agitation related to Huntington's Disease and hospice. Give IM only if necessary per the facility escalating behavior protocol.</p> <p>The facility's Escalating Behavior Protocol forms did not document when staff were to use IM medications.</p> <p>Resident #1's 8/10/16 Medication Regimen Review documented to discontinue the</p>	F 329	<p>Corrective Action</p> <p>Resident #1's physician was faxed on 12/28/16 with request for dose reduction, daily dose limit, and for discontinuation of IM order for Lorazepam. Resident #1's physician discontinued the Lorazepam on 01/02/2017. Resident #3's physician provided additional documentation on 12/01/2016 clarifying indication for ongoing use of Seroquel. The physician was also updated regarding this medication's efficacy on 12/27/2016. On 12/1/2016, Resident #3's Psychopharmacologic Behavior Monitor Sheets were updated to include on which shift his behavioral symptoms are occurring.</p> <p>Other residents</p> <p>All residents currently receiving psychotropic medications are at risk to be affected by this deficient practice. Between 12/28/2016 and 12/29/2016 an audit of all psychotropic medication orders was conducted by the Corporate Compliance Nurse. All Lorazepam orders without dose limits and/or with IM route option were forwarded to the attending physicians with request for discontinuation of IM route and clarification for dose limits. All psychotropic medications orders without clear indication for use were also forwarded to the attending physicians for</p>		

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F 329	<p>Continued From page 72</p> <p>Lorazepam IM order and to review the exceeded dose recommendations.</p> <p>Resident #1's September 2016 to November 2016 MARs document the resident received 2 mg of Lorazepam by mouth on 6 different days.</p> <p>Resident #1's 11/16/16 Medication Regimen Review documented to discontinue the Lorazepam IM order and to review the exceeded dose recommendations. The check box under the No New Suggestions was checked.</p> <p>The 11/16/16 Pharmacist's Medication Regimen Review documented Resident #1's medications were reviewed that month.</p> <p>On 12/1/16 at 2:20 pm, LN #2 reviewed the order and said Resident #1 could receive 12 to 24 mg of Lorazepam in a 24 hour period. She said nursing judgement would not allow her to give more than two doses in that time frame and she would call the physician to clarify the order after two doses. She said she would only use the IM route if the PO route failed at least three times or when the resident was trying to harm herself.</p> <p>On 12/1/16 at 3:15 pm, the DON reviewed the Lorazepam order and said it was over the recommended dosage. The DON reviewed Resident #1's 8/10/16 and 11/16/16 Medication Regimen Reviews and said the pharmacist wanted the physician to discontinue the IM route, but the physician declined.</p> <p>On 12/1/16 at 4:15 pm, the pharmacist said he notified the facility on 8/10/16 of the excessive dose and IM route concerns on the August 2016</p>	F 329	<p>clarification. There were no orders found to be out of compliance for physician notification. Licensed Nurse staff were in-serviced on 12/30/2016 regarding the importance of ensuring each resident's drug regimen is free from unnecessary drugs, following physician's orders, and obtaining clarification for medications with unclear indication for use.</p> <p>Facility Systems</p> <p>Beginning January 9th 2017, except in situations deemed by the physician to be emergent, all residents receiving new orders for psychotropic medication therapy will be reviewed by the DNS or designee prior to initiation of pharmacological therapy. The review will ensure that all orders are complete including appropriately documented indication for use, clinically appropriate dose limits, and per-shift behavior monitoring, and that any physician-ordered follow up is appropriately scheduled on the MAR. Physicians will be contacted immediately for clarification of any incomplete order. Licensed nursing staff were in-serviced on the implementation of this new facility system on 12/30/2016.</p> <p>Monitoring</p> <p>An audit of all new psychotropic medication orders will be conducted by the DNS or designee to ensure all psychotropic medication orders are in</p>		

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F 329	<p>Continued From page 73</p> <p>Pharmacist's Medication Regimen Review report. He said Resident #1 was on hospice at the time and generally hospice residents received higher doses of Lorazepam, but said Resident #1's dose was excessive. The pharmacist said the IM route should only be used in an emergency situation with physician involvement. He said the November 2016 Pharmacist's Medication Regimen Review report documented no new suggestions as he had already documented his concerns on 8/10/16 and his suggestions were not followed.</p> <p>4. Resident #3 was admitted to the facility on 11/9/16, with diagnoses that included dementia, FTT, Type II DM, and PU on the left buttock.</p> <p>An 11/21/16 physician order, signed by his PCP, documented "Seroquel 25 mg orally, BID, Advise me with effectiveness in one week."</p> <p>Resident #3's record did not include documentation that the PCP was informed of the effectiveness of Seroquel after 1 week of therapy as ordered.</p> <p>Resident #3's record did not include Physician Progress Notes, or other documentation with clear indications for ordering Seroquel.</p> <p>The manufacturer's information for Seroquel states it is not approved for use in psychotic conditions related to dementia. It is noted to increase the risk of death in older adults with dementia-related conditions. Additionally, Seroquel may cause high blood sugar, and for diabetic residents, their blood sugar may need to be monitored on a regular basis.</p>	F 329	<p>compliance. This audit will begin the week of January 9th 2017 and will be conducted weekly for four weeks, bi monthly for one month, and monthly for three months. Findings of these audits will be discussed monthly with the QA committee beginning with the next planned meeting, tentatively scheduled for 01/11/2017. After five months, the QA committee will determine the need for and frequency of ongoing auditing.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2016
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F 329	Continued From page 74 Resident #3's diagnoses included Type II DM, and blood sugar monitoring was not initiated until 11/25/16. Blood sugar testing was ordered once weekly, and on 11/25/16 Resident #3's blood sugar was 176 mg/dl. Psychopharmacologic Behavior Monitor Sheet for November 2016 did not specify during which shifts Resident #3's behaviors were observed. On 12/1/16 at 10:45 am, the Behavioral Unit Manager reviewed Resident #3's record and said Seroquel was implemented because of Resident #3's "negative behavior." She was not able to find documentation in Resident #3's record that the PCP was notified of the medication's effectiveness after 1 week of use. Resident #3's PCP ordered Seroquel without clear indications for its use, behavior monitoring did not identify the shifts Resident #3's exhibited behaviors, and the physician was not contacted to provide results of medication efficacy.	F 329			
F 369 SS=D	483.60(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS (g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to	F 369	Corrective Action:	1/19/17	

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F 369	<p>Continued From page 75</p> <p>consistently provide specialized eating equipment for 1 of 13 sampled residents (#1). This deficient practice had the potential to result in a decline in the resident's hydration and nutritional status. Findings include:</p> <p>Resident #1 was admitted to the facility on 4/18/14, with multiple diagnoses, including Huntington's Chorea and multiple contractures.</p> <p>Resident #1's 11/18/16 significant change MDS assessment documented she had bilateral upper and lower extremity ROM limitation, and required extensive assistance of 1 staff with eating.</p> <p>Resident #1's 6/21/16 diet and physician's orders documented, "Kennedy cups for all liquids."</p> <p>Resident #1's current Nutritional care plan documented, "All liquids in Kennedy cups."</p> <p>Resident #1's current meal tray cards documented, "Cup Kennedy."</p> <p>On 11/29/16 at 11:39 am, Resident #1 was observed in her Broda wheelchair, at a dining room table using Kennedy cups with an extended open-handle to the side, a lid and a straw protruding from a hole in the top of the lid. The resident was observed with contractures to both hands. Resident #1 was observed using the cups to drink as one hand gripped underneath the extended handle to provide lift and the other hand to help steady the cup. Resident #1 required minimal assistance with the cups from CNA #6, who was assisting her to eat.</p> <p>On 11/29/16 at 5:32 pm, Resident #1 was</p>	F 369	<p>Kitchen staff were educated on 12/01/2016 regarding the importance of sending out adaptive eating equipment/utensils for the residents that require it with their meal trays.</p> <p>Other Residents:</p> <p>All residents requiring the use of adaptive eating equipment/utensils have the potential to be affected by this deficient practice. All residents within the facility who have been identified to require adaptive eating equipment/utensils were assessed by the dietary manager to be sure that they are receiving their adaptive equipment at meal time by 12/30/2016.</p> <p>Facility Systems:</p> <p>Kitchen staff were in-serviced on 12/26/2016 regarding the regulatory requirement of F369 and the deficient practice and a new procedure was implemented to identify all adaptive eating equipment for residents and ensure that the equipment is distributed with the resident's meals. All other staff were in-serviced beginning on 12/27/2016 and continuing through 12/30/2016 regarding the regulatory requirement of F369 and the deficient practice. The Dietary Manager implemented a resident adaptive equipment list on 12/29/2016 for the kitchen staff to ensure that each resident requiring adaptive eating equipment receives it with their meals each day.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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FORM APPROVED
OMB NO. 0938-0391

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F 369	Continued From page 76 observed in her Broda wheelchair sitting at a table in the dining room. The Behavior Program Manager brought Resident #1's dinner to her table, without the Kennedy cups. The tray included a regular 8-ounce cup with water, a regular 6-ounce cup of juice, a regular 6-ounce cup of soy milk, and a 6-ounce box type container of a liquid supplement, all with straws in them. CNA #7 was observed assisting Resident #1 with her meal, including assisting the resident to drink from the cups. On 11/30/16 at 10:55 am and 11:20 am, the CDM said she was not sure why Resident #1 did not receive the Kennedy cups for her dinner meal. She said if the kitchen did not send the cups, then the CNAs were responsible for retrieving extra cups in a cabinet above the nurses station. On 11/30/16 at 11:15 am, the Speech Therapist said the Kennedy cups were in place to provide the resident with more independence due to her contractures. On 11/30/16 at 11:22 am, the cabinet above the nurses station was observed with one Kennedy cup on the shelf.	F 369	Monitoring: Beginning January 5th 2017, an audit will be conducted by the dietary manager or designee to ensure that the facility does not fail to distribute adaptive eating equipment to residents. The results of the audits will be reviewed at the monthly QA meeting. This audit will be conducted daily for four weeks, followed by bi-weekly audits for four weeks, and then monthly audits for three months after that, at which time the need for continued audits will be re-evaluated.		
F 490 SS=F	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 490		1/19/17	

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F 490	<p>Continued From page 77</p> <p>Based on observation, review of facility policies and procedures, resident grievances, and resident and staff interviews, it was determined the facility was not administered in a manner to effectively use its resources to assist residents attain or maintain their highest practicable well-being. This failed practice resulted in Immediate Jeopardy of serious harm for 2 of 13 (#1 and #4) sampled residents and one random resident (#16), and had the potential to harm all residents in the facility from staff mistreatment or abuse. Findings include:</p> <p>Immediate Jeopardy was identified in the following areas:</p> <ul style="list-style-type: none"> * Refer to F225 as it relates to the failure of the administration to ensure all alleged violations involving mistreatment, neglect, abuse, and injuries of unknown origin were thoroughly investigated and reported, and that residents were protected from the potential of further abuse while the investigation was in progress. * Refer to F226 as it relates to failure of the administration to operationalize its policies and procedures for the protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, and mistreatment. <p>On 12/5/16 at 9:25 am, the Administrator said he reviewed the IDT's completed investigations as the abuse coordinator.</p>	F 490	<p>Corrective Action:</p> <p>Please refer to the corrective action taken for Resident #1, Resident #4, and Resident #16 in F225 and F226.</p> <p>Other Residents:</p> <p>All residents have the potential to be affected by this deficient practice. Please refer to corrective action for other residents for F225 and F226.</p> <p>Facility Systems:</p> <p>All policies and procedures and operational implementation related to grievance reports and follow up investigations, accident and incident reports and follow up investigations, and abuse investigations and reporting protocol were reviewed by the Administrator, Corporate Compliance Nurse, and the Corporate Compliance Director. All accident and incident reports and all other ancillary documents and grievances submitted are now reviewed by members of the IDT at morning meeting, and overseen by the administrator and corporate compliance officer, to identify any potential injuries of unknown origin or any potential incidents of abuse. Action plans are now implemented for each accident and incident report, grievance, allegation of abuse, that requires additional follow up investigations. Copies of all abuse allegations, accident and incident reports,</p>		

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F 490	Continued From page 78	F 490	<p>occurrence reports, and grievance reports, along with IDT action plans are now submitted to the Corporate Compliance Director or designee for review. The Corporate Compliance Director and/or Corporate Compliance Nurse or appropriate designee will attend the monthly QA meetings and oversee the Nursing Home Administrators utilization of facility resources to effectively and efficiently maintain the highest practicable physical, mental, and psychological well-being of each resident.</p> <p>Monitoring:</p> <p>Beginning on January 5th 2017, the Corporate Compliance Director or designee will meet with the Nursing Home Administrator once a week to review all action plans and findings of abuse, accidents and incidents, grievances, and occurrences. The Nursing Home Administrator will present and review all action plans and findings on abuse allegations, accident and incidents, grievances, and occurrences at monthly QA meetings for any further follow up and for ongoing training purposes. The meeting between the Corporate Compliance Director and the Nursing Home Administrator will be conducted weekly for four weeks, followed by bi-monthly for two months, and then monthly for two months, at which time the need for continued audits will be re-evaluated.</p>		
F 520	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA	F 520		1/19/17	

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F 520 SS=F	<p>Continued From page 79 COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>(g) Quality assessment and assurance.</p> <p>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:</p> <p>(i) The director of nursing services;</p> <p>(ii) The Medical Director or his/her designee;</p> <p>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and</p> <p>(g)(2) The quality assessment and assurance committee must :</p> <p>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and</p> <p>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;</p> <p>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>(i) Sanctions. Good faith attempts by the</p>	F 520		

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F 520	<p>Continued From page 80</p> <p>committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, review of the facility's compliance history, and resident and staff interview, it was determined the facility's quality assessment and assurance (QAA) committee failed to take actions identify and resolve systemic problems for 4 of 13 sampled residents (#1, #3, #4 and #5) and one random resident (#16). This failure had the potential to affect all residents in the facility and resulted in the QAA committee providing insufficient direction and control necessary to ensure residents' quality of care needs were met and that residents were free from potential abuse. This failed practice had the potential to harm residents due to inadequate care and/or abuse. Findings include:</p> <p>The QAA committee failed to provide sufficient monitoring and oversight to sustain regulatory compliance as evidenced by the following citations for the current 12/5/16 annual recertification survey.</p> <p>1. On 12/1/16 at 12:25 pm, the facility was cited at F225 and F226 for Immediate Jeopardy when it failed to identify, thoroughly investigate and report allegations of abuse and injuries of unknown origin. Refer to F225 and F226 for additional information.</p> <p>2. The facility failed to ensure residents' medications:</p>	F 520	<p>Corrective Action:</p> <p>Please refer to the Corrective Action taken for Resident #1, Resident #3, Resident #4, Resident #5, and Resident #16 in tags; F157, F221, F225, F226, F241, F250, F252, F280, F281, F309, F312, F314, F318, F323, F325, F329, and F369.</p> <p>Other Residents:</p> <p>Please refer to the corrective action taken for Other Residents in tags; F157, F221, F225, F226, F241, F250, F252, F280, F281, F309, F312, F314, F318, F323, F325, F329, and F369.</p> <p>Facility Systems:</p> <p>Please refer to the corrective action taken for Facility Systems in tags; F157, F221, F225, F226, F241, F250, F252, F280, F281, F309, F312, F314, F318, F323, F325, F329, and F369 for interventions specific to each individual citation. Starting in January 2017, the Corporate Compliance Director and/or Corporate Compliance Nurse will attend and oversee the monthly QAA committee meetings.</p> <p>Monitoring:</p>		

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F 520	<p>Continued From page 81</p> <p>*Were not excessive; *Had adequate indications for use; and, *Were adequately monitored.</p> <p>The facility was cited at F329. The facility was cited at F329 on the three previous recertification surveys conducted on 4/27/12, 8/16/13 and 10/24/14. Refer to F329 for additional information.</p> <p>3. The facility failed to ensure residents' care plans were revised and was cited at F280. The facility was cited at F280 on the three previous recertification surveys conducted on 4/27/12, 8/16/13 and 10/24/14. Refer to F280 for additional information.</p> <p>4. The facility failed to ensure residents on the Behavioral Care Unit received adequate care. The facility was found out of compliance for 3 of 3 sampled residents (#1, 3, and 5) on the unit. See F157, F221, F225, F226, F241, F250, F252, F280, F281, F309, F312, F314, F318, F323, F325, F329, and F369.</p> <p>On 12/5/16 at 9:25 am, the Administrator said the IDT was responsible for addressing concerns on the Behavioral Care Unit and the IDT meeting was like an extension of the QAA committee.</p>	F 520	<p>Beginning with the January 11th 2017 QAA committee meeting, all individual audits of facility systems that were found to be deficient during the facilities recertification survey will be presented by the Nursing Home Administrator and the DNS or their designees and reviewed for further follow up and action to provide sufficient direction and control to ensure residents <input type="checkbox"/> quality of care needs are met and that the residents are free from potential abuse. The Corporate Compliance Director and Corporate Compliance Nurse will provide oversight and direction to the QAA committee to further ensure the regulatory compliance, the appropriate utilization of facility resources, that residents are free from potential abuse, and to ensure that residents <input type="checkbox"/> quality of care needs are met. This oversight from the Corporate Compliance Director will continue monthly for five months, at which time the need for continued audits will be re-evaluated.</p>		

Bureau of Facility Standards

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiency was cited during the State licensure survey conducted at the facility from November 28, 2016 to December 5, 2016.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator David Scott, RN Nina Sanderson, BSW, LSW Susan Costa, RN Edith Cecil, RN Marci Clare, RN</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of the Infection Control Committee (ICC) meeting attendance records, it was determined the facility failed to ensure a representative from required departments attend quarterly meetings. The lack of participation of these departments created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings include: On 12/1/16 at 5:00 pm, the facility's Infection Control Program was reviewed with the Infection Preventionist (IP.) The IP provided ICC attendance records dated 1/20/16, 2/17/16, 3/30/16, 4/13/16, 6/15/16, 7/27/16, 8/17/16, 9/28/16, 10/19/16, and 11/21/16. No ICC meeting minutes were provided for the month of May 2016. The records received documented the</p>	C 664	<p>Corrective Action:</p> <p>On 12/05/2016 IDT was educated on the state requirements for the Infection Control Committee.</p> <p>Other Residents:</p> <p>All residents in the facility have to potential to be affected by this deficient practice.</p> <p>Facility Systems:</p> <p>The IDT and Infection Control Committee have been educated to the committee requirements for the state of Idaho. All</p>	1/19/17

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 01/03/17
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C 664	<p>Continued From page 1</p> <p>following:</p> <p>The Director of Nursing did not attend the ICC meetings held on 1/20/16, 2/17/16, or 3/30/16 representing the first quarter.</p> <p>The Dietary Supervisor did not attend the ICC meetings held on 4/13/16 or 6/15/16 representing the second quarter.</p> <p>Housekeeping was not represented for the ICC meetings held 7/27/16, 8/17/16, or 9/28/16 representing the third quarter.</p>	C 664	<p>members of the committee will be present no less than quarterly per the state requirements. The Infection Control Committee attendance log has been updated to better identify each member of the committee and their title.</p> <p>Monitoring:</p> <p>The administrator or his designee will schedule the Infection Control Committee meetings so that all members are able to attend. The administrator or his designee will monitor and report any deficient findings to the Safety Committee.</p>	
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