



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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February 15, 2017

Dallas Clinger, Administrator
Power County Nursing Home
PO Box 420
American Falls, ID 83211-0420

Provider #: 135066

Dear Mr. Clinger:

On **January 27, 2017**, a survey was conducted at Power County Nursing Home by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **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 **February 27, 2017**. Failure to submit an acceptable PoC by **February 27, 2017**, may result in the imposition of penalties by **March 22, 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; and
- 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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 3, 2017 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **April 27, 2017**. A change in the seriousness of the deficiencies on **March 13, 2017**, may result in a change in the remedy.

Dallas Clinger, Administrator
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The remedy, which will be recommended if substantial compliance has not been achieved by **April 27, 2017** includes the following:

Denial of payment for new admissions effective **April 27, 2017**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 26, 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 & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **April 27, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **February 27, 2017**. If your request for informal dispute resolution is received after **February 27, 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,

A handwritten signature in black ink, appearing to read "David Scott for". The signature is cursive and somewhat stylized.

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

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

PRINTED: 03/15/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/27/2017
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint investigation conducted at the facility from January 23, 2017 to January 27, 2017. The surveyors conducting the survey were: Presie C. Billington, RN Debra Parker, RN Survey Definitions: ADM - Administrator CNA - Certified Nursing Assistant CP - Care plan cc - cubic centimeters DM - Diabetes Mellitus DON - Director of Nursing ICO - Infection Control Officer MD - Medical Director MDS - Minimum Data Set NN - Nursing Notes QAA - Quality Assessment and Assurance R/T - Related To	F 000			
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents,	F 167		2/27/17	

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

TITLE

(X6) DATE

Electronically Signed

02/27/2017

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 167	<p>Continued From page 1 and family members and legal representatives of residents, the results of the most recent survey of the facility.</p> <p>(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and</p> <p>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.</p> <p>(iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post a notice that surveys and complaint investigations for the 3 previous years were available for review. This violation had the potential of affecting all residents in the facility. Findings include: During observations of the common areas of the facility on 1/26/17 at 9:40 am, there was no notice posted that the previous surveys and complaint investigations for the past 3 years were available for review.</p> <p>The Administrator was interviewed on 1/27/16 at 8:45 am and said there was not a notice posted which stated surveys and complaint investigations from the previous 3 years were available for review. He said the facility did not</p>	F 167	<p>What corrective actions will be accomplished for those residents found to be affected by the deficient practice. All residents were potentially affected. Additional signs were posted in the common areas and entrances of the nursing facility about the availability to review and get copies of the facility's most recent survey results and plan of correction and past three (3) surveys, plans of correction, and complaint investigations.</p> <p>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken. This practice can affect all residents admitted to the facility. The additional</p>		

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F 167	Continued From page 2 have a policy for posting notices regarding surveys.	F 167	<p>signs were posted in the common areas and entrances of the nursing facility to give notice to all residents and the public about the availability to review and get copies of the facility's most recent survey results and plan of correction and past three (3) surveys, plans of correction, and complaint investigations.</p> <p>What measures will be put in place to ensure that the deficient practice does not recur. Signs were posted in several common areas to give notice to the public about the survey availability. A new policy and procedure regarding the posting of surveys was approved by the facility Board of Trustees on 2/20/2017. A QA check audit will also be done by the Administrator or Designee to check that the survey availability signs stay posted in public areas.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur. A QA audit to check that the current survey is available and all signs are posted for survey availability in common areas will be done by the Administrator or Designee. This audit will begin 2/27/17 and will be done two (2) times a month for one (1) month, then one (1) time a month for three (3) months. Deficiencies in this practice will be reported to the QA committee for review to determine if further actions are needed. All monitoring will be documented and retained</p>		

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F 167	Continued From page 3	F 167	according to our record practices.		
F 226 SS=C	<p>483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>483.12 (b) The facility must develop and implement written policies and procedures that:</p> <p>(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>(2) Establish policies and procedures to investigate any such allegations, and</p> <p>(3) Include training as required at paragraph §483.95,</p> <p>483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also 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:</p>	F 226		2/27/17	

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F 226	<p>Continued From page 4</p> <p>Based on staff interview and review of the facility's Abuse Policy and Procedure, it was determined the facility failed to ensure its Abuse Policies and Procedures incorporated all related regulatory requirements. This deficient practice impeded the ability of the facility to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. It also created the potential for delayed investigations of abuse. This was true for all residents residing in the facility. Findings include:</p> <p>The DON provided the copy of the facility's Abuse Policies and Procedures with an effective date of 4/21/14. The CMS LTC federal regulations found in Appendix PP Guidance to Surveyors for Long Term Care Facilities, were revised effective 11/28/16. The facility's Abuse Policies and Procedures did not incorporate current regulatory requirements. Examples include, but are not limited to:</p> <ul style="list-style-type: none"> * The facility's Abuse Policy and Procedure did not include definitions for mistreatment, exploitation, misappropriation of resident property, and injuries of unknown source. * The Pre-employment section of the policy stated, "Any individual who has a record of resident abuse or neglect will not be eligible for employment at PCSNR." The policy did not state individuals found guilty by a court of law of exploitation, misappropriation of property, or mistreatment, would not be eligible for employment at the facility, as required by 483.12(a)(3)(i) [F225]. * The facility's policy documented that if an 	F 226	<p>What corrective actions will be accomplished for those residents found to be affected by the deficient practice. All residents have potential to be affected. The facility has updated the Abuse and Neglect policies and procedures to reflect the new LTC regulations including added definitions of abuse and neglect and added definitions for pre-employment background checks for employees. We did have a policy with the current regulatory requirements and details regarding abuse reporting with serious bodily injury, titled Reporting Suspected Crimes (see attachments), but the DON failed to provide this policy to the surveyors. HR has also updated the new hire and annual staff abuse-neglect training to include information about financial abuse and dementia training.</p> <p>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken. All residents have potential to be affected. The facility has updated the Abuse and Neglect policies and procedures to reflect the new LTC regulations. HR has also updated the new hire and annual staff abuse training to include information about financial abuse and dementia training.</p> <p>What measures will be put in place to ensure that the deficient practice does not recur. Staff meetings were held on 2/21/17 and 2/22/17 with training that reviewed the</p>		

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F 226	Continued From page 5 individual suspected abuse which involved serious bodily injury the incident was to be reported to the state survey agency and law enforcement within 2 hours of suspecting the abuse. The facility's policy did not include the current regulatory requirement found at 483.95(c) (1), which documents the facility must, "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..." On 1/24/17 at 8:30 am, the DON said she was not aware the regulations were revised recently and asked the surveyor where she could get copy of the new regulations. The surveyor advised the DON to check the Bureau of Facility Standard's website and on 1/26/17 at 2:10 pm, the DON said she made a copy of the new regulations and would update the facility's Abuse Policies and Procedures.	F 226	abuse and neglect updated policies and reporting. All staff and new hires will continue to receive annual training on abuse-neglect policies, identification, and reporting. The Administrator and DON now have updated copies of the current LTC state and federal regulations for review, as well as receiving updated quarterly provider updates from Medicare and Medicaid for regulation changes, training, and implementation. These updates will be shared with all LTC staff at monthly meetings by the DON. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The HR department will monitor all LTC facility staff to ensure the completion of annual abuse-neglect training. This will be done for all new staff upon hire and for all staff annually thereafter. This audit will begin 2/27/17 and will continue monthly for 3 months and then annually thereafter. All audit findings and discrepancies will be reported to the QAA committee and LTC DON. All staff training will be documented and retained according to our record practices.		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest	F 309		2/27/17	

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F 309	<p>Continued From page 6</p> <p>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 staff interview and review of training documents, it was determined the facility failed to ensure CNAs received training on the care of individuals with dementia upon hire, and annually thereafter. This was true for 13 of 13 CNAs (#1 - #13) employed by the facility. This had the potential for harm if CNAs exacerbated behavioral symptoms, or otherwise provided inappropriate care, of residents with dementia. Findings include: During an interview with CNA #2, on 1/25/17 at 1:30 pm, she said she had not received training on dementia when she was hired. She said sometimes the Activity Director gave in-services but she could not remember the last time one was given on dementia.</p>	F 309	<p>What corrective actions will be accomplished for those residents found to be affected by the deficient practice. All residents with the diagnosis of dementia have the potential to be affected. All nursing staffs were affected by this deficient practice. To be in compliance with the LTC regulations, dementia training will now be required for all long term care facility staff upon hire and annually thereafter to provide staff with the tools and training for appropriate care for all residents with dementia.</p> <p>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken.</p>		

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F 309	Continued From page 7 During an interview with CNA #4, on 1/25/17 at 2:09 pm, she said the Activity Director usually went to some type of dementia care training every year and provided in-service to the CNAs when she got back. CNA #4 said she did not receive dementia care training upon hire. During an interview with the DON, on 1/25/17 at 2:18 pm, she said the facility did not have specific training on dementia care, but information on resident behaviors was covered sometimes during in-services. During an interview with the Activity Director, on 1/26/17 at 9:45 am, she said she had received training on the Hand in Hand dementia training. She said she had provided the Hand in Hand training to the facility. She said it had been a while since this training had been completed. Review of Hand in Hand training, indicated the last training provided was 2/12/15. During an interview with the Human Resources Assistant, on 1/27/17 at 10:00 am, she said dementia care training was not provided to CNAs upon hire or prior to them providing direct resident care. She said newly hired CNAs had 30 days to complete training on the computer while they were providing care on the floor. However, the Human Resource Assistant said dementia care training was not included with the training the CNAs were required to take on the computer. During an interview with the DON, on 1/26/17 at 2:00 pm, she said the facility did not have policies regarding the care of residents with	F 309	All residents admitted with a diagnosis of dementia or current residents with a change in condition that is diagnosed by their provider to include dementia have the potential to be affected. All new staffs hired have the potential to be affected. The mandatory and continued dementia training for all staff upon hire and annually thereafter will ensure that all staff have the tools and knowledge to best care for residents with dementia and ensures a better plan of care and quality of life for residents with dementia. What measures will be put in place to ensure that the deficient practice does not recur. A new policy was created and approved outlining the new dementia care and training requirements for all employees. LTC staff meetings were held on 2/21/17 and 2/22/17 with a review of the Hand-in-Hand dementia training that all nursing staff completed. The dementia training is also now available on our online in-service health program and will be used for annual training to be completed by all employees. The dementia training requirement was also added to the HR orientation checklist and is to be completed for all new employees, prior to working any shifts. The HR department will track and keep records of all training in employee files. How the corrective action(s) will be monitored to ensure the deficient practice will not recur.		

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F 309	Continued From page 8 dementia. The 13 CNAs employed by the facility (#1 - #13) did not receive training on dementia management upon hire and annually thereafter.	F 309	The HR department will monitor all LTC facility staff to ensure the completion of dementia training. This will be done for all new staff upon hire and for all staff annually thereafter. This audit will begin 2/27/17 and will continue monthly for 3 months and then annually thereafter. All audit findings and discrepancies will be reported to the QAA committee and LTC DON. All staff training will be documented and retained according to our record practices.	3/9/17	
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 323			

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F 323	<p>Continued From page 9</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:</p> <p>Based on observation, record review, policy review, and staff interviews, it was determined the facility failed to ensure side rails were installed only when necessary to treat a resident's medical symptoms or assist with physical functioning. This was true for 7 of 9 (#2, #3, #4, #5, #6, and #7) residents sampled for side rails. This deficient practice placed residents at risk of entrapment and increased risk for falls. Findings include:</p> <p>The facility's Information Regarding the Use of Side Rails policy documented potential benefits as:</p> <ul style="list-style-type: none"> * Prevention of falls which could result in injury * Allow medical treatment to proceed without interference * Maintain body alignment * Protect self, others, or staff from harm * Increase feelings of safety and/or security * Allow residents to be more independent with repositioning in bed * Keep call light within resident's reach at all times when in bed <p>Potential risks included:</p> <ul style="list-style-type: none"> * Injury resulting from trying to remove or get over/out of bed rail or assistive device, including the possibility of strangulation and death * Increased incontinence of bowel or bladder. * Loss of skin integrity. * Increased agitation or withdraw from social contact. 	F 323	<p>What corrective actions will be accomplished for those residents found to be affected by the deficient practice. Resident #1 has had some significant changes in condition in the last two weeks. She is now very alert and oriented to her surroundings and staff. Social Services met with her on 3/9/17 about the continued use of her side rails and she felt she does not utilize them and would be ok for them to be removed. Social Services and nursing also spoke with her hospice staff about her updated condition and obtained orders to remove all side rails and use pillows for repositioning as needed. The maintenance staff removed the side rails on 3/9/17. Resident #1's care plan, side rail assessment, recap, and physician orders were updated and she will continue to be assessed as her condition improves. Families were notified of the change.</p> <p>The DON and Social Services visited with residents #3 and #5 about their exact use of the side rails on their beds. It was assessed they were not using the side rail closest to the wall on each of the beds. The maintenance staff removed a side rail on the side nearest the wall on each of the beds on 3/2/17.</p> <p>Resident #3 was not sure about this plan, but did agree to it. She was instructed to alert nursing if she had any difficulties turning from side to side without it and a</p>		

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F 323	<p>Continued From page 10</p> <p>The facility's Initial Side Rail Usage Assessment documented the form must be completed upon admission to the facility and that quarterly assessments would be completed thereafter while the resident was at the facility.</p> <p>1. Resident #1 was admitted to the facility on 12/5/16, with multiple diagnoses including COPD and anxiety.</p> <p>Resident #1's admitting MDS assessment, dated 12/18/16, documented she was cognitively impaired, required extensive assistance of two staff for bed mobility and transfers, received hospice care, and used bed rails daily.</p> <p>Resident #1's December 2016 recapitulated physician's orders documented: "1/4 side rails [one of 4] for mobility."</p> <p>Resident #1's care plan documented her bed was equipped with one upper 1/4 side rails for mobility.</p> <p>Resident #1 was observed in bed with bilateral upper side rails in the upraised position on: *1/23/17 at 3:05 pm, *1/24/17 at 9:00 am, 10:15 am, and 12:15 pm, *1/25/17 at 9:25 am, and *1/26/17 at 8:15 am.</p> <p>The facility failed to assess the installation, need, and safety of bed side rails for Resident #1.</p> <p>2. Resident #2 was admitted to the facility on 3/7/16 with multiple diagnoses, including traumatic brain injury.</p>	F 323	<p>reassessment for the side rail could be done again with her involvement as part of the resident's right to take part in developing their plan of care.</p> <p>Resident #3 and Resident #5 were also both viewed by staff using the rail to enter and exit their beds and to hold their controls and call buttons with no problems. Resident #3 and Resident #5 care plans, side rail assessments, recaps, and physician orders for ¼ side rails on only one side only were updated. Families were all notified and discussions of risk documented. No other current residents are using side rails.</p> <p>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken. All residents that are assessed to need side rails have the potential to be affected. All current residents have been reassessed for side rail use, alternatives, or discontinuance and their care plans, quarterly assessments, recaps, physician orders, and necessary side rail maintenance updated as needed. This was updated and completed for all current residents by 3/9/17.</p> <p>What measures will be put in place to ensure that the deficient practice does not recur.</p> <p>A new policy Side Rails and Restraints was created and approved in compliance with LTC federal regulations to be followed by staff. Maintenance staff have checked the remaining side rails in use by</p>		

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F 323	<p>Continued From page 11</p> <p>Resident #2's Quarterly MDS assessment, dated 12/21/16, documented his cognition as moderately impaired and that he required the assistance of one staff for completing all ADLs. The MDS assessment also documented Resident #2 did not use a bed rail.</p> <p>Resident #2's Care Plan, initiated on 3/8/16, documented he was at risk for falls. Interventions included, "Keep 1/4 side rails up for my use in bed mobility..."</p> <p>Resident #2's January 2017 recapitulated physician's orders did not include an order for side rails.</p> <p>Resident #2 was assessed for side rails usage on 3/8/16 and a consent was signed on the same day. There were no quarterly assessments completed to reassess Resident #2's need for side rails.</p> <p>Resident #2's bed was observed with raised bilateral upper side rail on 1/23/17 at 2:55 pm and on 1/26/17 at 10:40 am. Resident #2 was not in his room during these observations.</p> <p>On 1/26/17 at 10:40 am, the DON said Resident #2 had bilateral side rails but no longer used them so they should have been lowered. When asked about the quarterly assessments for Resident #2's use of side rails the DON said those assessments were not completed.</p> <p>3. Resident #6 was admitted to the facility on 5/13/16, with multiple diagnoses including senile degeneration of the brain.</p>	F 323	<p>residents and found them to be in good working order. They will also be checking them monthly with their facility grounds checklists. An MDS checklist has been created to ensure that a staff member completing the MDS does not overlook all quarterly assessments, including side rail assessments to continually evaluate the effectiveness and safety of side rail use and side rail alternatives that should be tried for residents. This checklist will be completed, signed-off and put in the resident's chart for tracking and audits.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The DON or Assistant will perform an audit of the each resident's MDS checklist to ensure the quarterly assessments are completed. This audit began 2/27/17 and will be done monthly for six months and then quarterly thereafter. All audit findings and discrepancies will be reported to the QAA committee and Administrator. All audit tracking will be documented and retained according to our record practices.</p>		

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F 323	<p>Continued From page 12</p> <p>Resident #6's Quarterly MDS assessment, dated 1/5/16, documented her cognition was severely impaired, and she required the assistance of two staff for bed mobility and transfers. The MDS assessment also documented Resident #6 did not use a bed rail.</p> <p>Resident #6's Care Plan, initiated on 1/23/17, documented "I will have my side rails down at all times when I am in my bed due to risk for injury." Intervention included "Put side rails down when in bed."</p> <p>Resident #6's January 2017 recapitulated physician's orders did not include an order for side rails.</p> <p>Resident #6 was assessed for side rails usage on 5/13/16 and a consent was signed on the same day. There were no quarterly assessments completed to reassesses Resident #6's need for side rails.</p> <p>On 1/25/16 and 1/26/17 at 8:27 am, Resident #6 was observed in bed with both upper side rails in the upraised position.</p> <p>The facility failed to secure a physician's order for Resident #6's use of bed side rails, conduct quarterly reassessments of the resident's bed side rails, and follow Resident #6's care plan for bed side rail usage.</p> <p>4. An MDS assessment, dated 11/13/16, documented Resident #3 used bed rails daily.</p> <p>Resident #3's clinical record included a signed consent form listing potential risks and benefits,</p>	F 323			

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F 323	<p>Continued From page 13</p> <p>dated 11/11/13; an initial side rail usage assessment, dated 11/11/13; quarterly side rail assessments from 2014 and February 2015 only; and recapitulated physician's orders, dated 1/10/17, that did not include an order for bed side rails.</p> <p>Resident #3's current care plan documented, "I prefer that my 1/4 side rails are up to help me with turning and repositioning in bed." The care plan intervention was initiated on 8/19/14 and revised on 10/23/14.</p> <p>On 1/23/17 at 2:55 pm and on 1/24/17 at 10:30 am, bilateral upper side rails were observed in the upraised position while Resident #3 was resting in bed.</p> <p>During an observation on 1/24/17 at 11:10 am, Resident #3 was sitting on the side of the bed dozing and both upper side rails were up.</p> <p>The facility failed to secure a physician's order, conduct quarterly side rail assessments from February 2015 onward, and assess the correct installation of side rails to Resident #3's bed.</p> <p>5. An MDS assessment, dated 11/26/16, documented Resident #4 did not use bed side rails.</p> <p>Resident #4's recapitulated physician's orders, dated 1/12/17, did not include an order for bed side rails.</p> <p>Resident #4's care plan, revised on 1/18/17, documented side rails were not to be used due to injuries to her elbows, and that side rails were to</p>	F 323			

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F 323	<p>Continued From page 14</p> <p>be in the down position and padded while she was in bed.</p> <p>Resident #4's clinical record did not include an initial evaluation or reassessment of her need for side rails.</p> <p>Resident #4 was observed in bed with bilateral unpadded upper side rails that were down while she was in bed on: *1/23/17 at 3:00 pm *1/24/17 at 8:50 am and 1:30 pm *1/25/17 at 12:20 pm</p> <p>On 1/27/16 at 10:40 am, the DON said Resident #4 was not to have the side rails up on her bed. She said they were to be padded because Resident #4 was getting skin tears on her elbows, but that there was nothing to prevent staff, another resident, or family from raising the side rails.</p> <p>6. An MDS assessment, dated 1/18/17, documented Resident #5 used bed rails daily.</p> <p>Resident #5's recapitulated physician's orders, dated 1/12/17, did not include an order for bed side rails.</p> <p>Resident #5's clinical record included a signed side rail consent form, dated 7/5/16, that outlined potential risks and benefits and a care plan intervention, dated 7/12/16, for the use of side rails.</p> <p>On 1/26/17 at 2:40 pm, bilateral upper side rails were observed in the upraised position in Resident #5's bedroom.</p>	F 323			

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F 323	<p>Continued From page 15</p> <p>Resident #5's clinical record did not include an initial evaluation, or reassessment, of her need, safety, or correct installation of side rails.</p> <p>7. An MDS assessment, dated 12/21/16, documented Resident #7 used bed rails daily.</p> <p>Resident #7's recapitulated physician's orders, dated 1/12/17, documented, "Side rails up per family request 9/11/14."</p> <p>Resident #7's care plan, revised on 1/18/17, did not address the use of the side rails.</p> <p>Resident #7 was observed in bed with bilateral upper side rails in the upraised position on: *1/23/17 at 1:46 pm *1/25/17 at 11:30 am at 1:10 pm</p> <p>Resident #7's clinical record included a signed side rail consent form outlining the potential risks and benefits, dated 9/11/14, and an initial side rail usage assessment, dated 9/11/14. No subsequent quarterly reassessments for the use of side rails was found in Resident #7's clinical record..</p> <p>8. On 1/26/17 between 8:20 am and 8:30 am, the following beds were observed with side rails in the upraised position: 3A, 3B, 4B, 5A, 5B, 6A, 7B, 8A, 8B, 9A, 9B, 10A, 11A and 11B. The following beds were observed to have side rails in the down position: Bed 1A, and 4A.</p> <p>On 1/26/17 at 10:45 am, the DON said all beds in the facility had side rails installed. The DON said most residents and their families requested the</p>	F 323		

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F 323	Continued From page 16 side rails, and noted that residents were assessed for side rail usage upon admission to the facility, and consents were obtained, but the facility failed to complete quarterly assessments. The facility failed to recognized the presence of medical symptoms that would necessitate the use of side rails, perform a risk benefit assessment that would identify why other care interventions were not appropriate or effective, and conduct quarterly re-evaluations to determine the need and safety of bed side rail use.	F 323			
F 327 SS=E	483.25(g)(2) SUFFICIENT FLUID TO MAINTAIN HYDRATION (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- (2) Is offered sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure residents were provided sufficient access to fluids. This was true for 3 of 8 sampled residents (#5, #6 and #7) and 2 random residents (#10 and #11) . The deficient practice created the potential for residents to become dehydrated and/or develop urinary tract infections. Findings include:	F 327	What corrective actions will be accomplished for those residents found to be affected by the deficient practice. Resident #5 care plan has been updated to include hydration needs, fluids offered at 1000, 1500, evenings in TV room and fresh water at bedside. Resident #6 care plan has been updated to include hydration needs, fluids offered at 1000, 1500, evenings in TV room and	3/9/17	

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F 327	<p>Continued From page 17</p> <p>The facility's Bowel Cares Policy documented, the guidelines would help decrease urinary incontinence, dehydration, and urinary tract infection. The policy also documented staff were to offer fluids to all residents, unless contraindicated by their physician, and all residents were to have fresh water readily available to them at all times. This policy was not followed. Examples include:</p> <p>a. Resident #5 was admitted to the facility on 7/5/16, with multiple diagnoses including arthritis.</p> <p>Resident #5's 1/18/17 Quarterly MDS assessment documented she was cognitively intact and required set-up only for eating and drinking.</p> <p>On 1/24/16 at 9:22 am, 10:00 am, 10:47 am, 11:20 am, 11:35 am, and 11:50 am, Resident #5 was observed sitting in the TV room with no fluids within her reach, and no staff were observed to offer her fluids.</p> <p>On 1/26/16 between 8:15 am and 10:40 am, Resident #5 was observed sitting in the TV room with no fluids within her reach and no staff were observed to offer her fluids.</p> <p>b. Resident #9 was admitted to the facility on 7/12/16, with multiple diagnoses including arthritis and diabetes.</p> <p>Resident #9's 10/25/16 Quarterly MDS assessment documented she was cognitively impaired and required the assistance of one person for eating and drinking.</p>	F 327	<p>fresh water at bedside. This resident will be assisted to drink when fluids are offered.</p> <p>Resident #7 care plan has been updated to include hydration needs, fluids offered at 1000, 1500, evenings in TV room and fresh water at bedside. This resident will be assisted to drink when fluids are offered, since she needs full assist.</p> <p>Resident #10 care plan has been updated to include hydration needs, fluids offered at 1000, 1500, evenings in TV room and fresh water at bedside. This resident will also be given fluids thickened with staff to assist with each fluid pass.</p> <p>Resident #11 care plan has been updated to include hydration needs, fluids offered at 1000, 1500, evenings in TV room and fresh water at bedside. This resident will be assisted and encouraged to drink by staff with each drink pass.</p> <p>Resident #9 care plan has been updated to include hydration needs, fluids offered at 1000, 1500, evenings in TV room and fresh water at bedside. This resident will have fluids within reach in the TV room and bedroom and be reminded to drink by staff.</p> <p>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken. All residents have the potential to be affected. A Drinking Water and Hydration policy was updated with further instructions for staff on fluid passes. Additional care planning for hydration according to the patient's needs will be</p>		

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F 327	<p>Continued From page 18</p> <p>Resident #9's care plan did not address hydration.</p> <p>On 1/24/16 at 9:22 am, 10:00 am, 10:47 am, 11:20 am, 11:35 am, and 11:50 am, Resident #9 was observed sitting in the TV room with no fluids within her reach, and no staff were observed to offer her fluids.</p> <p>On 1/26/16 between 8:15 am and 10:40 am, Resident #9 was observed sitting in the TV room with no fluids within her reach and no staff were observed to offer her fluids.</p> <p>c. Resident #10 was admitted to the facility on 6/6/16, with multiple diagnoses, including stroke.</p> <p>Resident #10's 12/20/16 Quarterly MDS assessment documented she was cognitively impaired and required the assistance of one person for eating and drinking.</p> <p>Resident #10's care plan, initiated on 1/24/17, documented, "I am overwhelmed by too many food choices so only give me one food and drink at a time..."</p> <p>On 1/24/16 at 9:22 am, 10:00 am, 10:47 am, 11:20 am, 11:35 am, and 11:50 am, Resident #10 was observed sitting in the TV room with no fluids within her reach, and no staff were observed to offer her fluids.</p> <p>On 1/26/16 between 8:15 am and 10:40 am, Resident #10 was observed sitting in the TV room with no fluids within her reach and no staff were observed to offer her fluids.</p>	F 327	<p>done in collaboration with nursing and dietary staff. Nursing staff were also in-serviced on the importance of keeping residents hydrated, fluid documentation, and specific assignments given to staff for water and fluid passes.</p> <p>What measures will be put in place to ensure that the deficient practice does not recur.</p> <p>A Drinking Water and Hydration policy (see attachments) was updated to include care planning for hydration according to the patient's needs. The nursing and dietary staff will work together in collaboration to complete the care plans for hydration and tracking for each resident and their specific fluid needs. A staff meeting held on 2/21/17 and 2/22/17 in-serviced staff on the importance of keeping the residents hydrated, assisting and reminding them to drink. New staffing assignments were made to ensure certain staffs pass water or fluids daily at 1000 and 1500. Residents needing assistance to drink will receive staff help and nursing will document fluid intake at these times and meal times using the snack and fluid monitoring form daily and documentation in the EMR. The RN in charge will check the documentation weekly. Additional side tables have also been placed next to resident recliners in the TV room for easier fluid accessibility at all times.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice</p>		

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F 327	<p>Continued From page 19</p> <p>d. Resident #11 was admitted to the facility on 8/30/16, with multiple diagnoses, including dementia.</p> <p>Resident #11's 12/13/16, Quarterly MDS assessment documented she was cognitively impaired and required the assistance of one person for eating and drinking.</p> <p>Resident #11's care plan, revised on 1/18/17, documented, "...increase my fluid intake to [greater] than 1000 cc's per day."</p> <p>On 1/24/16 at 9:22 am, 10:00 am, 10:47 am, 11:20 am, 11:35 am, and 11:50 am, Resident #11 was observed sitting in the TV room with no fluids within her reach, and no staff were observed to offer her fluids.</p> <p>e. Resident #6 was admitted to the facility on 5/13/16 with multiple diagnoses, including senile degeneration of the brain and hypertension.</p> <p>Resident #6's 1/5/17 Quarterly MDS assessment documented she was cognitively impaired and required the extensive assistance of one person for eating and drinking.</p> <p>Resident #6's care plan, initiated on 10/19/16, documented, "Keep fluids at bedside and encourage me to drink with each interaction."</p> <p>On 1/24/16 at 9:22 am, 10:00 am, 10:47 am, 11:20 am, 11:35 am, and 11:50 am, Resident #6 was observed sitting in the TV room with no fluids within her reach, and no staff were observed to offer her fluids.</p>	F 327	<p>will not recur.</p> <p>An RN will perform an audit of the weekly fluid intake tracking forms completed by nursing. This audit will begin 2/27/17 and will be done weekly for one month and then monthly for six months. All report findings and discrepancies will be reported to the QAA committee and Administrator. All audit tracking will be documented and retained according to our record practices.</p>		

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F 327	Continued From page 20 f. Resident #7 was admitted to the facility on 9/11/14, with multiple diagnoses, including dementia. Resident #7's 12/21/16 Quarterly MDS assessment documented she was cognitively impaired, and was totally dependent on staff for eating and drinking. Resident #7's care plan, initiated on 12/19/16, documented a focus, "I have potential for dehydration r/t poor fluid intake." Interventions included, "...offer fluids at each interaction." On 1/24/16 at 9:22 am, 10:00 am, 10:47 am, 11:20 am, 11:35 am, and 11:50 am, Resident #7 was observed sitting in the TV room with no fluids within her reach, and no staff were observed to offer her fluids. On 1/26/16 at 10:40 am, the DON said the above residents should have been offered assistance to drink at least once every two hours, and water should be available within their reach.	F 327			
F 425 SS=E	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the	F 425		2/27/17	

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F 425	<p>Continued From page 21</p> <p>provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, policy review, and review of medication count sheets, the facility failed to log and reconcile controlled medications stored in the DON's office for 3 of 4 discharged residents. This created the potential for misuse or diversion of controlled medications. Findings include:</p> <p>During an observation on 1/27/17 at 9:25 am, in the DON's office, a review of discontinued medications identified the following:</p> <p>* A deceased resident's (date of death 12/15/16) morphine was stored awaiting destruction. There were 4 syringes of morphine but the count sheet for the morphine indicated there should have been 5 syringes. There was no log sheet showing when it had been placed in the safe for destruction and the morphine had not been counted when placed in the safe. This deceased resident also had Lorazepam 0.5 milligrams (mg), 23 tablets in the safe that was not logged in when placed in the safe.</p> <p>* A deceased resident's (date of death 12/15/16) Lorazepam 1 mg, 52 tablets, were in the safe. This medication was not logged in when placed in the safe.</p> <p>* A deceased resident's (date of death 1/9/17) liquid morphine, 28 doses, was in the safe. This medication was not logged in when placed in the safe.</p> <p>During an interview with the DON on 1/26/17 at</p>	F 425	<p>What corrective actions will be accomplished for those residents found to be affected by the deficient practice. All residents being dispensed medications have the potential to be affected. The medications of the deceased residents and all other expired or damaged medications in the DON's office were logged and disposed of in the pharmacy office and Sheriff's office on 2/6/17.</p> <p>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken. All residents being dispensed medications have the potential to be affected. A new policy Disposition of Medications was created to outline procedures for staff to properly and accurately log and dispose of medications. The policy includes logs and tracking mechanisms for disposal of all medications. The Pharmacy Consultant will review and countersign all monthly medication disposal logs.</p> <p>What measures will be put in place to ensure that the deficient practice does not recur. A new policy Disposition of Medications was created to outline procedures for staff to properly and accurately log and dispose of medications. The policy includes a log for nursing to record medications put into the safe for disposition and a log for two staff to</p>		

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F 425	Continued From page 22 9:25 am, she said the last time the medications were destroyed was when she took them to the Sheriff's Office and dropped them off on 7/1/16. During an interview with the pharmacy consultant on 1/26/17 at 1:00 pm, he said another pharmacist told him the State Board of Pharmacy said the facility could take the discontinued controlled medications to the Sheriff's Office and put it in the office's disposal bin. The facility's Policy and Procedure for Pharmacy Services, dated 4/21/14, stated "A licensed pharmacist will provide consultation on all aspects of the provision of pharmacy services in the facility. The pharmacy consultant will determine that drug records are in order and account for all controlled drugs maintained for periodic reconciliation."	F 425	review and sign monthly when disposing of the medications for better tracking. All non-narcotic medications logged for disposal will be taken by an RN to a vendor medication disposal bin locked in the upstairs pharmacy office for proper disposal. All narcotic medications to be disposed will be taken to the local Sheriff's office and the disposal co-signed by a Sherriff's office employee and PCSNF staff. The disposal logs will be kept in the Pharmacy Review binder and taken to the monthly Pharmacy Review meeting. The Pharmacy Consultant will review and countersign all monthly medication disposal logs. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The DON will perform a monthly audit of the safe and medication disposal logs to check for accuracy in logging information and signatures for disposal, beginning 2/27/17. This audit will be done monthly hereafter. All audit findings and discrepancies will be reported to the Pharmacy Review and QAA committee. All logs and audits will be documented and retained according to our record practices.		
F 431 SS=C	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit	F 431		2/27/17	

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F 431	<p>Continued From page 23</p> <p>unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--</p> <p>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>(g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>(h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked,</p>	F 431			

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F 431	<p>Continued From page 24</p> <p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, review of controlled medication count sheets, staff interview, and policy review, it was determined the facility failed to ensure discontinued controlled medications were reconciled for 1 of 4 discharged residents. This deficient practice created the potential for diversion of controlled medications. Findings include:</p> <p>On 1/27/17 at 9:25 am, in the DON's office, a review of discontinued medications indicated a deceased resident's (date of death 12/15/16) morphine was stored awaiting destruction. There were 4 syringes of morphine, but the count sheet for the morphine indicated there should have been 5 syringes.</p> <p>During an interview with the DON, on 1/26/17 at 9:25 am, she said the last time the medications were destroyed was when she took it to the Sheriff's Office and dropped it off on 7/1/16.</p> <p>During an interview with the pharmacy consultant on 1/26/17 at 1:00 pm, he said another pharmacist told him the State Board of Pharmacy said the facility could take the discontinued controlled medications to the Sheriff's Office and put it in the office's disposal bin.</p>	F 431	<p>What corrective actions will be accomplished for those residents found to be affected by the deficient practice. All residents being dispensed controlled medications have the potential to be affected. The narcotic medications of the deceased residents in the DON's office were logged, signed and disposed of with the Sheriff's office on 2/6/17.</p> <p>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken. All residents being dispensed controlled medications have the potential to be affected. A new policy Disposition of Medications was created to outline procedures for staff to properly and accurately log and dispose of medications including count sheets and countersignatures for narcotic medications. The Pharmacy Consultant will also review and countersign all monthly medication disposal logs.</p> <p>What measures will be put in place to ensure that the deficient practice does not recur.</p>		

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F 431	Continued From page 25 The facility's Policy and Procedure for Pharmacy Services, dated 4/21/14, stated, "A licensed pharmacist will provide consultation on all aspects of the provision of pharmacy services in the facility. The pharmacy consultant will determine that drug records are in order and account for all controlled drugs maintained for periodic reconciliation."	F 431	The new policy Disposition of Medications outlines procedures for staff to properly and accurately log and dispose of all narcotic medications, including additional count sheets for narcotics; countersignatures for narcotics disposed at the local Sheriff's office; narcotic log audit forms to be kept in the pharmacy review binder; and monthly review of the audit and disposal logs will be done by an RN with any discrepancies or errors corrected and reported to the Pharmacy Consultant and monthly at the Pharmacy Review meeting. All narcotic counts found to be in error will also require a QMM and investigation be completed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The DON or RN will perform a weekly audit of the narcotics log, beginning 2/27/17. This audit will be done weekly for eight weeks, then monthly thereafter. All audit findings and discrepancies will be corrected and reported to the Pharmacy Review Committee, QAA committee, and Pharmacy Consultant. All logs and audits will be documented and retained according to our record practices.		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 441		2/27/17	

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F 441	Continued From page 26 (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 441		

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F 441	<p>Continued From page 27</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of staff training documents, and staff interview, it was determined the facility failed to ensure glucometers were cleaned and disinfected between residents for 1 of 1 (#3) sampled resident and 3 of 3 (#13, #14 and #15) random residents that required blood glucose monitoring. This created the potential for the spread of infection among residents. Findings include: During an observation of medication administration on 1/24/17 from 11:12 am to 11:30 am, LN #1 performed blood glucose monitoring on 4 residents (#3, #13, #14 and #15) and did not clean or disinfect the glucometer between residents.</p>	F 441	<p>What corrective actions will be accomplished for those residents found to be affected by the deficient practice. The glucose monitors for each of the affected residents (#3, #13, #14, #15) were thoroughly disinfected by the Infection Control Officer (ICO). The ICO also ordered new individually packaged disinfection wipes that are easier for the nursing staff to properly clean the monitors at each patient's testing site to prevent cross-contamination.</p> <p>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken.</p>		

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F 441	<p>Continued From page 28</p> <p>During an interview with LN #1 on 1/24/17 at 11:45 am, she said the manual stated the glucometer only needed cleaned once a day or per facility policy.</p> <p>During an interview with the DON on 1/25/17 at 9:15 am, she said the facility did not have a policy that instructed staff on when the glucometer needed disinfected and they just went by the manual.</p> <p>During an interview with the Infection Control Director on 1/26/17 at 12:55 pm, she said the glucometers were to be disinfected after each resident use.</p> <p>The manual for the Precision Xceed Pro glucometer was reviewed on 1/24/17 at 3:30 pm. The manual recommended cleaning the exterior surface of the glucometer daily or following the facility's policy and procedures for infection control.</p> <p>The facility's Annual Certification - POCT Abbott Precision Xceed Pro document used to train personnel, provided by the Infection Control Director, was review on 1/25/17 at 3:45 pm. Under the cleaning section the instructions were to wipe the instrument after each resident and/or if the instrument becomes visually contaminated.</p> <p>On the Center for Disease Control and Prevention's website at www.cdc.gov, an article titled Infection Prevention during Blood Glucose Monitoring and Insulin Administration states, "If blood glucose meters must be shared, the device should be cleaned and disinfected after every</p>	F 441	<p>All residents needing glucose monitoring have the potential to be affected. The ICO retrained all LTC staff that perform glucose monitor testing on 2/21/17 and 2/22/17 with an emphasis on cleaning of multiuse monitors after each patient to prevent cross-contamination and using the new disinfection wipes.</p> <p>What measures will be put in place to ensure that the deficient practice does not recur. The ICO will do annual training for LTC staff on the use and cleaning of the glucose monitor according to the CDC guidelines for shared meter disinfection and the PCHD policy was updated to reflect this. The ICO will also do training for all new staff that will be performing patient testing with the glucose monitor as part of their new hire orientation.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The ICO will use surveillance monitoring to ensure the staff is doing proper cleaning on the glucose monitors between patients as part of the IC QAA program. These surveillance audits will be done by the ICO and will begin 2/27/2017 and will be done weekly for three months, then monthly for 3 months. If the issue is resolved at that time surveillance will be discontinued with annual assessment and in-services to continue thereafter. All report findings and discrepancies will be reported to the ICC and QAA committees.</p>		

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F 441	Continued From page 29 use, per manufactures instructions, to prevent carry-over of blood and infectious agents." Sources for the document were National Center for Disease Control and Prevention, Emergent and Zoonotic Infectious Disease and Division of Health Care Quality Promotion.	F 441	All audits and training will be documented and retained according to our record practices.		
F 498 SS=E	483.35(c); 483.95(g)(1)(2)(4) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS 483.35 (c) Proficiency of Nurse Aides The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. 483.95 (g) Required in-service training for nurse aides. In-service training must- (g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. (g)(2) Include dementia management training and resident abuse prevention training. (g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of CNA personnel records, it was determined the facility failed to ensure 4 of 4 CNAs (#1, #5, #6 and #7) whose personnel files were reviewed,	F 498	What corrective actions will be accomplished for those residents found to be affected by the deficient practice. All residents have potential to be affected.	2/27/17	

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F 498	<p>Continued From page 30</p> <p>demonstrated competency in skills and techniques necessary to care for resident needs upon hire and before providing direct resident care. This deficient practice had the potential to compromise the safety of all residents residing in the facility. Findings include:</p> <p>During an interview with the Human Resources Assistant (HRA), on 1/27/17 at 10:10 am, she said newly hired CNAs were not required to have competency evaluations before direct care was given. According to the HRA, none of the CNA's employed at the facility had received a competency evaluation when hired. In addition, she said that yearly CNA competency evaluations were not required by the facility.</p> <p>On 1/27/17 at 10:10 am, the personnel records of CNAs #1, #5, #6 and #7 were reviewed with the HRA. There were no competency evaluations in the records of the 4 CNAs.</p> <p>During an interview with the DON on 1/26/17 at 2:00 pm, and on 1/27/17 at 9:50 am, she said the facility did not have policies regarding competency evaluations for CNAs.</p>	F 498	<p>To meet LTC regulations and ensure proper training and skills of our nurses and nurse aides for resident care, the facility has added a new Nursing Competency policy that outlines annual nursing competency training requirements, procedures, other trainings, and tracking.</p> <p>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken. All residents have potential to be affected. To meet the new LTC regulations and ensure proper training and skills of our nurse aides for resident care, the facility has added a new Nursing Competency policy. The policy outlines that all nursing staff will receive a competency review upon hire and annually thereafter along with annual training to include, but is not limited to dementia training, cognitive impairments, and abuse prevention for residents. Nurse aide competency training will be no less than 12 hours per year in accordance with regulations.</p> <p>What measures will be put in place to ensure that the deficient practice does not recur. The HR department has added the nurse aide competency check to the new hire orientation checklist to be completed before staff may begin work on the floor with residents. During the orientation, new nurse aides will be sent with a competency form to an appointed preceptor to show their competency and</p>		

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F 498	Continued From page 31	F 498	<p>passage of skills or knowledge for each of the listed areas before they can work on the floor. Orientation and annual nursing staff training requirements also includes dementia, cognitive impairment, and abuse training.</p> <p>The DON or RN will also review various competency skills and knowledge training monthly at staff meetings to help meet the minimum 12 hours per year of training. Staff meeting minutes will be given to the HR department to track and record in the employee's file. The DON will review the annual competency hours of all nurse staff during their annual employee review to ensure they have enough required training hours. Staff found to be deficient in training hours will be assigned to additional training to make up for the hours missed.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</p> <p>The HR department will audit and monitor all LTC facility nurse aide staff to ensure the completion of the competency training required hours. This will be done for all new nurse aides upon hire and for all nurse aides annually thereafter. This audit will begin 2/27/17 and will continue monthly for 6 months and then biannually thereafter. All audit findings and discrepancies will be reported to the QAA committee and LTC DON. All staff training and audits will be documented and retained according to our record practices.</p>		

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F 520 SS=E	<p>483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA 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		3/9/17	

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F 520	<p>Continued From page 33</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, staff interview, record review, and review of policies and procedures, it was determined the facility's Quality Assessment and Assurance committee failed to identify quality of care issues for 7 of 8 sampled residents (#1, #2, #3, #4, #5, #6, and #7) and 7 (#9, #10, #11, #12, #13, #14 and #15) random residents. This deficient practice had the potential to affect all residents in the facility. The deficient practices created the potential for residents experience injuries, falls, and/or entrapment from the use of side rails, inappropriate care of residents with dementia, and diversion of controlled medications. Findings include:</p> <p>*Refer to F323 as it relates to the failure of the administration to ensure side rails were only used when necessary to treat a resident's medical symptoms or assist with physical functioning.</p> <p>*Refer to F309 as it relates to the failure of the administration to develop a policy and procedure regarding the care residents with dementia, and to provide dementia care training for staff.</p> <p>*Refer to F425 as it relates to the failure of the administration ensure staff recorded and reconciled all unused controlled medications properly.</p> <p>*Refer to F431 as it relates to the failure of the administration to develop a policy and procedure regarding the disposition of unused controlled</p>	F 520	<p>What corrective actions will be accomplished for those residents found to be affected by the deficient practice. Those residents found to be affected by the deficient practices of the QAA Committee will be addressed through the plan of correction process with new policies and activities put into place. The new QAA activities will also be reviewed at future monthly LTC staff meetings. All current survey citations, corresponding QAA activities, and survey regulations will be discussed at the next quarterly QAA Committee meeting for additional input on the activities, survey process, and insight from the QAA Committee members on the new regulation changes to further assist with any revisions for better resident care.</p> <p>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken. All residents have the potential to be affected by the deficient practices related to the QAA committee. QAA activities related to resident quality care and the new LTC federal regulations will be addressed at monthly LTC staff meetings for input from the staff.</p> <p>The Administrator and LTC managers will present information on the new and upcoming LTC regulations at each of the quarterly QAA Committee meetings to:</p>		

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F 520	<p>Continued From page 34 medications.</p> <p>On 1/25/17 at 2:18 pm, the DON said she was not aware of the federal regulations, the need to train staff on dementia care, or the requirement for CNAs to have competency evaluations. She said she attended the QAA meeting as required and the QA Committee had not discussed dementia care, nurse aide competencies, or pharmacy requirements.</p> <p>On 1/26/17 at 2:00 pm, the QAA chairperson said she was the DON of the hospital and did not know what the federal regulations were for the nursing home. She said she was not aware of the requirements for dementia care training, competency evaluations for CNAs, regulations regarding use of side rails in the nursing home, or pharmacy requirements for the nursing home. She also said the QAA committee had not addressed training requirements the CNA's needed before caring for residents with dementia.</p> <p>The facility failed to develop and implement policies and procedures concerning dementia care, reconciliation and disposition of unused controlled medications, and use of bed rails based on residents' medical symptoms or conditions. Additionally the facility failed to assess and reassess the effectiveness or necessity of bed rails on a regular basis.</p>	F 520	<p>better inform and discuss the changes for input from all QAA Committee members; help the LTC department address and correct any quality deficiencies related to the regulations; and gather input on potential QAA activities, policies, or changes that should be followed-up on for better resident care and compliance with the new regulations.</p> <p>What measures will be put in place to ensure that the deficient practice does not recur.</p> <p>The quarterly QAA Committee meetings will be rescheduled for a more convenient day and time to include all of the required attendees including director of nursing and medical director or designee, and LTC staff for their required input and participation.</p> <p>LTC QAA activities and plans of action will be discussed at the monthly LTC staff meetings for input and understanding of the projects and new regulations for all staff.</p> <p>The Administrator and LTC managers will also present four of the new, revised, and/or upcoming LTC regulations at each of the QAA Committee meetings hereafter. This will help to better inform and gather the input of the entire committee about the regulations, related QAA activities, policies, and identifying potential areas for improvement and follow-up to improve patient care and be in compliance with the regulations.</p> <p>How the corrective action(s) will be</p>		

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F 520	Continued From page 35	F 520	<p>monitored to ensure the deficient practice will not recur.</p> <p>The DON will present the LTC QAA activities related to the survey at the monthly LTC staff meetings and quarterly QAA Committee meetings for additional input with the goal to improve patient care and meet all new and revised federal regulations. Four members of the LTC facility on the QAA Committee will also present information about a specific regulation tag and its changes and implications for the facility at each of the quarterly QAA Committee meetings to better inform the committee about the regulations and gather their input on any further QAA activities that may be necessary. All project tracking and meeting attendance and minutes will be documented and retained according to our record practices.</p>		

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the state relicensure survey conducted at the facility from January 23, 2017 to January 27, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Presie C. Billington, RN Debra Parker, RN</p>	C 000		
C 159	<p>02.100,09 Record of Ptnt/Rsdnt Personal Valuables</p> <p>09. Record of Patient's/Resident's Personal Valuables. An inventory and proper accounting shall be kept for all valuables entrusted to the facility for safekeeping. The status of the inventory shall be available to the patient/resident, his conservator, guardian, or representative for review upon request.</p> <p>This Rule is not met as evidenced by: Based on staff interview, review of facility complaints, and record review, it was determined the facility failed to maintain a complete and accurate inventory of residents' belongings. This was true for 1 of 8 (#8) sampled residents. This failed practice created disagreement between the facility and the resident's family when the Inventory of Personal Effects form was not signed by the facility and by the resident's family, and when the form was not updated when the family brought items to the facility for Resident #8. Findings include:</p> <p>Resident #8 was admitted to the facility on 11/21/14, with multiple diagnoses, including diabetes mellitus, and passed away on 10/11/16.</p>	C 159	<p>What corrective actions will be accomplished for those residents found to be affected by the deficient practice. A replacement lamp was purchased at the request of Resident #8's family and the Administrative Assistant contacted them to come pick it up on 2/23/17. The Administrator and Social Services had also contacted the local police on 1/30/17 to discuss the property discrepancy. Social Services followed up with the police on 2/23/17 and they have attempted to contact the family with no response.</p> <p>How will you identify other resident(s)</p>	2/27/17

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/27/17
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C 159	<p>Continued From page 1</p> <p>Resident #8's 11/21/14 Inventory of Personal Effects documented the personal belongings she brought in with her when she was admitted to the facility, but the form was not signed by the resident or by her family. The staff also did not sign the form.</p> <p>A Nurses' Note, dated 10/12/16, documented Resident #8's family refused to sign the Inventory of Personal Effects form and took it with them. The Nurses' Note also documented "...family stated there was a coin collection, black hills gold jewelry, and a thousand dollars in cash. They stated it was in a firebox."</p> <p>A 10/20/16 letter from Resident #8's family to the facility stated the Inventory of Personal Effects form did not include a \$2,000.00 chair, \$700.00 dresser, plastic totes, prepaid gift cards, and Resident #8's valuables. The letter further documented, "None of her jewelry is on the list, her dentures are not listed...Magnifier light the social worker broke is not on this list...her small safe is not this list and the antique money and jewelry that was in it..."</p> <p>On 1/24/17 at 3:12 pm, the DON said the Inventory of Personal Effects form was given to the Resident #8's family upon admission, but it was not signed by the family or by the staff who admitted her. She said it was the CNA's responsibility to make sure the form was signed. The DON also said it was the mistake of the facility for not signing the form and not having Resident #8 or a family member sign it. She said it was also the facility's mistake for not updating the inventory form when Resident #8's family brought something for the resident. With regards</p>	C 159	<p>having the potential to be affected and what corrective action(s) will be taken. All residents have the potential to be affected. An audit of 17 out of 17 resident files was performed on 2/21/17 to ensure that all residents had a signed inventory list in their file. An audit was performed on 2/21/17 to ensure that inventory reminder signs were posted at the nurses' station and in each of the resident rooms asking that family please add any new personal belongings brought into the facility to the inventory list. A new Resident's Financial Choice Waiver has also been added to each resident's file that identifies any residents that are entrusting money to be kept in the facility safe and guidelines for doing so. Staffs were also instructed on 2/21/17 and 2/22/17 to always complete a QMM for any resident's personal belonging that is damaged and will be reported to Social Services. Social Services will enter a note in the resident record for each communication regarding the resolution of the broken item until the item has been replaced or a satisfactory resolution has been reached with the resident or resident's family.</p> <p>What measures will be put in place to ensure that the deficient practice does not recur. An inventory of all resident personal belongings will be performed during the resident's annual MDS review. Inventory lists will be signed by the resident/resident's representative within one week of admission or daily phone</p>	

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C 159	<p>Continued From page 2</p> <p>to the safe and its contents, the DON said the facility's investigation found that none of the facility's employees or staff remembered a safe being brought in to the facility. Resident #8's roommate, the two previous social workers, and the CNAs, were interviewed and none of them saw the safe. The DON also stated, Resident #8 would have been very anxious if any of her personal belongings were misplaced or out of her sight, and would have asked staff for it. She said no one from the facility had heard Resident #8 ask for the safe or that she was looking for it.</p> <p>On 1/25/17 at 8:45 am, the LSW said Resident #8's family brought the magnifier light in 2-3 weeks before Resident #8 passed. She said it was the part of the magnifier light that allowed it to be screwed on to the table, that was broken. She said it could not be repaired. She said it broke when she was helping Resident #8 rearrange her room. The LSW said she offered to replace the lamp but Resident #8 told her she would like to shop with the LSW and choose the replacement herself. The LSW said whenever she asked Resident #8 to go out and get the lamp replacement, she was not feeling well. The LSW said she did not inform the family when the light broke. The LSW said she did not document the times she asked Resident #8 to go shopping with her and Resident #8 could not go due to illness. The LSW said she probably should have just gone out and bought the lamp, but she was trying to respect Resident #8's feelings. Resident #8 passed away without the lamp being replaced.</p> <p>The facility failed to ensure an accurate accounting of Resident #8's belongings was maintained during her stay in the facility.</p>	C 159	<p>calls will be made by designated staff members until the lists are signed. All LTC staff were instructed at a training on 2/21/17 and 2/22/17 to make sure all new items being brought into the facility are added to the resident's inventory. Staff members were also reminded that any resident money being added or taken from the facility safe was to be done by Social Services, Activities Director, or DON only. All resident files have been updated to include a Resident's Financial Choice Waiver and the form added to the admission paperwork.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</p> <p>Social Services will perform a monthly chart audit to ensure an inventory list and Resident's Financial Choice Waiver is in each file, beginning 2/27/17. This audit will be done once a month for three months and then once a quarter for two quarters and then annually thereafter. All audit findings and discrepancies will be reported to the QAA committee and LTC DON.</p> <p>The DON will perform an audit of the QMM's related to resident belongings and ensure follow up notes and a resolution are completed timely. This audit will be done once a month for three months, and then once a quarter for three quarters. All report findings and discrepancies will be reported to the QAA committee and Administrator. All audit tracking will be documented and retained according to our record practices.</p>	

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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 review of the Infection Control Meeting minutes and staff interview, it was determined the facility failed to ensure a representative from each department were present and signed in at their quarterly Infection Control Meetings. This failure had the potential to affect all residents, staff and visitors in the facility. Findings include:</p> <p>On 1/25/16 at 3:15 pm, the Infection Control Officer provided their Quarterly Infection Control Minutes and the sign-in sheets. Upon review of the sign-in sheets, it was determined the following departments were not represented on:</p> <p>*July 13, 2016 meeting - DON, ADM, MD *October 12, 2016 meeting - Housekeeping, DM</p>	C 664	<p>What corrective actions will be accomplished for those residents found to be affected by the deficient practice. All residents have the potential to be affected. The Infection Control Committee (ICC) will change the time of the quarterly meetings to ensure attendance and input by all committee members and will be rescheduled as needed each quarter to accommodate all members.</p> <p>How will you identify other resident(s) having the potential to be affected and what corrective action(s) will be taken. All residents have the potential to be affected. The rescheduling and tracking of ICC meeting attendance, for all required members, will ensure that infection control issues will be discussed and addressed by all committee members for patient care.</p> <p>What measures will be put in place to ensure that the deficient practice does not recur. A prepared signature log that includes all of the committee members required to be present will be signed at each meeting and tracked by the ICO. Emails will be sent out with an annual schedule of the required meeting dates and reminders</p>	2/27/17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001630	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2017
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NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 664	Continued From page 4	C 664	<p>sent to all committee members of the mandatory attendance prior to each meeting. If there is a conflict for one of the mandatory representatives, then the ICO will communicate with the committee members to reschedule and accommodate all attendees.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The ICO will track quarterly meeting attendance beginning 2/27/2017 and quarterly thereafter. All audit findings and discrepancies will be reported to the QAA committee and LTC Medical Director. All meeting attendance and tracking will be documented and retained according to our record practices.</p>	



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
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May 19, 2017

Dallas Clinger, Administrator
Power County Nursing Home
PO Box 420
American Falls, ID 83211-0420

Provider #: 135066

Dear Mr. Clinger:

On **January 27, 2017**, an unannounced on-site complaint survey was conducted at Power County Nursing Home. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted from January 23, 2017 through January 27, 2017.

The identified resident's clinical record, Resident Council minutes from September 2016 through January 2017, and the facility's Grievance File from October 2016 through January 2017 were reviewed.

Interviews were conducted with multiple residents, residents' family member, the Administrator, Director of Nursing, Licensed Social Worker, Licensed Practical Nurse, housekeeping staff, and three Certified Nursing Aides.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007408

ALLEGATION #1:

Several expensive items belonging to an identified resident were not included on the resident's

inventory sheet at the time of his/her expiration at the facility. The resident's inventory sheet had not been signed upon admission to the facility and several of those expensive items were not returned to the expired resident's family.

FINDINGS:

The identified resident's personal belongings brought into the facility had been recorded on the Inventory of Personal Effects form of November 2014, but the form was not signed by the resident, an interested party or by staff. The Director of Nursing said the Inventory of Personal Effects form was part of the admitting process and should have been signed by the resident, his/her family and by a staff member upon admission. The Director of Nursing also said the form should have been updated whenever additional personal belongings were brought into- and remained in the facility for the resident's use.

Based on record review and interviews, this allegation was substantiated and the facility was cited at C159 for failure to ensure an accurate accounting of the identified resident's belongings was maintained during his/her stay in the facility.

CONCLUSIONS:

Substantiated. State deficiencies related to the allegation are cited.

ALLEGATION #2:

An identified resident was unable to see during his/her last two weeks of life because facility staff had broken, but not replace, the resident's magnifier lamp approximately two weeks prior to the resident's expiration at the facility.

FINDINGS:

The staff member involved with the magnifier lamp stated rather than the lamp that was broken it was the lamp screw attaching it to the table that was broken when the staff member was helping the resident to rearrange his/her room. The staff member said she offered to replace the lamp, but the identified resident stated he/she wanted to accompany staff to shop for a new lamp. The staff member stated the identified resident did not feel well enough to shop for a new lamp whenever offers were made to do so. The staff member stated she regrets not shopping for a new lamp without the resident present, but was trying to respect the identified resident's feelings and wishes. The resident expired at the facility before a new replacement magnifier lamp was purchased.

Based on interview and record review, this allegation could not be substantiated.

Dallas Clinger, Administrator
May 19, 2017
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CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large, stylized "D" and "S".

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

DS/lj