



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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March 1, 2017

Donna Nelson, Administrator
Midland Rehabilitation And Healthcare Center
46 North Midland Boulevard
Nampa, ID 83651

Provider #: 135076

Dear Ms. Nelson:

On **January 30, 2017**, a survey was conducted at Midland Rehabilitation And Healthcare Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious 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.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 6, 2017**. Failure to submit an acceptable PoC by **March 6, 2017**, may result in the imposition of penalties by **April 5, 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 13, 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 30, 2017**. A change in the seriousness of the deficiencies on **March 16, 2017**, may result in a change in the remedy.

Donna Nelson, Administrator
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The remedy, which will be recommended if substantial compliance has not been achieved by **April 30, 2017** includes the following:

Denial of payment for new admissions effective **April 30, 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 29, 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 30, 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 **March 6, 2017**. If your request for informal dispute resolution is received after **March 6, 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,



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

DS/lj
Enclosures

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

PRINTED: 03/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/30/2017
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NAME OF PROVIDER OR SUPPLIER MIDLAND REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint investigation survey conducted at the facility January 23, 2017 to January 30, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Linda Kelly, RN Marcia Mital, RN</p> <p>Acronyms include: & = and ADON = Assistant Director of Nursing AIT = Administrator in Training BG = Blood glucose BIMS = Brief Interview for Mental Status c = with CHF = Congestive Heart Failure cm = centimeter CVA = Cerebral Vascular Accident DON = Director of Nursing d/t = due to ER = Emergency Room ESBL = Extended-Spectrum Beta-Lactamase GDR = Gradual Dose Reduction H&P = History and Physical HS = at bedtime IDT = Interdisciplinary Team IM = Intramuscular injection IV = Intravenous LE = Lower Extremity [leg] MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set mL/hr = milliliter per hour MRSA = Methicillin-resistant Staphylococcus</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/06/2017
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 aureus LN = Licensed Nurse LPN = Licensed Practical Nurse NP = Nurse Practitioner PICC = Peripherally Inserted Central Catheter PO = Orally [by mouth] Q = Every QD = Every Day RBC = Red Blood Cell R or RT = Right RD LD = Registered Dietitian Licensed Dietitian RN = Registered Nurse RNC = Regional Nurse Consultant R/T = Related To SCU = Secure Care Unit SS-E1 = Social Services-employee #1 TAR = Treatment Administration Record TX = Treatment UTI = Urinary Tract Infection VP = Vice President WBC = White Blood Cell WCTM = Will Continue to Monitor X or x = By	F 000			
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's	F 157		3/8/17	

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F 157	<p>Continued From page 2</p> <p>physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to</p>	F 157	Preparation and submission of this plan of correction by, Midland Rehabilitation		

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F 157	<p>Continued From page 3</p> <p>ensure a family member was notified in a timely manner of a pressure ulcer for 1 of 4 residents (Resident #5) reviewed for pressure ulcers. This deficient practice had the potential to result in missed opportunities for medical intervention and family involvement. Findings include:</p> <p>Resident #5 was admitted to the facility on 7/22/16, with diagnoses including dementia with delusional features, depression, and anxiety.</p> <p>A podiatrist progress note, dated 1/12/17, documented, "...R lateral ankle with 1 cm superficial lesion, gentle cleansing debridement...."</p> <p>A Nurses' Note, dated 1/16/17 at 7:45 pm, documented, "...noted resident to have an open area to rt [right] lateral ankle [with] 90% eschar [dead tissue] approx. [approximately] 1.1 x 0.8 cm [with] no depth eschar approx. 0.6 x 0.3 cm no drainage or odor noted. Surrounding wound is red [and] blanchable/tender to the touch. MD notified. Fam [family] notified..."</p> <p>A Weekly Body Audit form, dated 1/16/17, documented, "...Reddened area to R lateral ankle. Blanchable & not painful. WCTM [will continue to monitor] at this time TX [treatment] [with]." There was a lack of documentation of what the treatment was being done for the right ankle.</p> <p>Resident #5's Nurses' Notes lacked documentation from 1/6/17 through 1/15/17, related to Resident #5's right ankle or the family or physician being notified.</p>	F 157	<p>and Healthcare Center, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.</p> <p>1. On 01/16/17 Family notified of skin impairment, open area on the ankle, by the Licensed Nurse (LN). On 02/15/2017 Resident #5's family was notified by the Director of Nursing (DON) of the progress of healing resident's open area on the ankle.</p> <p>2. On 02/14/2017 the Interdisciplinary Team (IDT) completed an audit of the 24 hour reports and physician orders, appointments, and the consultants for the last 30 days of other residents to ensure that the resident's responsible party was notified of changes, including new or changing condition of the open areas on the skin, and new orders. Concerns were addressed as identified at that time.</p> <p>Root Cause: With investigation by the IDT it was discovered that the DON met with family member who was at the facility and verbally reported the change in the condition of the skin, however it was not recorded in the clinical record.</p> <p>3. 2/17/17, the Regional Clinical Nurse</p>		

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F 157	Continued From page 4 During an interview on 1/24/16 at 4:33 pm, the DON stated Resident #5's family should have been notified of the open area on the ankle on 1/6/17. He said the family should have been notified of the podiatrist debridement of the pressure ulcer. An undated facility policy, titled Midland Skin and Wound Care Program, documented, "If there is a Pressure Ulcer or Non Pressure ulcer: a. MD and Responsible party will be notified..." The facility failed to ensure this policy was followed.	F 157	educated the Administrator, DON, and IDT on requirements for notification of changes (Injury/Decline/Room, Etc.) including changes in skin condition. Beginning on 02/17/2017 the nursing staff were re-educated on the requirement for notify of changes (Injury/Decline/Room, Etc.) including changes in skin condition by the Administrator, DON, and Staff Development Coordinator (SDC). 4. Beginning the week of 03/08/2017 the DON or designee will conduct audits of the 24 hour reports, physician's MD orders, appointments and consultations , weekly for 4 weeks then monthly for 2 months and quarterly there after to ensure that resident's responsible party is notified of the changes of the resident. A report will be submitted to Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months, at that time the QAPI committee will make recommendations for and determine continued monitoring. The Director of Nursing will be responsible for the monitoring and follow-up.		
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--	F 167		3/8/17	

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F 167	Continued From page 5 (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (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 (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (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, it was determined the facility failed to ensure: a) the results of complaint investigations completed since the last recertification survey (4/1/16) were readily accessible to residents, and b) a notice was posted that surveys and complaint investigations for the 3 previous years were available for review. These deficient practices affected all residents or their representative or visitors who may want to review the survey results. Findings include: On 1/24/17 at 10:30 am, a survey results binder was observed in the facility entry way. The binder did not contain the results of the complaint investigation survey completed on 10/18/16.	F 167	1. On 01/24/17 the 3 years of surveys and complaint investigations were posted in the survey binder that is readily accessible to residents, family members and responsible parties, by the Regional Vice President. On 02/23/2017 the Administrator ensured that a) the results of the complaint investigations completed since the last recertification survey (04/01/2016) were readily accessible to residents, and b) a notice was posted that surveys and complaint investigations for the 3 previous years were available for review. 2. On 02/23/2017 the Administrator		

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F 167	Continued From page 6 During the same observation of the entry area of the facility on 1/24/17 at 10:30 am, there was no notice posted that the previous surveys and complaint investigations for the past 3 years were available for review. On 1/24/17 at 10:30 am, the Regional VP said he was unaware of the regulations were revised on 11/28/16.	F 167	completed an audit of the Survey posting to ensure that the surveys and complaint investigations for the 3 previous years were available for review. Root Cause: with investigation by the IDT it was discovered that the Administrator was unaware of the new regulation that was revised on 11/28/2016, and did not transfer the most recent complaint survey to the posted binder. 3. On 02/15/2017, the Regional Nurse Consultant reeducated the Administrator and the DON on the requirement of the Survey posting, to ensure that the surveys and the complaint investigations were readily accessible to residents, family members and responsible parties, and b) a notice was posted that the surveys and complaint investigations for the 3 previous years were available for review. Beginning on 02/17/2017, staff were re-educated on the requirements of the Survey posting, to ensure that the surveys and the complaint investigations were readily accessible to residents, family members and responsible parties, and b) a notice was posted that the surveys and complaint investigations for the 3 previous years were available for review by the Administrator. 4. Beginning the week of 03/08/2017 the Administrator or designee will conduct audits of the posted surveys and complaint investigations to ensure that the surveys and the complaint		

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F 167	Continued From page 7	F 167	investigations were readily accessible to residents, family members and responsible parties, and b) a notice was posted that the surveys and complaint investigations for the 3 previous years were available for review, weekly for the next 4 weeks then monthly for 2 months and quarterly thereafter. A report will be submitted to the QAPI committee monthly for 3 months, at that time the QAPI committee will make recommendations for and determine continued monitoring. The Administrator will be responsible for monitoring and follow-up.		
F 241 SS=E	<p>483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and resident and staff interview, it was determined the facility failed to ensure all staff knocked and/or announced themselves before entering residents' rooms. This failure directly impacted 3 of 5 residents in a group interview and 4 random residents (#18, #25, #26 and #27). The failure to honor residents' privacy created the potential for a negative psychological effect. Findings include:</p> <p>During the Group Interview on 1/25/17 at 10:10 am, 3 of 5 residents said that some staff, including housekeepers, did not always knock</p>	F 241	<p>1. On 02/25/2017 the Administrator interviewed residents #18, #25, #26, and #27 and were asked if the staff were knocking on doors and announcing themselves before entering, there were no concerns noted from the resident interviews. On 02/22/2017 and 02/23/2017, Residents' #18, #25, #26, and #27 were assessed by the Social Service Director (SSD) regarding staff entering their room before knocking and there were no concerns noted.</p>	3/8/17	

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F 241	<p>Continued From page 8 before they enter residents' rooms.</p> <p>On 1/25/17, Housekeeper #1 was observed when she entered Resident #25 and #26's room at 12:20 pm and Resident #18 and #27's room at 1:05 pm. Housekeeper #1 did not pause, knock, or announce herself before she entered either room. Resident #25 was in her room and Resident #18 was in his room at the time of the observations.</p> <p>On 1/26/17 at 11:30 am, Resident #25 said that some staff, especially the housekeeper, do not always knock before they enter her room.</p>	F 241	<p>2. Beginning on 02/15/2017 an audit of housekeeping knocking on door and asking to enter rooms before entering was conducted by the Housekeeping Supervisor; no concerns were noted. On 02/22/2017 the SSD completed audits throughout the facility of staff knocking on resident doors and asking to enter prior to entering, concerns were addressed at that time. On 02/24/17 the Administrator was invited to Resident Council and asked the residents if the staff were knocking on doors and announcing themselves before entering, the residents had no negative responses.</p> <p>Root Cause: With investigation by the IDT it was discovered that training was needed with the housekeeping department on requirements to respect the dignity and respect of individuality by knocking on resident doors and announcing self before entering.</p> <p>3. On 01/31/2017 the Housekeeping Supervisor re-educated the housekeeping staff of knocking on doors, announcing self and asking to enter prior to entering. On 02/17/2017 the facility staff were re-educated by the Administrator on requirements to respect the dignity and respect of individuality by knocking on resident doors, announcing self and waiting for a response before entering.</p> <p>4. Beginning the week of 03/08/2017, the Administrator or designee will complete audits of staff in adherence of Dignity and</p>	

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F 241	Continued From page 9	F 241	Respect of Individuality, specifically on requirements to respect the dignity and respect of individuality by knocking on resident doors, announcing self and waiting for a response before entering. Audits will be completed by the Administrator or designee weekly for 4 weeks, monthly for 2 months and quarterly thereafter, to ensure staff are knocking on resident doors, announcing self and waiting for a response before entering the resident's room. A report will be submitted to the QAPI committee monthly for 3 months, at that time the QAPI committee will make recommendations for and determine continued monitoring. The Administrator will be responsible for monitoring and follow-up.		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that	F 279		3/8/17	

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F 279	<p>Continued From page 10</p> <p>includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative (s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care</p>	F 279			

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F 279	<p>Continued From page 11</p> <p>plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure an Interim Care Plan addressed condom catheter care, transfers, wound care, and daily weights and an initial care plan addressed smoking. This was true for 2 of 13 sample residents (#3 and #9). The failed practice created the potential for harm if the residents' needs were unmet due to lack of direction about condom catheter care, Hoyer transfers, wound care, daily weights, and smoking. Findings include:</p> <p>1. Resident #9 was readmitted to the facility 1/20/17, with multiple diagnoses including CHF, sacrum pressure ulcer, incontinence, and muscle weakness.</p> <p>a. A hospital physician's discharge order, dated 1/20/17, documented the use of a condom catheter for Resident #9, as needed for incontinence.</p> <p>Resident #9's Interim Care Plan, dated 1/20/17, documented Resident #9 had a Foley catheter. The Interim Care Plan did not include the condom catheter care, as ordered, or use of a urinal at bedside.</p> <p>On 1/25/17 at 10:15 am, Resident #9 was observed without a catheter and/or urinal at bedside. Resident #9 said he had a condom catheter when admitted to the facility on 1/20/17,</p>	F 279	<p>1. On 02/10/2017 Resident #9 was discharged from the facility, then readmitted on 02/28/2017. On 02/28/2017, Resident #9 was assessed by the DON for need of condom catheter care, transfer status, wound care and daily weights and the physician was notified of changes in condition and gave orders for the resident current needs. 02/28/2017 the care plan was updated by the DON. On 02/12/2017 the DON, and SSD completed a smoking evaluation on resident #3, the Smoking Care Plan was updated on 02/12/2017 by the DON, and SSD, to reflect Resident #3 current smoking status.</p> <p>2. 02/16/17 the SSD completed an audit of other residents care plans who smoke to ensure plans were updated to reflect resident's current smoking status; no concerns were noted. Beginning on 02/24/2017 the IDT completed reviews of other residents care plans and updated care plans as indicated to ensure care plans reflected current residents medical status. Beginning on 03/02/2017 the IDT completed an audit of residents who were admitted within the last 30 days for review of admission orders, assessments and treatments, to ensure that treatments and care plans were reviewed and transcribed per admission orders and</p>		

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F 279	<p>Continued From page 12</p> <p>but the facility did not know how to manage the care. In addition, Resident #9 said he was incontinent and the staff had not offered him a urinal.</p> <p>On 1/25/17 at 10:20 am, CNA #4 was unaware of Resident #9 having a condom catheter. CNA #4 said Resident #9 had been incontinent. CNA #4 said she had offered the urinal without success.</p> <p>On 1/25/17 at 10:25 am, after reviewing Resident #9's clinical record, the DON said the care plan should have documented staff was to provide condom catheter care, instead of Foley catheter care, and given instructions for providing Resident #9 with a urinal at bedside.</p> <p>b. Resident #9's Interim Care Plan, dated 1/20/17, was left blank on how to transfer Resident #9. The care plan did not include Resident #9's need for the assistance of two staff members with Hoyer transfers.</p> <p>On 1/24/17 at 4:30 pm, Resident #9 was observed with two staff members transferring him with the Hoyer lift. Resident #9 informed the staff of how he needed to be transferred with the Hoyer lift and two staff members.</p> <p>c. A Physician's order, dated 1/20/17, documented treatment orders for Hydrogel and optifoam dressing to Resident #9's coccyx daily and Nystatin Powder to his pannus and scrotum twice daily until healed.</p> <p>Resident #9's Interim Care Plan, dated 1/20/17, did not include wound care to his coccyx, pannus and scrotum area.</p>	F 279	<p>residents current needs are met; concerns were addressed at that time.</p> <p>Root Cause: With investigation by the IDT it was discovered that the resident was admitted and the communication from shift to shift was not clear for follow up. The IDT will complete a review of the clinical record after the admission to ensure communication is followed and orders, assessments and care plans are accurate and meet the resident's needs.</p> <p>3. On 02/25/2017 the Regional Nurse Consultant and Administrator re-educated the IDT on the need for comprehensive or interim care plans to reflect resident's current status and IDT follow up of new admissions to ensure that resident need are met. Beginning on 02/17/2017 the nursing staff were re-educated by the DON and SDC on processing new admission orders, and assessing the resident for current needs.</p> <p>4. Beginning 03/08/2017 Audits will be completed by the IDT, and MDS Nurse upon admission, quarterly, annually and with any change of condition for the need to establish or update comprehensive care plans. IDT will review new physician orders, incident/accident reports, 24 hour reports and other status changes of residents weekly for 4 weeks, monthly for 2 months and quarterly thereafter, to ensure that the resident is assessed , orders are processed per admission orders and care plans are developed to</p>		

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F 279	Continued From page 13 d. A hospital discharge Physician Order, dated 1/20/17, documented daily weights for Resident #9. Resident #9's Interim care plan, dated 1/20/17, did not include daily weights. On 1/25/17 at 10:15 am, the DON said the Interim Care Plan should have been filled out accurately upon readmission for the staff to meet Resident #9's care needs. The facility failed to ensure an Interim Care Plan developed following Resident #9's readmission met his current care needs. 2. Resident #3 was admitted to the facility on 8/30/16 and readmitted on 9/12/16, with multiple diagnoses including lack of coordination, recurrent major depressive disorder, and delusional disorders. Resident #3's 9/5/16 admission MDS assessment documented his cognition was intact with a BIMS score of 15, and tobacco use. The quarterly MDS assessment, dated 11/11/16, documented the same BIMS score but was blank at the question for tobacco use. On 1/24/17 at 10:45 am, Resident #3 said he smoked cigarettes. At 11:10 am, Resident #3 was observed propelling his wheelchair in the B hallway and said he was going out to smoke. On 1/26/17 at 2:30 pm, 2:50 pm, and 4:30 pm, Resident #3 was observed smoking cigarettes in the designated smoking area outside of the C	F 279	meet the resident needs. A report will be submitted to the QAPI committee monthly for the next 3 months, at that time the QAPI committee will make recommendations for and determine continued monitoring. The DON is responsible for monitoring and follow-up.		

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F 279	Continued From page 14 hallway. Resident #3's care plan did not address cigarette smoking. On 1/26/17 at 9:00 am, the RNC said the need for a care plan related to smoking was missed when Resident #3 was admitted.	F 279			
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The	F 280		3/8/17	

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F 280	<p>Continued From page 15 planning process must--</p> <p>(i) Facilitate the inclusion of the resident and/or resident representative.</p> <p>(ii) Include an assessment of the resident's strengths and needs.</p> <p>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.</p> <p>483.21 (b) Comprehensive Care Plans</p> <p>(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the</p>	F 280			

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F 280	<p>Continued From page 16 resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, it was determined the facility failed to ensure care plans were updated to reflect current interventions. This was true for 1 of 4 residents sampled for pressure ulcers (Resident #5). This deficient practice had the potential to result in further deterioration of Resident #5's pressure ulcer. Findings include:</p> <p>Resident #5 was admitted to the facility on 7/22/16, with diagnoses including dementia with delusional features, depression, and anxiety.</p> <p>A Nurses' Note, dated 1/16/17 at 7:45 pm, documented, "...noted resident to have an open area to RT [right] lateral ankle...Resident is to have bilateral feet elevated on pillows to relieve pressure & wear only non-skid socks..."</p> <p>Resident #5's care plan, dated 1/16/17, documented, "Actual impaired skin integrity related to a pressure ulcer located on R lateral ankle R/T [related to] [decreased] mobility in bed..." The care plan lacked documentation that Resident #5 was to wear only non-skid sock instead of shoes.</p>	F 280	<p>1. On 02/15/2017 the DON updated resident #5's family on the progress of the wound healing on the right lateral ankle. On 02/22/2017 the Licensed Nurse Manager assessed open area on Resident#5's right lateral ankle, documented wound skin progress, updated care plan for resident to be able to wear shoes, and notified family and physician of progression of open area healing.</p> <p>2. Beginning on 02/16/2017, the Licensed Nurse Manager completed an audit of residents with wounds and updated the care plan to ensure that the care plan reflected and met the needs of the residents; concerns were addressed at that time. Beginning 02/22/2017 the nurse management team completed skin assessments of other residents, care plans and established/revised as indicated to reflect the resident's current status.</p> <p>Root Cause: With investigation by the IDT</p>		

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F 280	Continued From page 17 Resident #5 was observed on 1/26/17 at 9:25 am, sitting in her wheelchair in the dining room. She did not have non-skid socks on and had shoes on both feet. During an interview on 1/24/17 at 3:15 pm, LN #3 stated she was not sure why the care plan had not been updated to include instructions for Resident #5 to wear non-skid socks instead of shoes.	F 280	it was discovered that the IDT and Licensed Nurses needed re-educated on the up-dating of resident care plan as medical status and needs change. 3. On 02/15/2017 the Regional Nurse Consultant educated Administrator, DON and Nurse Management Team on updating care plans. L.N.s were re-educated by the SDC on 02/17/2017 and again on 02/28/2017 regarding revising care plans when reviewing physician orders, incident/accident reports, 24 hour report and other status changes of residents. 4. Beginning 03/08/2017 IDT will review physician orders, incident/accident reports, 24 hour report and other status changes of residents to update comprehensive care plan weekly for 4 weeks then monthly for 2 months and quarterly thereafter, to ensure that care plans are updated and reflect the resident's current status and needs. A report will be submitted to QAPI committee monthly for the next 3 months, at that time the QAPI committee will make recommendations for and determine continued monitoring. The DON will be responsible for monitoring and follow-up.		
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 281		3/8/17	

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F 281	<p>Continued From page 18 must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure the administration of medications and treatments was consistent with accepted standards of practice. This was true when:</p> <p>a) Two insulin medications were pre-documented for 1 of 10 residents (#17) during medication pass observations and diabetic nail care was pre-documented for 1 of 16 sample residents (#3).</p> <p>b) The medications and services were not provided consistent with physicians' orders and current standards of practice for 6 of 16 sampled residents (#2, #4, #5, #7, #8, and #9).</p> <p>These failures created the potential for more than minimal harm if residents were to receive the wrong amount of insulin, or not receive their insulin; diabetic nail care was not provided; and medications, including antipsychotics, and treatments, were not provided as ordered. Findings include:</p> <p>1. Resident #5 was admitted to the facility on 7/22/16, with diagnoses including dementia with delusional features, depression, and anxiety.</p> <p>a. A physician's order, dated 1/18/17, documented an order for a multivitamin with minerals every day.</p>	F 281	<p>1. On 02/18/2017 Resident #17 was assessed by the DON, with no negative outcome regarding pre-documented medication pass. Resident #2 was assessed on 02/16/2017 by DON, care plan reviewed for GDR of antipsychotic medication was started per physician orders, and MAR was reconciled against physician orders by L.N. Manager to ensure the physician orders were followed. On 02/16/2017, Hospice was notified. Resident #3 was assessed on 02/18/2017 by the DON for nail care. No negative outcomes resulted from the nail care being pre-documented. On 02/24/2017, Resident #3, was assessed to prefer to do own nail care. The DON assessed the resident to ensure ability and the care plan was updated to reflect the resident's rights. Resident#5 was assessed by DON on 02/27/2017 and the MAR and TAR for resident #5 was reviewed for accuracy against current physician orders, no negative findings were noted. On 01/27/2017 the multivitamins was discontinued per the physician since she had other vitamins scheduled, and the Ammonium Lactated was started when available on 01/19/2017 for resident #5. On 02/27/2017 Resident #7 was assessed by DON, the MAR for residedent#7 was reviewed for accuracy against current</p>		

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F 281	<p>Continued From page 19</p> <p>Resident #5's MAR lacked documentation of the order for the multivitamin with minerals.</p> <p>During an interview on 1/24/17 at 4:33 pm, the DON said the multivitamin with minerals had not been administered as ordered.</p> <p>b. A physician's order, dated 1/12/17, documented, "...Ammonium Lactate [an ointment used for dry scaly itchy skin] 12% cream...Apply to B/L [bilateral] feet and callused skin bid [twice a day] for 180 days..." Resident #5's TAR, dated January 2017, documented the treatment was added to the TAR 5 days later on 1/17/17, and was not started until 1/19/17.</p> <p>During an interview on 1/24/17 at 4:33 pm, the DON stated he did not know why the treatment had not been added to the TAR until 1/17/17 and not started until 1/19/17.</p> <p>c. A physician's order, dated 11/21/16, documented, "Will attempt GDR...Risperdal [an antipsychotic medication] 0.5 mg Q [every] HS [bedtime]..."</p> <p>Resident #5's MAR, dated November 2016, documented the 11/21/16 order for Risperdal 0.5 mg was discontinued and stated "see N.O." [new order].</p> <p>Resident #5's record lacked documentation of further orders for the Risperdal until 12/5/16, at which time an order for Risperdal 1 mg every HS was documented.</p> <p>Resident #5's MAR, dated November 2016, documented Risperdal 1 mg every HS, dated</p>	F 281	<p>physician orders, no negative findings were noted. On 02/28/2017 Resident #4 was assessed by DON and noted to be at her overall neurological baseline. Resident#4 has not had a fall since 10/07/2016. Resident#8 was assessed by DON on 02/17/2017, PICC line was D.C.'d on 02/10/2017, care plan and treatment orders updated. Resident #8 did not have any adverse effects from PICC line dressing not being changed the next morning on 01/25/2017. Resident #9 was discharged from the facility on 02/10/2017 and readmitted on 02/28/2017. On 02/28/2017, the DON assessed Resident #9 and reviewed new orders of treatment and medications for accuracy against physician orders, and there were no concerns noted.</p> <p>2. Beginning on 02/22/2017, an audit by L.N. Manager was completed on nurses completing accurate MAR/TAR documentation on other residents; concerns were addressed at that time. On 02/26/2017, an audit was completed by L.N. Manager of physician orders, reconciliation against MAR and TAR for accuracy, the medical record against the MAR and TAR to ensure that there are physician's orders for the medication or treatment were accurate and concerns were addressed at that time.</p> <p>Root Cause: with investigation by the IDT it was discovered that the "8 Rights of Medication Administration" were not being followed and re-education is needed to</p>		

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F 281	<p>Continued From page 20</p> <p>11/22/16. The MAR documented Risperdal 1 mg had been administered on 11/22/16 through 11/30/16 at bedtime, instead of the Risperdal .5 mg ordered by the physician.</p> <p>Resident #5's MAR, dated December 2016, documented he received Risperdal 1 mg 12/1/16 through 12/4/16, instead of the Risperdal 0.5 mg as ordered by the physician.</p> <p>During an interview on 1/24/17 at 4:33 pm, the DON said he was not able to find an order to increase the Risperdal to 1 milligram on 11/22/17. He stated the nurse had called about the reduction of the Risperdal ordered by the physician and the family did not want the medication decreased. He said the physician had not been contacted and the medication had been increased back to 1 milligram.</p> <p>2. Resident #7 was readmitted to the facility on 1/3/17, with diagnoses including chronic pain, hiatal hernia, and hyperlipidemia [high cholesterol].</p> <p>Resident #7's readmission orders, dated 1/3/17, documented an order for Simvastatin [a medication for high cholesterol] 40 mg every night at bedtime.</p> <p>Resident #7's January 2017 MAR did not include an order for the Simvastatin.</p> <p>During an interview on 1/26/17 at 10:38 am, the DON said he was not able to find the order for the Simvastatin on the MAR.</p> <p>During an interview on 1/27/17 at 2:10 pm, the</p>	F 281	<p>prevent any type of medication error. L.N. need re-educated on the fact that it is never approved to pre-document medication or treatments.</p> <p>3. On 03/02/2017, L.N. staff were re-educated by the SDC on Lippincott "8 Rights of Medication Administration" and facility procedure on recording Neuro checks after an un-witnessed fall or a fall when resident hit their head.</p> <p>4. Beginning 03/08/2017 audits will be completed by DON or designee, on accurate documentation on the MAR and TAR, physician's orders and reconciliation with MAR/TAR and care plans updated as orders are received. These will be completed weekly for 4 weeks, monthly for 2 months and quarterly thereafter. A report will be submitted to QAPI committee monthly for 3 months, at that time the QAPI committee will make recommendations for and determine continued monitoring. Director of Nursing will be responsible for monitoring and follow-up.</p>		

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F 281	<p>Continued From page 21</p> <p>DON said he had found a card of Simvastatin for Resident #7 with 15 tablets which had been received from the pharmacy on 1/6/17. He said the card was empty and the medication had been given. He did not know who had given the medication because it was not on the MAR and not signed out.</p> <p>The Lippincott NursingCenter.com website accessed on 1/30/17, includes the following among the "8 rights of medication administration":</p> <ul style="list-style-type: none"> * Right medication - Check the medication label - Check the order * Right dose - Check the order * Right route - Again check the order and appropriateness of the route ordered * Right time - Check the frequency of the ordered medication - Double check you are giving the ordered dose at the correct time. * Right documentation - Document administration AFTER giving the ordered medication. Chart the time, route, and any other specific information as necessary. <p>The above rights of medication administration were not followed when Resident #7 was administered Simvastatin.</p> <p>3. Resident #2 was readmitted to the facility on 1/13/16 with diagnoses including Alzheimer's disease, Parkinson's disease, and schizoaffective disorder.</p> <p>A physician's order, dated 12/15/16, documented, "Seroquel [an antipsychotic medication] 200 mg 1 by mouth once a day at bedtime."</p>	F 281			

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F 281	<p>Continued From page 22</p> <p>Resident #2's MAR for December 2016 documented, "Seroquel 300 mg po Q HS" dated 12/15/16.</p> <p>During an interview on 1/26/17 at 2:45 pm, LN #2 said the physician's order was for 200 mg not 300 mg. She said the nurse had transcribed the order incorrectly so Resident #2 had received Seroquel 300 mg instead of 200 mg. The order for Seroquel 300 mg was not received until 12/22/16.</p> <p>4. On 1/25/17 at 5:45 pm, LPN #1 was observed as she prepared 2 insulin medications, Lantus and Novolog, for Resident #17. The LPN initialed the medications as administered before she left the medication cart. Then she took took the 2 insulin medications to Resident #17's room and administered them. Upon return to the medication cart, LPN #1 said she had pre-initialed the 2 insulin medications and that it was a "bad habit."</p> <p>According to Lippincott Nursing Center, an online professional resource, accessed on 2/15/17, there are 8 rights of medication administration. Right #6 stated, "Document administration AFTER giving the ordered medication."</p> <p>5. Resident #4 was admitted to the facility in 2002 and readmitted in 2012 with multiple diagnoses, including unspecified cerebrovascular disease and Alzheimer's disease was diagnosed in 2016.</p> <p>A Resident Incident Report documented Resident #4 had a witnessed fall from her wheelchair on</p>	F 281			

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F 281	<p>Continued From page 23</p> <p>10/7/16 at 4:10 pm and landed "face down onto the floor." Resident #4 sustained a 3 cm long laceration to the left forehead and a bruise to the left knee. The fall was witnessed by LPN #4 who assessed Resident #4 and sent her to an ER for further assessment. A Nurses' Note attached to the incident report documented a 10/10/16 "Clinical review" of the 10/7/16 fall, which noted, "...Resident declined to be treated at ER and was returned to facility..."</p> <p>No neurological assessments related to the 10/7/16 fall with head injury were found in Resident #4's clinical record.</p> <p>On 1/25/17 at 3:50 pm, LPN #4 said that neurological checks were not done because Resident #4 went to the ER "right away" and they were not done when she returned to the facility. LPN #4 said Resident #4's neurological status should have been assessed after the fall.</p> <p>The website www.hcpro.com, which provides integrated information, education, training, and services related to healthcare regulation and compliance, accessed on 2/21/17, documents the following:</p> <ul style="list-style-type: none"> * Assess the resident immediately after the fall, then frequently throughout the shift. Assessment should continue for a minimum of 72 hours (or until the resident is asymptomatic for a specified period of time). * Perform frequent neurologic assessments every: <ul style="list-style-type: none"> - 15 minutes for two hours - 30 minutes for two hours - 60 minutes for four hours 	F 281			

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F 281	<p>Continued From page 24</p> <ul style="list-style-type: none"> - Eight hours for 16 hours - Eight hours until at least 72 hours have elapsed and resident is stable <p>6. Resident #3 was admitted to the facility on 8/30/16, and readmitted on 9/12/16, with multiple diagnoses including type 2 diabetes mellitus.</p> <p>Resident #3's diabetes care plan, dated 9/12/16, documented, "Nailcare by LN," as one approach.</p> <p>Resident #3's clinical record was reviewed on 1/24/17 and a copy of his January 2017 TAR was received at 5:30 pm on 1/24/17. The January 2017 TAR documented diabetic nail care by an LN was done weekly including on 1/25/17, which had not yet occurred. Initials were in the space for documentation on 1/25/17.</p> <p>On 1/25/17 at 12:50 pm, Resident #3's finger nails were observed to be short. Resident #3 said he usually trimmed his own nails and that no one in the facility trimmed his finger or toe nails.</p> <p>On 1/25/17 at 5:00 pm, the RNC said nurses should not pre-document anything, including nail care.</p> <p>7. Resident #8 was admitted to the facility 11/4/16 with multiple diagnoses including intraspinal abscess, MRSA in the spine, and osteomyelitis.</p> <p>The Recapilization Physician Orders, dated January 2017, documented Resident #8 was to have a PICC line transparent dressing change and the PICC needleless injection caps were to</p>	F 281			

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F 281	<p>Continued From page 25</p> <p>be changed every week and as needed, beginning 11/4/16.</p> <p>The January 2017 TAR documented Resident #8's PICC line dressing and injection caps were due to be changed 1/25/17 on the night shift.</p> <p>On 1/25/17 at 11:30 am, Resident #8's PICC line dressing was observed with a date of 1/18/17.</p> <p>On 1/26/17 at 9:35 am, Resident #8's PICC line dressing was observed with a date of 1/18/17 and the bottom edges of the dressing were lifted.</p> <p>On 1/26/17 at 11:10 am, DON reviewed Resident #8's TAR and saw it did not include documentation that the PICC line dressing and the PICC needleless injection caps were changed per the physician's orders. The surveyor and DON then observed that Resident #8's PICC line dressing was still dated 1/18/17. The DON said the PICC line dressing and the PICC line injection caps should have been changed on the 1/25/17 night shift.</p> <p>8. Resident #9 was re-admitted to the facility 1/20/17 with multiple diagnoses including CHF, sacrum pressure ulcer, incontinence, and muscle weakness.</p> <p>a. Resident #9's Physician's Orders, dated 1/20/17, documented a licensed nurse was to apply Nystatin powder to his pannus and scrotum twice daily until the redness healed, then as needed.</p> <p>Resident #9's TAR, dated 1/20/17, did not include documentation that the treatment was performed</p>	F 281			

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F 281	<p>Continued From page 26 per Physician's Orders.</p> <p>On 1/25/17 at 10:35 am, RN #3 was unable to find the Nystatin powder in the treatment cart.</p> <p>On 1/25/17 at 10:45 am, the DON called the pharmacy, the pharmacy representative said they did not receive an order for Nystatin powder. The DON said the nurses should have documented the medication was not available, notified the doctor, and called the pharmacy to have the Nystatin powder delivered.</p> <p>b. Resident #9's Physician's Orders, dated 1/20/17, documented an order for a condom catheter, as needed for incontinence.</p> <p>Resident #9's Interim Care Plan, dated 1/20/17, documented Resident #9 had a Foley catheter. The Interim Care Plan did not include the condom catheter care, as ordered.</p> <p>Resident #9's 1/21/17 TAR, documented that every shift staff were to:</p> <ul style="list-style-type: none"> * Provide catheter care * Ensure the catheter bag was to be in the privacy bag * Assure the patency of Resident #9's gravity drain * Check to ensure the catheter strap in place <p>Resident #9's TAR, dated 1/23/17 and 1/24/17, documented staff provided the above catheter care every shift.</p> <p>On 1/24/17 at 11:10 am, Resident #9 was observed in the therapy gym without a catheter in</p>	F 281			

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F 281	Continued From page 27 place or a catheter privacy bag. On 1/24/17 at 3:30 pm, Resident #9 was observed in bed without a catheter in place or a catheter privacy bag. On 1/25/17 at 10:00 am, Resident #9 was observed without a catheter in place. Resident #9 said, staff was unable to apply the condom catheter appropriately. At that time, he said he had been without a catheter for a couple days. Resident #9 said the staff assisted him with incontinence care. On 1/25/17 at 10:00 am, the DON said Resident #9 did not have a catheter as of 2:00 am on 1/24/17. The facility failed to ensure Physician Orders were followed and care provided accurately documented. c. In addition, the facility failed to ensure Resident #9's order for oxygen was consistent with his current needs.	F 281			
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 314		3/8/17	

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F 314	<p>Continued From page 28</p> <p>pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record and policy review, and resident and staff interview, it was determined the facility failed to identify, assess, and ensure interventions to promote healing of pressure ulcers were implemented for 1 of 4 sampled residents (Resident #5) with pressure ulcers. This placed Resident #5 at risk of more than minimal harm when a reddened area to her right ankle developed into an unstageable pressure ulcer, which the facility failed to assess and treat in a timely manner. Findings include:</p> <p>Resident #5 was admitted to the facility on 7/22/16, with diagnoses including dementia with delusional features, depression, and anxiety.</p> <p>A Quarterly MDS assessment, dated 10/26/16, documented Resident #5 had short and long term memory problems and was moderately impaired with decision making. It further stated Resident #5 required extensive assistance by staff for bed mobility and dressing.</p> <p>A "Norton" pressure ulcer risk form, dated 10/26/16, documented a score of 14. The form stated a score of 11-15 was moderate risk for developing a pressure ulcer.</p>	F 314	<p>1. On 01/17/2017 Resident #5's Responsible Party was notified of skin impairment verbally by the DON. Resident #5 was again assessed by DON on 02/15/2017, care plan updated, responsible party notified of continued wound healing progress. 02/22/2017 wound on right lateral ankle was assessed by L.N. Manager, the care plan updated, and the physician and responsible party notified of continued progression toward healing. New physician orders on 02/27/2017 for change in treatment of right lateral ankle wound, the TAR and care plan updated. Responsible party was notified of change in treatment by the L.N. Manager.</p> <p>2. Beginning on 02/16/2017 skin assessments were completed on residents with wounds, physician orders verified, the physician was notified weekly of wound measurement, orders received if indicated. Responsible party notified weekly of wound measurement, and any change in treatment by the SDC/Experienced Wound Nurse. TARs</p>		

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F 314	<p>Continued From page 29</p> <p>A care plan, dated 8/2/16, with an target date of 1/26/17, documented, "Skin: Resident is at risk for issues with skin integrity...LE edema...LN to provide weekly body audits...Assist resident to change position in w/c or bed 1-3 x a shift..."</p> <p>A Weekly Body Audit form, dated 12/2016, did not include documentation that a weekly skin assessment was completed on 12/31/16.</p> <p>A Weekly Body Audit form, dated 1/6/17, documented, "Reddened area to R lateral ankle. Blanchable & not painful. WCTM [will continue to monitor] at this time TX [with]." There was a lack of documentation of what treatment was completed for Resident #5's right ankle.</p> <p>Resident #5's TAR for January 2017 documented, "Sure prep [skin protectant] to R lateral ankle reddened & blanchable area 1/6/17..." There was no documentation to indicate the treatment had been completed on 1/8/17, 1/9/17, and 1/10/17.</p> <p>Resident #5's physician's orders did not include an order, dated 1/6/17, for the Sure prep.</p> <p>The Nurses' Note lacked documentation on 1/6/17 of an assessment or that Resident #5's physician was notified of the area on Resident #5's ankle.</p> <p>During an interview on 1/25/17 at 9:48 am, LN #2 stated she had found the area on Resident #5's ankle on 1/6/17. LN #2 said she thought she had written the order for the Sure prep and had written a note in Resident #5's chart.</p>	F 314	<p>were updated if indicated with new or changed physician's orders. Care Plan reviewed and updated if indicated by L.N. Manager. Beginning on, 02/16/2017, the L.N. Managers completed a skin assessment audit on other residents to ensure that the other resident's needs were being addressed, and that the care plans reflected and met the resident's needs; concerns were addressed at that time.</p> <p>Root Cause: With investigation by the IDT it was discovered that IDT and L.N. need re-education communicating information when new orders are given by outside consultants, and on updating resident care plan as medical status and needs change. The IDT will review 24 hour report, appointments, new orders and the MAR and TAR to ensure that the residents changes are addressed and communicated to ensure needs are being met.</p> <p>3. On 02/15/2017, IDT was educated by the Regional Nurse Consultant on the regulatory requirements for the prevention of development of skin breakdown and the process on assessing, identifying potential for risk, interventions for prevention of skin breakdown. On 02/17/2017 the SDC re-educated the nursing staff on the Skin and Wound program, and on wound care and reporting changes in skin condition, including assessments or treatments by</p>		

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F 314	<p>Continued From page 30</p> <p>A Podiatrist progress note, dated 1/12/17, documented, "...R lateral ankle with 1 cm superficial lesion, gentle cleansing debridement...Assessment...neurotropic ulceration [a pressure sore with nerve disorder involvement] ...Plan...R lateral ankle was debrided of partial thickness, fibrotic tissue...Orders: Daily dressing changes...Cleanse affected area and pat dry. Apply Bacitracin [antibacterial ointment], 2 x 2 gauze..."</p> <p>During continued interview with LN #2 on 01/25/17 at 9:48 am, she stated she had been off a few days prior to the podiatrist seeing Resident #5. LN #2 said she did not remember the podiatrist telling her about debriding Resident #5's ankle on 1/12/17, when she took care of Resident #5. She said she had gotten the order from the podiatrist for the treatment to Resident #5's ankle on 1/13/17, about 10:00 pm.</p> <p>Nurses' Notes did not include documentation of assessments of Resident #5's right ankle on 1/6/17 when the wound was first noted, through 1/15/17.</p> <p>Resident #5's TAR for January 2017, documented the treatment ordered by the podiatrist on 1/12/17 was started 1/14/17, 2 days after the order was issued.</p> <p>A Nurses' Note, dated 1/16/17 at 7:45 pm, documented, "...noted resident to have an open area to RT lateral ankle [with] 90% eschar [dead tissue] approx. 1.1 x 0.8 cm [with] no depth eschar approx. 0.6 x 0.3 cm no drainage or odor noted. Surrounding wound is red...tender to the</p>	F 314	<p>outside consultants.</p> <p>4. Beginning the week of 03/08/2017 audits of wounds and skin assessments will be completed by the SDC or designee weekly for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure that changes in condition are assessed and reported to DON and Nurse Managers timely. A report will be submitted to the QAPI committee monthly for the next 3 months, at that time the QAPI committee will make recommendations for and determine continued monitoring. Director of Nursing will be responsible for monitoring and follow-up.</p>		

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F 314	<p>Continued From page 31</p> <p>touch. MD notified...N.O. [new order] tx. Cleanse wound [with] NS [normal saline] pat dry, sure prep peri wound [around the outside of the ulcer] & apply Iodosorb [wound ointment] to wound bed [with] eschar...Resident is to have bilateral feet elevated on pillows to relieve pressure & wear only non-skid socks...c/o [complained of] tenderness around R lateral ankle..."</p> <p>A Weekly Pressure Ulcer Record form, documented the date of onset for Resident #5's right lateral ankle pressure ulcer was 1/16/17. The pressure ulcer stage was, "Unstageable-Slough and/or eschar: known but not stageable due to non-removable bed by slough - and/or eschar."</p> <p>The 1/23/17 measurements of Resident #5's pressure ulcer were 0.8 cm x 0.7 cm and it was documented as unstageable due to slough and eschar.</p> <p>A care plan, dated 1/16/17, documented, "Actual impaired skin integrity related to a pressure ulcer located on R lateral ankle R/T [decreased] mobility in bed..." The care plan did not include instructions that Resident #5 was to wear only non-skid socks instead of shoes.</p> <p>A Nutrition Service Progress Note, dated 1/18/17, documented, "...New pressure ulcer to r heel. Recommend starting on MVI [with] minerals to aid in wound healing..."</p> <p>Resident #5's physician's order, dated 1/18/17, documented, "Recommend starting multivitamin [with] minerals QD."</p>	F 314			

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F 314	<p>Continued From page 32</p> <p>Resident #5's MAR for January 2017, did not include the order for the multivitamin with minerals.</p> <p>Resident #5 was observed on 1/26/17 at 9:25 am, sitting in her wheelchair in the dining room. She did not have non-skid socks on and had shoes on both feet.</p> <p>Resident #5's pressure ulcer treatment was observed on 1/26/17 at 9:55 am, and the DON measured the wound. The measurements were 1 cm by 0.9 cm, the depth was not able to be determined due to yellow/white slough at the edges of the wound and eschar in the center. This was an increase in size from the measurements on 1/23/17, when the wound was 0.8 cm x 0.7 cm. Resident #5 stated her ankle still hurt. The DON said he would inform CNAs not to put shoes on Resident #5 and to put on non-skid socks.</p> <p>During an interview on 1/24/17 at 4:33 pm, the DON stated staff should be assessing, measuring, and documenting on the pressure ulcer in Nurses' Notes until it is healed. He said they were not aware the podiatrist had debrided Resident #5's ankle until they received the progress note. He further said the podiatrist should have notified the staff when the ankle was debrided. He stated the order for the multivitamin with minerals was not on the MAR and he was not aware of the pressure ulcer until 1/16/17.</p> <p>During an interview on 1/27/17 at 5:30 pm, the Corporate Nurse stated they had in-serviced the facility nursing staff on pressure ulcers on 1/11/17.</p>	F 314			

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F 314	Continued From page 33	F 314			
F 315 SS=D	<p>An undated facility policy, titled Midland Skin and Wound Care Program, documented, "The nurse will assess skin weekly and report concerns to the Director of Nursing and the Physician...If there is a Pressure Ulcer or Non Pressure Ulcer...MD and Responsible Party will be notified...Treatment obtained and followed...DON or designee will complete wound rounds...Weekly Measure reports will be completed..." The facility failed to ensure this policy was followed.</p> <p>483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>(e) Incontinence.</p> <p>(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and</p>	F 315		3/8/17	

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F 315	<p>Continued From page 34</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure that 1 of 13 sampled residents (#13) received appropriate care to prevent urinary tract infections, urosepsis, and reoccurring hospitalizations. This failed practice had the potential for harm to Resident #13, who experienced uroseptic shock from a UTI and was sent to the hospital. Findings include:</p> <p>Resident #13 was admitted to the facility on 10/27/14 with multiple diagnoses including CVA with left-sided hemiparesis, bed-bound, chronic kidney disease, and a history of UTIs.</p> <p>Resident #13 had a history of readmissions to the facility for recurrent UTI's with E-coli that required emergent medical treatment and hospitalizations on 10/27/14, 2/27/15, 11/4/16, and 1/17/17.</p> <p>Resident #13 was readmitted to the facility on 11/4/16 with multiple diagnoses including severe sepsis and septic shock related to UTI, metabolic encephalopathy, and CVA.</p>	F 315	<p>1. On 02/15/2017, a bladder evaluation was completed by L.N. Manager for Resident#13 and the care plan was updated to meet resident's urinary incontinence needs. On 02/22/2017 Resident#13's physician also assessed the resident, and the physician reviewed the Urologist consultation report, and did not give new orders pending the scheduled cystoscopy. On 02/22/2017 Resident #13 is being followed by Urologist, cystoscopy was scheduled for 02/23/2017, taken to appointment but was not able to complete related to resident anatomical position, the Urologist, Physician and Responsible Party were notified, by the L.N. Manager, and the Urologist ordered labs to determine further testing.</p> <p>2. Beginning on 02/14/2017 the IDT completed audits of appointments and consultations of other residents for the past 30 days to ensure that appointments or consultations were followed up per</p>		

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F 315	Continued From page 35 A hospital H&P, dated 10/31/16, documented Resident #13 became unresponsive at the facility and was sent to the ER with hypotension and possible UTI. Resident #13 received IV fluids and antibiotics, and a urinalysis was obtained that was positive for the presence of leukocyte esterase, bacteria, RBC, and WBC. A facility H&P, dated 11/3/16, documented Resident #13 had been found with a diminished respiratory rate and unresponsive by staff at the facility. The H&P documented Resident #13 was sent to the hospital on 10/31/16 where he/she was admitted to the ICU for sepsis secondary to UTI. The admission MDS assessment, dated 11/4/16, documented Resident #13 required extensive assistance with bed mobility, Hoyer lift transfers, dressing, eating, personal hygiene, and toileting. He/She was always incontinent of urine, but the facility had not attempted a toileting program. The UTI Care Plan, dated 11/4/16, documented staff was to assist Resident #13 with incontinent care 2-3 times each shift and prn, provide pericare after each incontinent episode, encourage Resident #13 to consume adequate fluid, and offer fluids frequently. A Nurses' Note, dated 12/30/16 at 3:00 am, documented Resident #13 was yelling out; the nurse administered Ativan prn at 8:00 pm and midnight with little effect. Resident #13 was dry, and fluids and food were offered. A Nurses' Note, dated 12/31/16 at 7:20 pm,	F 315	physician ordered appointments or consultations. Beginning the week of 02/21/2017 other residents were assessed for elimination by L.N. Managers to identify if they were appropriate for bowel/bladder retraining program, and to ensure that toileting needs are being met; concerns were addressed at that time. Root Cause: with investigation by the IDT it was discovered that follow up with appointments for specialists need to be tracked and recorded to ensure timely follow-up for residents to prevent medical complications. On 01/07/17 the resident had an urology appointment scheduled, however it was re-scheduled per urology office for 01/24/17, however Resident #13 was in the hospital at that time. This appointment was rescheduled when she returned to the facility, and was seen by the urologist as scheduled. 3. On 02/17/2017 the Nursing Staff were re-educated by the DON regarding urinary incontinence and the minimizing risk of UTI and communicating on the 24 hour report for the administrative staff to review in the morning clinical meeting to ensure that appointments and consultations are scheduled as ordered. On 02/22/2017 the Assistant Director of Nursing (ADON) completed education with nursing staff on Bladder Elimination Patterning. 4. Beginning 03/08/2017 ,assessments		

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F 315	<p>Continued From page 36</p> <p>documented Resident #13 was screaming as loud as she could and staff were unable to redirect her.</p> <p>Resident #13 did not have Nurses Notes' on 1/1/17 and 1/2/17 documenting behaviors or changes of condition.</p> <p>A Nurses' Note, dated 1/3/17 at 6:00 am, documented Resident #13 was yelling throughout the night. Resident #13 received Ativan prn at 1:00 am with no effectiveness.</p> <p>A Nurse's Note, dated 1/3/17 at 7:47 pm, documented the NP was in the facility and was requested to assess Resident #13's increased behaviors.</p> <p>A Physician Progress Note, dated 1/3/17, documented Resident #13 had increased encephalopathy when she had a UTI in the past. The NP documented he straight catheterized Resident #13 after two attempts from facility staff, obtained urine that was very cloudy and turbid appearing. The urine sample was sent to the lab and antibiotics would be ordered.</p> <p>A Physician's Order, dated 1/3/17, documented Rocephin 1 gm IM daily.</p> <p>A Nurses' Note, dated 1/4/17 at 6:00 am, documented Resident #13 received IM Rocephin and Ativan twice in the middle of the night without effectiveness.</p> <p>A Nurses' Note, dated, 1/4/17 at 9:18 pm, documented Resident #13 became very agitated and her yelling increased. The facility received</p>	F 315	<p>will be completed by L.N. upon admission, quarterly, annually and upon change of condition if resident could benefit from a bowel/bladder retraining program. Medical justification for residents with indwelling catheter upon admission and/or upon change of medical condition. Audits of assessments, the ADL records for elimination, and the 24 report will be competed by the DON or designee weekly for 4 weeks, monthly for 2 months and quarterly thereafter, to ensure that resident toileting needs are being assessed and plan of care is implemented to reflect the residents current status, and outside appointments are scheduled as needed. A report will be submitted to the QAPI committee monthly for 3 months, at that time the QAPI committee will make a recommendation for and determine continued monitoring. Director of Nursing will be responsible for monitoring and follow-up.</p>		

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F 315	Continued From page 37 positive lab results of urine, notified the physician, and the physician ordered to have Resident #13 sent to the hospital for evaluation and treatment. Resident #13 was admitted for UTI on 1/4/17. Resident #13's Hospital Progress Note, dated 1/4/17, documented Resident #13 was admitted with a UTI. The urinalysis was positive for E-coli increasingly resistant and now was an ESBL. ESBL are many types of bacteria and more resistant to antibiotics. Resident #13 received IV fluids and antibiotics. Resident #13 was readmitted to the facility on 1/17/17, with multiple diagnoses including ESBL E-coli UTI and encephalopathy. On 1/27/17 at 4:30 pm, the Clinical Liaison said Resident #13 had increased behaviors when she had a UTI. The Clinical Liaison said the facility had talked to the physician in the past for further evaluations by an Urologist or OB/GYN to prevent further UTIs. The facility was unable to provide documentation. The facility failed to ensure a Urology appointment was ordered after multiple hospitalizations occurred from UTI's. The facility failed to notify the physician timely and this failed practice could have contributed to the reoccurring need for Resident #13's emergent medical hospitalizations.	F 315			
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes,	F 322		3/8/17	

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F 322	Continued From page 38 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- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of clinical records, policies, and grievances, it was determined the facility failed to ensure adequate care and treatment was provided to 2 of 3 sample residents (#7, #14) reviewed for feeding tube use. The failures created the potential for more than minimal harm if complications developed when: a) Resident #7's feeding tube placement was not verified prior to medication administration, medications administered via feeding tube were pushed with a syringe rather than gravity flow, and the enteral feeding bag was not changed every 24 hours per facility policy; and b) Resident #14's microlipids were not provided in her tube feeding as ordered. Findings include:	F 322	1. On 02/16/2017, Resident #7 was assessed by L.N. Manager, and no concerns related to Tube Feeding placement , medication administration, and the report of the feeding bag being dated greater then 24 hours, were noted.Resident # 14 was discharged from the facility on 11/5/16. 2. Other residents who are fed by enteral means had evaluations completed on 02/21/17 by S.D.C.to ensure the LNs changed to bags every 24 hours, medications were administered via gravity, and placement of tubing was checked prior to administering medications and the tube feeding formula		

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F 322	<p>Continued From page 39</p> <p>1. Resident #7 was admitted to the facility on 1/3/17 with multiple diagnoses, including Barrett's esophagus [disorder in which the lining of the esophagus is damaged by stomach acid], and dysphagia.</p> <p>Resident #7's 1/3/17 care plan for Barrett's esophagus documented a feeding tube was required related to "previous intractable" nausea and vomiting and a history of ileus [lack of movement in the intestines that leads to a buildup or blockage of food material]. Approaches included discarding enteral feeding administration sets per facility policy and tube placement verification by aspiration prior to medication administrations.</p> <p>Resident #7's Admission Orders, dated 1/3/17, documented a continuous tube feeding of Jevity 1.2 at 60 mL/hr 24 hours a day. On 1/11/16, the rate of the tube feeding was ordered to be maintained at 30 mL/hr.</p> <p>During the initial tour of the facility, starting at 2:57 pm on 1/23/17, Resident #7's Jevity 1.2 enteral feeding was observed running through an enteral feeding pump. The bag of Jevity was dated 1/21/17.</p> <p>On 1/23/17 at 5:40 pm, RN #2 was observed as she prepared to administer promethazine via Resident #7's feeding tube. RN #2 did not inject air into the feeding tube and auscultate the resident's abdomen with a stethoscope or aspirate the feeding syringe to check for residual gastric volume. Also, RN #2 pushed the promethazine into the feeding tube using the plunger in the syringe.</p>	F 322	<p>was available as ordered ; no concerns were noted.</p> <p>Root Cause: with investigation by the IDT it was discovered that the Licensed Nurses needed re-education on enteral medication administration.</p> <p>3. Beginning on 2/14/17 the L.N.s were re- education on Enteral Nutrition and Medication administration through an enteral tube, and ensuring that the feeding bag is changed daily by the S.D.C. Beginning on 02/17/17 the S.D.C. completed observations and educated the L.N.s on administering enteral nutrition, the tube feeding formula is administered as ordered, and ensuring the feeding bag was changed as required.</p> <p>4. Beginning 03/08/17 SDC or designee will audit enteral nutritional administration of the tube feeding medications and feeding bags weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure that the LNs' change feeding bags every 24 hours, medications are administered via gravity, placement of tubing is checked prior to administering medication and tube feeding formula is delivered as ordered. A report will be submitted to the QAPI committee monthly for 3 months, at that time the QAPI committee will make recommendations for and determine continued monitoring. Director of Nursing will be responsible for monitoring and follow-up.</p>		

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F 322	<p>Continued From page 40</p> <p>On 1/23/17 at 5:45 pm, RN #2 said Resident #7's bag of Jevity 1.2 was dated 1/21/17. The RN said it was facility policy to change the bag "every week." The RN said she changed the bags daily when she worked, but she did not work on 1/22/17.</p> <p>On 1/25/17 at 12:27 pm, RN #2 was observed as she administered metoclopramide via Resident #7's feeding tube. After verifying tube placement, the RN pushed the metoclopramide into the feeding tube using the plunger in the syringe.</p> <p>On 1/26/17 at 4:15 pm, RN #2 said she did not verify tube placement or aspirate for residual gastric volume when she administered Resident #7's promethazine on 1/23/17. RN #2 said she used the plunger in the syringe to administer Resident #7's medications via feeding tube, "because it doesn't flow well by gravity."</p> <p>On 1/26/17 at 4:04 pm, the RNC said the facility educates staff to let medications administered via feeding tube to "go by gravity." The RNC provided the facility's Gastronomy Feeding policy which documented, "...Check gastric residual volume (GRV)...prior to administration of medications...to monitor tolerance: ...Verify for placement by Inject [sic] air into the tube. If air is heard, pull back slowly and aspirate total amount of gastric contents...Change bag every 24 hours..." The RNC also provided the facility's Medication Administered through an Enteral Tube policy which documented, "...Do not push medications through a tube..."</p> <p>2. Resident #14's closed clinical record</p>	F 322			

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F 322	<p>Continued From page 41</p> <p>documented the resident was admitted to the facility on 9/20/16, with multiple diagnoses including gastroparesis, gastrostomy, paraplegia, and status post right carpal tunnel release; and the resident was discharged to home on 11/5/16.</p> <p>Resident #14's 9/20/16 tube feeding care plan documented the goal was the resident would receive nutrition and hydration per the physician's orders without complications for 90 days. Interventions included administration of "tube feeding formulation" per the physician's orders.</p> <p>Resident #14's Interagency/Interfacility Physician Orders, dated 9/16/16, included resumption of outpatient tube feedings with Vivonex Ten per the resident's preference via J-tube.</p> <p>Resident #14's September 2016 Physician Orders, signed by the physician and noted by a facility LN on 9/21/16, included: mix 3 packets of Vivonex Ten or Vivonex RTF, 2 packets of unflavored juven, and 45 mL of microlipids with enough water for a total volume of 1000 mL and administer at 45 mL/hr until infused (about 22 hours). Microlipids are a 50% fat emulsion, made with safflower oil that can be added to foods and beverages to help increase calorie content.</p> <p>A 10/28/16 Grievance Form for Resident #14 documented, "Multiple concerns please see attached." A Resident Care Conference, dated 11/3/16, was the only thing attached to the grievance. The grievance investigation findings documented the resident was admitted with, "understanding of Microlipid supply to be provided by family - d/t vendor preference - Upon [no] receipt[,] facility reached out to multiple</p>	F 322			

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F 322	<p>Continued From page 42</p> <p>vendors & had a challenge [with] receipt of med[ication]..." The Notification of Results to Resident/Involved Party documented, "...11/3/16 - Set areas discussed Res[ident] & [family member] satisfied [with] investigation...significant family dynamics."</p> <p>The 11/3/16 Resident Care Conference documented the goal was for Resident #14 to discharge with home health and personal care services when the resident and family were ready and, "All supplies or [sic] from [name of infusion services provider]." The status of the microlipids was not specifically addressed.</p> <p>On 1/27/17 at 5:40 pm, RN #3 did not recall issues related to Resident #14's microlipids.</p> <p>On 1/27/17 at 5:50 pm, the DON and LPN #4 did not recall concerns regarding the microlipids until closer to Resident #14's discharge. LPN #4 said the infusion services provider "dropped off" a pallet of supplies at the facility which should have been delivered to the resident's home.</p> <p>The microlipids were not mentioned in Resident #14's Nurse's Notes, dated 9/20/16 through 11/5/16, or Resident Social Progress Notes, dated 9/20/16 through 11/7/16.</p> <p>Resident #14's Enteral Administration Records documented the Vivonex, juven and microlipid mixture was administered daily 9/21/16 to 9/30/16, but it was not administered 3 times in October 2016 or on 11/1/16.</p> <p>The microlipids were not consistently administered as ordered.</p>	F 322			

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F 323 SS=D	<p>483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>(d) Accidents. The facility must ensure that -</p> <p>(1) The resident environment remains as free from accident hazards as is possible; and</p> <p>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>(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.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, clinical record review, and policy review, it was determined the facility failed to ensure residents who smoked tobacco products were assessed to determine if they were safe to smoke and the level of supervision needed. This was true for 1 of 1 sample residents (#3) reviewed for smoking. The failure created the potential for more than minimal harm if Resident</p>	F 323	<p>1. On 02/12/17 DON and SSD, completed a new Smoking Safety Evaluation for resident #3, and updated the care plan for Resident #3 to ensure that the assessment and the care plan reflected the residents current status and meet resident's needs.</p> <p>2. On 12/16/17, the Social Service</p>	3/8/17	

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F 323	<p>Continued From page 44</p> <p>#3 was unsafe while smoking unsupervised. Findings include:</p> <p>Resident #3 was admitted to the facility on 8/30/16, and readmitted on 9/12/16, with multiple diagnoses including lack of coordination, recurrent major depressive disorder, and delusional disorders.</p> <p>Resident #3's 9/5/16 admission MDS assessment documented his cognition was intact with a BIMS score of 15; he required supervision with ambulation on and off the unit; and he used a wheelchair and tobacco. The most recent recent quarterly MDS assessment, dated 11/11/16, documented the same except the question for tobacco use was blank.</p> <p>On 1/24/17 at 10:45 am, Resident #3 said he smoked cigarettes. He said that sometimes he was alone outside when he smoked, sometimes other residents were there, and "most of the time" no staff were present.</p> <p>On 1/24/17 at 11:10 am, Resident #3 was observed propelling his wheelchair in the B hallway. He said he was going out to smoke.</p> <p>A smoking assessment was not found in Resident #3's clinical record when it was reviewed on 1/24/17 and 1/25/17.</p> <p>On 1/26/17 at 9:00 am, the RNC provided the facility's Smoking Policy as requested. The RNC also provided a Smoking Safety Evaluation, dated 1/25/17, for Resident #3. The RNC said she did not find smoking assessments for Resident #3, so they completed one on 1/25/17.</p>	F 323	<p>Director completed an audit of other residents that smoke to ensure that smoking assessment was accurate and care plan was established with current smoking status; no concerns were noted.</p> <p>Root Cause: with investigation by the IDT it was discovered that with investigation by the IDT it was discovered that the initial smoking evaluation could not be located.</p> <p>3. Beginning on 02/17/17 staff were re-educated on the smoking policy and on resident's smoking care plan by the SSD and the S.D.C.</p> <p>4. Beginning 03/08/17, the Social Service Director, and DON or designee will evaluate residents who smoke and establish/update care plan as indicated, weekly for 4 weeks then monthly for 2 months and quarterly thereafter, to ensure that residents are assessed and care plans are updated to reflect resident's current status and needs are met, and that the smoking assessment and care plan is present in the clinical record. A report will be submitted to the QAPI committee monthly for 3 months, at that time the QAPI committee will make recommendations for and determine continued monitoring. Social Service Director will be responsible for monitoring and follow-up.</p>		

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F 323	Continued From page 45 The Smoking Policy, dated March 2015, documented that each resident who smokes, "shall be evaluated for safe smoking on admission, quarterly and in the event of a change in condition. On 1/26/17 at 2:30 pm, 2:50 pm and 4:30 pm, Resident #3 was observed smoking cigarettes while alone in the designated smoking area outside of the C hallway.	F 323			
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a	F 329		3/8/17	

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F 329	<p>Continued From page 46</p> <p>resident, the facility must ensure that--</p> <p>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interviews, it was determined the facility failed to ensure antipsychotic and hypnotic medications were not used in excessive doses and used only when necessary with adequate monitoring. This was true for for 2 of 8 residents (#2 and #5) receiving antipsychotic medications and 1 of 6 residents (#9) receiving hypnotic medications. These deficient practices placed residents at increased risk of adverse events related to the use of antipsychotic medications, and medical complications related to sleep disturbances or over-sedation. Findings include:</p> <p>1. Resident #5 was admitted to the facility on 7/22/16, with diagnoses including dementia with delusional features, depression, and anxiety.</p> <p>Resident #5's Nurses' Note, documented on 11/15/16 at 10:30 am, stated, "Psychotropic review...Receives Risperdal [an antipsychotic medication] 1 mg QD for dementia [without] behaviors. Resident has had no verbal or</p>	F 329	<p>1. On 02/16/17 Resident #5 was assessed by DON, care plan reviewed to reflect resident's current status, medication administration record and treatment records have been reconciled against physician order on 02/28/17 by L.N. On 2/06/17 the DON and SSD assessed resident and behavior monitoring and care plan reviewed to reflect the resident's current status. On 2/20/17 the DON was able to locate the order for antipsychotic dated 12/5/17. On 02/22/17, the Physician reviewed resident for need of medication, and clarified the need for the medication. Resident #2 was assessed on 02/16/17 by DON, care plan reviewed for a GDR of antipsychotic medication which was started per physician orders, and MAR was reconciled against physician orders by L.N Manger to ensure the physician's orders were followed.Hospice was notified on 02/16/17. Resident #9 was</p>		

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F 329	<p>Continued From page 47</p> <p>physical aggression IDT recommends to D/C Risperdal R/not being a danger to self or others..."</p> <p>A physician's order, dated 11/21/16, documented, "Will attempt GDR...Risperdal 0.5 mg Q HS..."</p> <p>A Nurses' Note, dated 11/22/16 at 2:30 pm, documented, "New order received to GDR [of] Risperdal. Daughter notified and declined decrease. This LN educated resident has not had any verbal or physical aggression and facility is required to GDR unless contraindicated by MD. Daughter insistent [with] not making [changes] to Risperdal. This LN contacted [Name of] Mental Health to notify [Psychiatrist] and awaiting return call."</p> <p>Resident #5's November 2016 MAR documented the order for Risperdal 0.5 mg was discontinued on 11/21/16, and stated "see N.O. [new order]."</p> <p>Resident #5's record did not include further orders for the Risperdal until 12/5/16, when a physician's order was received for Risperdal 1 mg every hs.</p> <p>Resident #5's November 2016 MAR, documented Risperdal 1 mg every hs, dated 11/22/16. The MAR documented Risperdal 1 mg was administered on 11/22/16 through 11/30/16 at bedtime.</p> <p>During an interview on 1/24/17 at 4:33 pm, the DON stated he was not able to find an order to increase the Risperdal to 1 milligram on 11/22/17. He said the nurse had called the family about the reduction of the Risperdal ordered by</p>	F 329	<p>discharged on 02/10/17 and re-admitted on 02/28/17. On 02/28/17 re-admission orders obtained. New medication orders were transcribed to MAR by L.N. and reconciled with physician orders on 02/28/17, including reason for, and effectiveness of medication. On 02/28/17 Social Service Manager re-established sleep monitor flow sheets to document resident's hours of sleep. Care Plan is in place for Alteration in Mood/Behaviors related to diagnosis of Depression, sleeplessness to reflect the resident's current status.</p> <p>2. On 02/17/17, the Social Service Director, and DON completed an audit of other residents receiving psychotropic or hypnotic medications, to ensure that; sleep monitors for residents on hypnotics, behaviors are documented and Gradual Does Reductions (GDR) are completed; concerns were addressed at that time.</p> <p>Root Cause: With investigation by the IDT it was discovered that requirements of antipsychotic and hypnotic use, behavior monitoring documentation, sleep monitors and GDR were not followed per requirements, that nursing staff needed re-educated. Also it noted that the physician was notified of continuing same does, however the signed communication was delayed. One resident was monitored for sleep patterns, however was discharged to the hospital and the sleep monitor was not immediately re-established.</p>		

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F 329	<p>Continued From page 48</p> <p>the physician and the family did not want the medication decreased. He said the physician had not been contacted and the medication had been increased back to 1 milligram.</p> <p>Resident #5's November and December 2016 MARs, and January 2017 MAR, included a Psycho-Pharmacological Tracking Record for Risperdal. The records documented tracking of the following behaviors on both the day and night shifts:</p> <ul style="list-style-type: none"> * History of Paranoia - Thinking others are taking her things * Believes husband has left her * Striking out/Hitting others <p>During all 3 months staff were to use the following behavioral interventions when responding to Resident #5's behavior:</p> <ul style="list-style-type: none"> * Reapproach in 10-15 minutes * Engage in conversations of "Her life stories." <p>The Tracking Records documented the following in regard to the effectiveness of the above interventions:</p> <ul style="list-style-type: none"> * The Risperdal Psycho-Pharmacological Tracking Record for November 2016, documented Resident #5 expressed thoughts that her husband has left her on 25 of 30 days on the day shift and 1 time on the night shift. The tracking record documented the interventions were successful 1 time. On the other days, each shift documented a "0" showing the interventions did not change Resident #5's behaviors. 	F 329	<p>3. On 02/15/17 Regional Nurse Consultant completed education IDT on requirements of antipsychotic and hypnotic use, behavior monitoring, sleep monitors and GDR as required. On 02/17/17 the DON and the SDD, re-educated the nursing staff on unnecessary medication, and GDR requirements, nursing staff were also reeducated on documentation on behaviors, on documentation of hours of sleep and writing telephone orders to ensure that Physicians orders are followed.</p> <p>4. Beginning 03/08/17 Social Service Director or designee, will complete audits of Psychotropic Medication, and Hypnotic Medication weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure that resident's need of medication is documented, sleep monitors are completed, and physician's orders are followed. A report will be submitted to the QAPI committee monthly for 3 months, at that time the QAPI committee will make recommendations for and determine continued monitoring. Social Service Director will be responsible for monitoring and follow-up.</p>		

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F 329	<p>Continued From page 49</p> <p>* The Risperdal Psycho-Pharmacological Tracking Record for December 2016, documented Resident #5 demonstrated the behaviors of "Thinking her husband has left her" and "History of Paranoia - Thinking others are taking her things," 27 of 31 days on the day shift. On each of the 27 days, the day shift staff documented a "0" showing the interventions did not change Resident #5's behaviors.</p> <p>* The Risperdal Psycho-Pharmacological Tracking Record for January 2017, documented Resident #5 expressed thoughts that her husband has left her on 31 of 31 days on the day shift. On each of the 31 days, the day shift staff documented a "0" showing the interventions did not change Resident #5's behavior.</p> <p>During an interview on 1/25/17 at 9:07 am, the SSD stated they reviewed residents' behaviors in the psychotropic meeting that met monthly. She said they did not review every resident monthly and that Resident #5's behaviors were reviewed quarterly. She said the intervention for managing Resident #5's behaviors had not changed.</p> <p>2. Resident #2 was readmitted to the facility on 1/13/16 with diagnoses including Alzheimer's disease, Parkinson's disease, and schizoaffective disorder.</p> <p>A physician's order, dated 11/16/16, documented, "Seroquel [an antipsychotic medication] 150 mg po Q HS for schizoaffective disorder."</p> <p>Resident #2's Nurses' Note documented on 12/8/16 at 4:00 am, stated, "Administered PRN Ativan [anti-anxiety medication]... @ [12:00 am]</p>	F 329			

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F 329	<p>Continued From page 50</p> <p>[with] no relief. Continued with s/s [of increased] anxiety aggitation [sic]...Staff stated res[ident] is having [greater] baseline aggitation [sic]. Added res[ident] to alert charting. Will continue [with] measure to assist res[ident] in calming [familiar] CNA with soothing voice/touch..."</p> <p>A Nurses' Note, dated 12/9/16 at 6:00 am, documented, "...s/s [of increased] aggitation [sic] chomping teeth, legs jerking/feet-legs...Up in lounge chair to distract & monitor. In bed at [2:30 am]. Continue to monitor..."</p> <p>A Nurses' Note, dated 12/10/16 at 2:30 am, documented, "[No] reports of [increased] anxiety this shift..."</p> <p>A Hospice note, dated 12/8/16, documented, "I arrived and [Resident #2] was on gurney for showers. [Resident #2] tolerated well however became increasingly anxious when his roommate had a visitor."</p> <p>A physician's order, dated 12/15/16, documented, "Seroquel 200 milligrams 1 by mouth once a day at bedtime."</p> <p>Resident #2's December 2016 MAR documented, "Seroquel 300 mg po Q HS," dated 12/15/16.</p> <p>During an interview on 1/26/17 at 2:45 pm, LN #2 said the physician's order was for 200 mg not 300 mg. She said the nurse had transcribed the order incorrectly so Resident #2 had received Seroquel 300 mg instead of 200 mg. The order for Seroquel 300 mg was not received until 12/22/16.</p>	F 329			

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F 329	<p>Continued From page 51</p> <p>A Hospice Chaplin Visit Note, dated 12/28/16, documented, "[Resident #2] is in bed and shaking and asking 'Can I go?'...Nurse confirms that she is aware of [Resident #2's] shaking and verbal repetition. [Resident 2] calms somewhat when CH [Chaplin] plays music but [Resident #2] remains agitated and verbally only offers 'Can I go?' CH listens to music with [Resident #2] and offers prayer, and while [Resident #2] calms somewhat, his shaking and verbal repetition remain..."</p> <p>A Physician's order, dated 12/28/16, documented, "Seroquel 400 milligrams by mouth; once a day; Give 400 mg by mouth daily for anxiety and behaviors..."</p> <p>Resident #2's Nurses' Notes, did not include documentation of behaviors prior to the increase in Seroquel.</p> <p>Resident #2's December 2016 MAR included a Psycho-Pharmacological Tracking Record. The record documented tracking of the following behaviors on both the day and night shifts:</p> <ul style="list-style-type: none"> * Voicing he is not real * Manic episodes * Yelling and calling others degrading names <p>From 12/1/16 through 12/31/16, both shifts documented a "0" each day, showing the behaviors did not occur. The interventions for the behaviors were "1. Change the subject/talk about music. 2. Praise him for all his accomplishments. 3. Offer to take him on a stroll outside."</p>	F 329			

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F 329	<p>Continued From page 52</p> <p>During an interview on 1/26/17 at 2:00 pm, the SSD stated the nurses were to give her a copy of the orders and put the medication changes on the 24 hour report to notify her of medication changes. She said she did not believe Resident #2 had exhibited behaviors to warrant increasing his Seroquel. The SSD stated she had not been notified of an increase in behaviors for Resident #2. She said the nurses should document specific behaviors and new interventions should be put into place before a medication is increased.</p> <p>During an interview on 1/26/17 at 2:45 pm, LN #2 stated Resident #2 got restless every once in a while. She said the interventions of talking to him to distract him, singing to him, and talking about playing the piano and about music worked to calm most of the time. LN #2 stated she had not noticed an increase in behaviors in the month of December for Resident #2. She said his restlessness was about the same as it was now. LN #2 said the interventions usually worked.</p> <p>A facility policy, titled Internal Practice: Antipsychotic/Psychotropic Medication, dated 5/6/16, documented, "For residents that are currently on an antipsychotic...the following will be done: Document behaviors that the resident has in the appropriate place within the MAR...If a resident displays behaviors a nursing note will be written providing a narrative of these behaviors...Nursing note needs to include...The behavior displayed...The frequency of the behavior...Interventions will be attempted to stop the behavior...If there is an order to increase or decrease an antipsychotic...medication the following will be done...Indications for increase or</p>	F 329			

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F 329	<p>Continued From page 53</p> <p>decrease...Notify the MD to ensure clinical needs have been evaluated for possible reasons for the change in behavior...Process the order...Put resident on Alert charting...Nursing note will include...The name of the medication...If there is an increase, decrease, or no changes in behaviors..."</p> <p>From 12/1/16 through 12/31/16, Resident #2's Seroquel was increased from 150 mg daily at bedtime to 400 mg daily at bedtime. During the same time period, behavior tracking records documented zero incidents of Resident #2's target behaviors.</p> <p>3. Resident #9 was readmitted to the facility on 1/20/17, with diagnoses including CHF, sacrum pressure ulcer, obstructive sleep apnea, and depression.</p> <p>Resident #9's Recapilization Physician Orders, dated 1/20/17, documented Trazadone 50 mg, take 12.5 mg at bedtime and Melatonin 3 mg at bedtime, as needed, for sleep.</p> <p>Resident #9's January 2017 MAR, documented Resident #9 was receiving Trazadone 12.5 mg every evening. On 1/21/17 at midnight, Resident #9 received Melatonin 3 mg. The MAR did not document the reason for, and effectiveness of, the medication. On 1/23/17 at 1:30 am, Resident #9 received Melatonin 3 mg. The MAR did not document the reason for, and effectiveness of, the medication.</p> <p>Resident #9's 1/20/17 through 1/25/17 MAR, did not include documentation that his hours of sleep were being monitored.</p>	F 329			

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F 329	Continued From page 54 On 1/25/17 at 10:15 am, the DON said the nurses should have documented on the MAR the reason for, and the effectiveness of, the Melatonin. The DON also said Resident #9's sleep should have been monitored and documented on the MAR. On 1/25/17 at 12:15 pm, the SSD said she reviewed sleep monitoring flow sheets and interviewed staff and residents for reason and effectiveness of hypnotic medications. The facility failed to ensure Resident #9's MAR documented his hours of sleep 1/20/17 through 1/25/17, after Resident #9 was readmitted on 1/20/17.	F 329			
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff.	F 353		3/8/17	

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F 353	<p>Continued From page 55</p> <p>(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>(i) Except when waived under paragraph (e) of this section, licensed nurses; and</p> <p>(ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observations, a Resident Group Interview, and staff interviews, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of all residents. This was true for 1 random resident (#22), 3 of 5 residents who attended a group interview, and had the potential to affect all other residents who lived in the facility. The failure created the potential for the flu to spread when</p>	F 353	<p>1. On 02/24/17 the Administrator attended a resident council meeting upon invitation to ensure that resident were satisfied with call light responds, only one resident voiced concern, and said the call light seemed like it was on awhile before it was answered. The other residents in attendance did not have any complaints about the time it took staff to answer call</p>		

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F 353	<p>Continued From page 56</p> <p>Resident #22's isolation was not maintained and for psychosocial and physical harm if call lights were not answered in a timely manner and care needs were not addressed. Findings include:</p> <p>1. On 1/23/17 at 5:10 pm, during an initial tour of the facility an isolation cart was observed in the hallway by Resident #22's door and a sign to check with nurses before entering the room was posted by the door.</p> <p>Immediately afterward, RN #2 said Resident #22 was in isolation for the flu. RN #2 then identified Resident #22 who was wearing a mask while at a table in the Friendship Cove dining room with 3 other residents at the table. RN #2 said Resident #22 tested positive for influenza A and he had been on Tamiflu since 1/20/17. RN #2 said Resident #22 could not be left alone because he was at risk for falls and needed assistance with eating. RN #2 said Resident #22 was in the dining room because there were not enough staff to help him eat in his room.</p> <p>2. On 1/25/17 at 10:10 am, during a group interview with 5 residents, 3 residents said it sometimes took 30 minutes for call lights to be answered. Two residents said a "couple weeks ago" it had taken an hour for their call lights to be answered. One resident said "upper management staff" answer call lights while surveyors were in the building but that was not usually the case. The residents said the call light response time issue was on all shifts. All of the residents said the staff are "hard working" but more help was needed.</p> <p>CNA #5 and CNA #6 were observed in the facility</p>	F 353	<p>lights. On 2/16/17 the Unit Manger assessed Resident #22 and there were no concerns noted, the Resident was clear of infection. On 2/24/17 the Unit Manager assessed residents who were seated at the same table as Resident # 22, and there were no related infections contracted by these residents; furthermore there were no other residents on the unit that had concerns regarding infections. On 02/28/17 the DON assessed Resident #22 for infections present, he was clear of infections at this time. On 2/28/2017 the Administrator audited the staff posting to ensure staff who were present and working in the facility are recorded on the daily staff posting, and the facility was fully staffed.</p> <p>2. Beginning on 02/13/17, IDT started completing supervisor audit 5x week on resident responses to questions about enough staff to provide resident care and to answer call lights. Concerns are identified and addressed at that time.</p> <p>Root Cause: The RN did not assign staff or notify the DON or lead CNA (who is available to assist with cares) to coordinate resident care, Nursing staff were also unaware that they can ask for meal from Dietary for residents who eat in their room that need assistance eating, anytime to ensure that staff are available to assist that resident. The IDT will complete supervisor audits on resident responses to adequate staffing to provide resident cares and to answer call lights.</p>		

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F 353	<p>Continued From page 57</p> <p>during the day shift on 1/24/17, 1/25/17, 1/26/17 and 1/27/17. Both of the CNAs said they were from a "sister" facility and they were not on the schedule for this facility. Both of the CNAs said they were in this facility to help train CNAs and they also "floated" throughout the facility to answer call lights and provide care to residents.</p> <p>On 1/26/17 at 9:00 am, the AIT said CNA #5 and CNA #6 were brought to the the facility to help out but they were not on the schedule.</p> <p>On 1/27/17 at 10:20 am, the Administrator said CNA #5 and CNA #6 were not on the schedule and their time was not counted in the number of CNAs on duty or the total CNA hours per shift per day. The Administrator said it was nice to have the extra help.</p>	F 353	<p>3. On 02/17/17 a systemic change was started by the Administrator for nursing staff asking for a "request" meal tray at mealtime for any resident on isolation precautions, or other reasons that requires assistance with eating. The "request tray" can be ordered at any time during the scheduled mealtime to ensure that staff are available to assist residents that may require special needs and need assistance with eating based on resident need. Beginning on 02/17/17 nursing and dietary staff were educated by the Administrator on "request tray" during meal time for residents that need nursing staff assistance with eating, that are on isolation precautions in their room. Staff were also reeducated on following infection control practices, and to alert DON, the Administrator, or lead CNA, to ensure resident specific needs are being met.</p> <p>4. Beginning on 03/08/17 the Administrator or designee will audit meal times weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure that residents on isolation precautions, that need assistance while eating in their room or for other reasons, has nursing staff available at the time they receive their meal tray, and receive assistance as needed. A report will be submitted to QAPI committee monthly for 3 months, at that time the QAPI committee will make recommendations for and determine continued monitoring.</p>		

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F 353	Continued From page 58	F 353	The Administrator and IDT will be responsible for monitoring and follow-up.	3/8/17
F 356 SS=C	<p>483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION</p> <p>483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis:</p> <p>(i) Facility name.</p> <p>(ii) The current date.</p> <p>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:</p> <p>(A) Registered nurses.</p> <p>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law)</p> <p>(C) Certified nurse aides.</p> <p>(iv) Resident census.</p> <p>(2) Posting requirements.</p> <p>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.</p> <p>(ii) Data must be posted as follows:</p> <p>(A) Clear and readable format.</p>	F 356		

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F 356	<p>Continued From page 59</p> <p>(B) In a prominent place readily accessible to residents and visitors.</p> <p>(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of posted information, and staff interview, it was determined the facility failed to ensure the posted staffing information was complete and accurate. The failure had the potential to mislead all residents and visitors who want to know the information. Findings include: On 1/27/17 at 10:45 am, CNA #3 said she was also the staff scheduler. She provided copies of the Daily Staff Posting information for 1/24/17, 1/25/17, 1/26/17 and 1/27/17, which were observed to be incomplete and inaccurate. CNA #3 said the night shift staff were to fill out the information and she did not know why the information was incomplete.</p> <p>a. The Daily Staff Posting information for 1/24/17 did not contain information for the evening or night shifts. In addition, the number of day shift CNAs and their total hours worked did not reflect CNA #5 or CNA #6's presence or time.</p>	F 356	<p>1. On 01/28/17 the nurse staffing data was checked and updated by the Staffing Coordinator. On 01/30/17 the Staffing Coordinator and RN house supervisor began to check the staff posting each shift for accurate census and staffing data.</p> <p>2. On 2/28/17 the Administrator completed an audit on accuracy of Daily Staff Posting information including, accurate census, correct staffing numbers and total hours worked each shift.</p> <p>Root Cause: the Staffing Coordinator needed to be re-educated on Daily Staff Posting Requirements and updating each shift.</p> <p>3. On 02/15/17 the Regional Nurse Consultant educated the Administrator, DON and Staffing Coordinator on Daily Staff Posting information and</p>		

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F 356	<p>Continued From page 60</p> <p>On 1/24/17 at 10:45 am, CNA #5 said she and CNA #6 were from a "sister" facility and they were in this facility to help precept CNAs and to float throughout the facility to answer call lights and provide care to residents.</p> <p>b. The Daily Staff Posting information for 1/25/17 did not contain the census for the night shift. In addition, the number of day shift CNAs and their total hours worked did not reflect CNA #5 or CNA #6's presence or time.</p> <p>On 1/25/17 at 9:45 am, CNA #5 said she and CNA #6 were working in the facility but neither of them were on the schedule. CNA #5 said she and CNA #6 had been coming to this facility for "about a week" to "help out."</p> <p>c. The Daily Staff Posting information for 1/26/17 also did not contain the census for the night shift. In addition, the number of day shift CNAs on duty and their total hours worked did not reflect CNA #5 or CNA #6's presence or time.</p> <p>On 1/26/17 at 9:00 am, the AIT said CNA #5 and CNA #6 were brought to the facility to help retrain CNAs. The AIT said CNA #5 and CNA #6 work from 6:00 am to 2:00 pm, but they were not on the schedule and their time was not counted in the daily schedule. The AIT said CNA #5 was orienting CNA #7 who also was not on the daily schedule but should have been.</p> <p>d. The Daily Staff Posting information for 1/27/17 did not contain the census for the day shift. In addition, the number of day shift CNAs on duty and their total hours worked did not reflect CNA #5 or CNA #6's presence or time.</p>	F 356	<p>requirements for accuracy of census, number of staff working and total hours working to be posted in a prominent place readily accessible to residents and visitors. On 03/02/17 the DON educated the licensed nursing staff on requirements for Daily Staff Posting information and requirements for accuracy of census, number of staff working and total hours working to be posted in a prominent place readily accessible to residents and visitors.</p> <p>4. Beginning the week of 03/08/17, the Administrator or designee will conduct audits of the Daily Staff Posting information weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure accuracy of each shifts census, total number of staff and total hours. A report will be submitted to QAPI committee monthly for 3 months, at that time the QAPI committee will make recommendations for and determine continued monitoring. The Administrator will be responsible for monitoring and follow-up.</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/30/2017
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F 356	Continued From page 61	F 356			
F 371 SS=D	<p>On 1/27/17 at 10:20 am, CNA #5 and CNA #6 both said they were from a "sister" facility and in this facility to help out for a few hours. Both of the CNAs said they were providing direct care to residents. The Administrator was present at the time and said CNA #5 and CNA #6 were not on the schedule and their hours were not reflected in the posted staffing information.</p> <p>483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced</p>	F 371		3/8/17	

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F 371	<p>Continued From page 62</p> <p>by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure residents' plates, cups, saucers, and bowls were clean and sanitary, storage areas were clean, and staff entering the kitchen wore hairnets. This deficient practice had the potential to affect 75 residents who consumed food prepared in the kitchen. This created the potential for resident to develop infections due to cross-contamination. Findings include:</p> <p>During the kitchen tour on 1/24/17 at 11:15 am, the following were observed:</p> <p>a. The three lid storage shelves, which stored lids for pans and plate covers, had food particles, paper, and a plastic wrapper on them.</p> <p>b. 7 of 24 cups stored ready to use had food particles inside them. The Dietary Manager, present during the observation, stated the staff were going to have to check the cups better after washing them.</p> <p>c. 4 of 4 plates in the plate warmer had food particles on them.</p> <p>d. 6 of 13 small bowls stored ready to use had food substances in them.</p> <p>e. 2 of 12 saucers stored ready to use had food particles on them.</p> <p>f. 8 of 16 plates stored ready to use had food particles on them. The Dietary Manager stated the plates were not coming clean and they needed to soak them.</p>	F 371	<p>1. On 1/23/17 the Dietary Manager removed the dirty items identified by the surveyor and they were cleaned before placing them back in service. On 02/10/17 the Dietary Manager re-educated dietary staff on monitoring staff entering the dietary department to ensure they are wearing hairnets.</p> <p>2. On 02/23/17 the Administrator completed a sanitation audit of the Dietary Department to ensure that dishes were clean and stored correctly. On 02/23/17 the Administrator reviewed sanitation audit with the Dietary Manager and completed an in-service on the sanitation of the Dietary Department.</p> <p>Root Cause: with investigation by the IDT it was discovered that Dietary staff required re-education on dishwashing procedures, and inspecting dishes that are stored after washing the dishes, and staff need to be re-educated on requirement of wearing a hairnet if entering the Dietary Department.</p> <p>3. On 1/23/17 the Dietary Manager removed the dirty items identified by the surveyor and they were cleaned before placing them back in service. On 02/10/17 the Dietary Manager re-educated dietary staff on monitoring staff entering the dietary department to ensure they are wearing hairnets. On 02/17/17 staff were</p>		

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F 371	Continued From page 63 g. CNA #1 was observed entering the kitchen at 11:28 am, without a hairnet covering her hair. She then went over to the coffee pot and was beginning to pour a cup of coffee. At the time of the observation, Cook #1 said CNA #1 should have had a hair net on prior to entering the kitchen.	F 371	re-educated on sanitary requirements in the Dietary Department, including the cleanliness of dishes, food covers, cups, saucers, plates and shelves where dishes are stored. On 2/17/ 17 the Administrator re-educated staff on the requirement to wear a hairnet when entering the Dietary Department. 4. Beginning the week of 03/08/17, the Administrator or designee will conduct sanitation audits of the Dietary Department weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure sanitary conditions in the Dietary department, to include cleanliness of dishes. Beginning the week of 03/06,2017 the Dietary Manager will audit staff entering the Dietary Department to ensure they are wearing hairnets. A report will be submitted to QAPI committee monthly for 3 months, at that time the QAPI committee will make recommendations for and determine continued monitoring. The Administrator and Dietary Manager will be responsible for monitoring and follow-up.		
F 441 SS=E	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: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and	F 441		3/8/17	

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F 441	<p>Continued From page 64</p> <p>communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);</p> <p>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct</p>	F 441			

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F 441	<p>Continued From page 65</p> <p>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 and staff interview, it was determined the facility failed to ensure staff consistently implemented standard hand washing and transmission-based precautions for 1 random resident (#22) in isolation, 1 of 10 residents (#12) during medication pass observations, and 1 of 5 residents (#13) during BG check observations. This had the potential to affect other residents living in the SCU and residents in RN #1's care. The failure created the potential for influenza A to spread when isolation was not maintained for Resident #22 and for infection from cross-contamination when hand hygiene was not performed before or after administration of Resident #12's eye drops or Resident #13's BG check. Findings include:</p> <p>1. On 1/23/17 at 5:10 pm, during an initial tour of the facility, an isolation cart was observed in the</p>	F 441	<p>1. On 2/16/17 the Unit Manger assessed Resident #22 and there were no concerns noted, the resident was clear of infection. On 2/24/17 On the Unit Manager assessed residents who were seated at the same table as Resident # 22, and there were no related infections contracted by these residents; furthermore there were no other residents on the unit that had concerns regarding infections. On 02/28/17 the DON assessed Resident #22 for infections present, he was clear of infections at this time. On 02/16/17 Unit Manager assessed, Resident #12 for concerns regarding receiving eye drops from LN, who was reported to not use proper hand hygiene and there were no concerns or signs or symptoms of infection. The Unit</p>		

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F 441	<p>Continued From page 66 hallway by Resident #22's door and a sign to check with nurses before entering the room was posted by the door.</p> <p>Immediately afterward, RN #2 said Resident #22 was in isolation for the flu. The RN then identified Resident #22 who was wearing a mask while at a table in the Friendship Cove dining room with 3 other residents at the table. RN #2 said Resident #22 tested positive for influenza A and he had been on Tamiflu since 1/20/17. RN #2 said Resident #22 could not be left alone because he was at risk for falls and needed assistance with eating. RN #2 said Resident #22 was in the dining room because there were not enough staff to help him eat in his room.</p> <p>2. RN #1 did not perform hand hygiene before applying gloves or after glove removal for medication administration, including eye drops, for Resident #12 and a BG check for Resident #13.</p> <p>a. On 1/24/17 at 11:20 am, RN #1 was observed as he poured 1 acetaminophen pill and Systane lubricant eye drops for Resident #12, took the medications to the resident's room, applied gloves, administered 1 eye drop in each eye, administered the acetaminophen by mouth, removed and discarded the gloves, then left the room. RN #1 did not perform hand hygiene before or after applying the gloves to administer eye drops.</p> <p>b. On 1/24/17 at 11:30 am, RN #1 was observed as he prepared to check Resident #13's BG level, took the BG check equipment and supplies to the resident's room, applied gloves, performed a</p>	F 441	<p>Manger assessed Resident #13 for concerns regarding resident receiving blood glucose checks by the LN who was reported to not use proper hand hygiene and there were no concerns or signs or symptoms of infection.</p> <p>2. On 02/23/17 L.N. Manager researched #22 table-mates medical status and could determine none of the table-mates of Resident #22 contacted influenza A, form being possibly exposed and there were no concerns identified; furthermore there were no other residents who were assessed to have infection related concerns. Starting on 02/17/17 Hand Washing Return Demonstrations were started by SDC with nursing. Starting the week of 02/13/17 SDC observed hand hygiene when L.N. administered eye drops for other residents.</p> <p>Root Cause: With investigation by the IDT it was discovered that L.N. staff need re-education on hand washing procedure during medication administration and a systematic change was needed for requesting meal trays for residents on isolation, needing assistance with eating in their room, and following isolation precautions.</p> <p>3. Beginning on 02/17/17, the staff were re-educated on infection control practices, Hand Hygiene when providing treatments and cares and following isolation precautions. On 02/17/17 Administrator</p>		

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F 441	Continued From page 67 finger stick, checked the BG, removed the gloves, assessed Resident #13's BP and oxygen saturation level, conferred with LPN #3 who was also in the room, then left the room. RN #1 did not perform hand hygiene before or after applying gloves for the finger stick/BG check. On 1/24/17 at 12:10 pm, RN #1 said he used gloves but did not wash his hands or use hand sanitizer before or after he administered Resident #12's eye drops or did the finger stick and BG check for Resident #13.	F 441	completed education with staff on "request trays" from Dietary when a resident is in their room on isolation and requires assistance with eating. 4. Beginning the week of 03/08/17 the S.D.C will audit staff for hand hygiene during eye drop administration, hand hygiene during blood glucose checks and monitor any resident on isolation that requires assistance with eating while in their room. Audits will be completed weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure infection control practices are being followed during medication administration and isolation precautions. A report will be submitted to QAPI committee monthly for 3 months, at that time the QAPI committee will make recommendations for and determine continued monitoring. The Staff Development Coordinator will be responsible for monitoring and follow-up.		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 514		3/8/17	

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F 514	Continued From page 68 (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure the clinical records for 2 of 16 sample residents (#5 and #9) were accurate and complete. This deficient practice placed residents at risk of medical complications due inaccurate and/or incomplete medical records. Findings include: 1. Resident #9 was re-admitted to the facility on 1/20/17, with diagnoses including CHF, sacrum pressure ulcer, and muscle weakness. a. Hospital Discharge Physician Orders, dated	F 514	1. Resident #5 was assessed by DON on 02/27/16 and the MAR and TAR for resident #5 was reviewed for accuracy against current physician orders to ensure for accuracy, physician was notified and there were no changes to Resident's orders; no negative findings were noted. On 02/27/17 Resident #9 was discharged from facility on 02/10/17 then re-admitted on 02/28/17. On 02/28/17 L.N. received re-admit orders for oxygen and weights, orders were transcribed to the MAR and TAR, reconciled with physician orders by the DON with second L.N. who reviewed		

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F 514	<p>Continued From page 69</p> <p>1/20/17, documented daily weights, oxygen 2-3 liters per minute, and condom catheter as needed for incontinence.</p> <p>The facility transcribed the Physician Orders, dated 1/20/17, documented oxygen 2-3 liters per minute, as needed, to keep his oxygen blood saturation levels above 90%.</p> <p>On 1/23/17 at 4:30 pm, Resident #9 was observed with oxygen 3 liters per minute via nasal cannula.</p> <p>On 1/24/17 at 11:10 am, Resident #9 was observed working with therapy with oxygen 3 liters per minute via nasal cannula.</p> <p>On 1/24/17 at 3:30 pm, Resident #9 was observed resting in bed with oxygen 3 liters per minute via nasal cannula.</p> <p>On 1/25/17 at 10:15 am, Resident #9 was observed with oxygen 3 liters per minute via nasal cannula.</p> <p>On 1/25/17 at 4:50 pm, Resident #9 was observed with oxygen 3 liters per minute via nasal cannula and he said his oxygen level ran at 3 liters per minute via nasal cannula continuously.</p> <p>The 1/20/17 through 1/25/17 MAR, did not include documentation of daily weights and documentation of Resident #9 receiving 3 liters of oxygen continuously.</p> <p>On 1/25/17 at 10:00 am, the DON said upon admission, the admitting nurse should have</p>	F 514	<p>for accuracy.</p> <p>2. On 02/25/17, an audit by LN Manager was completed on L.N.'s completing accurate MAR/TAR documentation on other residents. On 02/26/17, an audit was completed by L.N. Manager of reconciliation of physician's orders against MAR and TAR, and physical order for accuracy. An audit was completed on 02/27/17 by Assistant Director of Nursing (ADON) for residents that receive oxygen routine and PRN of physician's orders, to ensure accuracy, on the MAR, TAR, and Care Card, documentation is complete and resident has a care plan for oxygen use.</p> <p>Root Cause: with investigation by the IDT it was discovered that the use of the "three part" form was not being utilized consistently for transcribing new orders, so that Medical Records could transcribe the accurate physician orders on the MAR or TAR.</p> <p>3. On 02/28/17. L.N. staff were re-educated by the SDC, on Lippincott "8 Rights of Medication Administration" and Facility procedure on recording Neuro Checks after an unwitnessed fall or a fall when resident hit their head. On 03/02/17, L.N.'s were re-educated by the S.D.C. on the use of "three part form" for new orders to ensure communication to the medical records for recapitalization of physician orders on the MAR or TAR</p>		

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F 514	<p>Continued From page 70</p> <p>transcribed the orders on the three part form then medical records would have transcribed the Recapilization Physician Orders and the MAR and TAR. The DON was unable to provide the three part form transcription orders by the admitting nurse.</p> <p>On 1/25/17 at 6:00 pm, the Regional Nurse Consultant provided the facility's policy and procedure for New Admissions Expectations. The policy documented an LN was to transcribe admission orders to the facility's forms and a second LN was to review the forms for accuracy.</p> <p>2. Resident #5 was admitted to the facility on 7/22/16, with diagnoses including dementia with delusional features, depression, and anxiety.</p> <p>a. A Weekly Body Audit form, dated 1/6/17, documented, "Reddened area to R lateral ankle. Blanchable & not painful. WCTM [will continue to monitor] at this time TX [with]." There was a lack of documentation of what treatment was completed for Resident #5's right ankle.</p> <p>Resident #5's TAR for January 2017 documented, "Sure prep [skin protectant] to R lateral ankle reddened & blanchable area 1/6/17..." There was no documentation to indicate the treatment had been completed on 1/8/17, 1/9/17, and 1/10/17.</p> <p>Resident #5's physician's orders did not include an order, dated 1/6/17, for the Sure prep.</p> <p>The Nurses' Note lacked documentation on 1/6/17 of an assessment or that Resident #5's physician was notified of the area on Resident #5's ankle.</p>	F 514	<p>4. Beginning 03/08/17 audits will be completed by DON or designee, of MARs and TARs, and the clinical record weekly for 4 weeks then monthly for 2 months and quarterly thereafter, to ensure accurate documentation in the MAR and TAR, and transcription of physician's orders are complete, including oxygen orders. A report will be submitted to the QAPI committee monthly for 3 months, at that time the QAPI committee will make recommendations for and determine continued monitoring. Director of Nursing will be responsible for monitoring and follow-up.</p>		

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

PRINTED: 03/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/30/2017
NAME OF PROVIDER OR SUPPLIER MIDLAND REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651		
(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 514	Continued From page 71 During an interview on 1/25/17 at 9:48 am, LN #2 stated she had found the area on Resident #5's ankle on 1/6/17. LN #2 said she thought she had written the order for the Sure prep and had written a note in Resident #5's chart. b. A physician's order, dated 11/21/16, documented, "Will attempt GDR...Risperdal 0.5 mg Q HS..." Resident #5's November 2016 MAR documented the order for Risperdal 0.5 mg was discontinued on 11/21/16, and stated "see N.O. [new order]. Resident #5's record did not include further orders for the Risperdal until 12/5/16, when a physician's order was received for Risperdal 1 mg every HS. Resident #5's November 2016 MAR, documented Risperdal 1 mg every HS, dated 11/22/16. The MAR documented Risperdal 1 mg was administered at bedtime from 11/22/16 through 11/30/16. Resident #5's December 2016 MAR, documented she received Risperdal 1 mg 12/1/16 through 12/4/16, instead of the Risperdal 0.5 mg as ordered by the physician. During an interview on 1/24/17 at 4:33 pm, the DON stated he was not able to find an order to increase the Risperdal to 1 milligram on 11/22/17.	F 514			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001480	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/30/2017
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NAME OF PROVIDER OR SUPPLIER MIDLAND REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651
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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
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the state recertification and complaint investigation survey conducted at the facility January 23, 2017 to January 30, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Linda Kelly, RN Marcia Mital, RN</p> <p>Acronyms include: & = and ADON = Assistant Director of Nursing AIT = Administrator in Training BG = Blood glucose BIMS = Brief Interview for Mental Status c = with CHF = Congestive Heart Failure cm = centimeter CVA = Cerebral Vascular Accident DON = Director of Nursing d/t = due to ER = Emergency Room ESBL = Extended-Spectrum Beta-Lactamase GDR = Gradual Dose Reduction H&P = History and Physical HS = at bedtime IDT = Interdisciplinary Team IM = Intramuscular injection IV = Intravenous LE = Lower Extremity [leg] MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set mL/hr = milliliter per hour MRSA = Methicillin-resistant Staphylococcus aureus LN = Licensed Nurse</p>	C 000		
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Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
03/06/17

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001480	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/30/2017
NAME OF PROVIDER OR SUPPLIER MIDLAND REHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651		
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C 000	Continued From page 1 LPN = Licensed Practical Nurse NP = Nurse Practitioner PICC = Peripherally Inserted Central Catheter PO = Orally [by mouth] Q = Every QD = Every Day RBC = Red Blood Cell R or RT = Right RD LD = Registered Dietitian Licensed Dietitian RN = Registered Nurse RNC = Regional Nurse Consultant R/T = Related To SCU = Secure Care Unit SS-E1 = Social Services-employee #1 TAR = Treatment Administration Record TX = Treatment UTI = Urinary Tract Infection VP = Vice President WBC = White Blood Cell WCTM = Will Continue to Monitor X or x = By	C 000		
C 664	02.150,02,a Required Members of Committee 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 Quality Assurance Performance Improvement meeting minutes and staff interview, it was determined the facility failed to ensure the pharmacist participated in the facility's Infection Control Meetings at least quarterly. This failure created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings included:	C 664	Preparation and submission of this plan of correction by, Midland Rehabilitation and Healthcare Center, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted	3/8/17

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001480	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/30/2017
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NAME OF PROVIDER OR SUPPLIER MIDLAND REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651
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C 664	<p>Continued From page 2</p> <p>On 1/27/17 at 10:30 am, the Infection Control Program was reviewed with the Interim ADON. The Interim ADON said the facility held its Quality Assurance Performance Improvement meetings on a monthly basis and infection control was a component of those meetings.</p> <p>The Interim ADON provided the attendance records, dated 5/24/16, 6/28/16, 8/23/16, 10/25/16 and 11/23/16. The records documented the following: on 10/25/16, the pharmacist did not participate in the Infection Control Meeting. On 11/23/16, the pharmacist did not participate in the Infection Control Meeting.</p> <p>On 1/27/17 at 11:00 am, the Clinical Liaison said the facility did not have a December meeting and January's meeting is scheduled for next week. The facility was unable to provide additional documentation for the pharmacist attendance.</p>	C 664	<p>solely pursuant to the requirements under state and federal laws.</p> <p>C664</p> <ol style="list-style-type: none"> On 02/28/17 the Pharmacist attended the monthly Quality Assurance Performance Improvement(QAPI) committee meeting. The Pharmacist will be notified a month in advance of date for monthly QAPI meetings. <p>Root Cause: QAPI members need to know in advance the dates for QAPI meetings, and sign the QAPI sign in sheet for the meeting.</p> <ol style="list-style-type: none"> On 02/17/17 the Regional Nurse Consultant educated the Nursing Home Administrator on the required members of the QAPI committee, including the Pharmacist. Beginning 03/08/17 the Nursing Home Administrator will audit monthly attendance at QAPI meeting to ensure required members attend at least quarterly. A report will be submitted to the QAPI committee monthly for 3 months, at that time the QAPI committee will make recommendations for and determine continued monitoring. The Administrator will be responsible for monitoring and follow-up. 	
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

May 19, 2017

Chase Gunderson, Administrator
Meadow View Nursing and Rehabilitation
46 North Midland Boulevard
Nampa, ID 83651

Provider #: 135076

Dear Mr. Gunderson:

On **January 30, 2017**, an unannounced on-site complaint survey was conducted at Meadow View Nursing And Rehabilitation. An on-site complaint investigation was conducted from January 23, 2017 through January 30, 2017. Observations were conducted throughout the facility. Multiple interviews were conducted with residents, family members, and staff members. Clinical records of 24 residents were reviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007451

ALLEGATION #1:

The facility failed to administer medication per physician's order.

FINDINGS:

The facility was cited with deficient practice F282, for failing to follow physician's orders. Please refer to F281 of the 2567 federal report for specific findings.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility failed to notify an identified resident's family of the development of a pressure ulcer.

Chase Gunderson, Administrator
May 19, 2017
Page 2 of 2

FINDINGS:

The facility was cited with deficient practice at F157, Notification of Change, and F314, Pressure Ulcers. Please refer to F157 and F314 on the federal 2567 report for specific findings.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility failed to document a treatment/medication after completion.

FINDINGS:

The investigation determined there was inadequate evidence that facility staff had documented treatments had been given prior to the actual provision of medications/treatments. Although the allegation could not be substantiated for the identified resident, it was substantiated for other residents in the facility.

The facility was cited with deficient practice F281, Professional Standards. Please refer to F281 on the federal 2567 report for specific findings.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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 "David Scott". The signature is written in a cursive style and is positioned above the typed name of the sender.

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

Chase Gunderson, Administrator
May 19, 2017
Page 3 of 2

DS/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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E-mail: fsb@dhw.idaho.gov

May 31, 2017

Chase Gunderson, Administrator
Meadow View Nursing and Rehabilitation
46 North Midland Boulevard
Nampa, ID 83651

Provider #: 135076

Dear Mr. Gunderson:

On **January 30, 2017**, an unannounced on-site complaint survey was conducted at Meadow View Nursing And Rehabilitation. The complaint was investigated in conjunction with facility's federal recertification and State licensure survey conducted January 23, 2017 to January 30, 2017.

Immediately after entering the facility, the survey team conducted a general tour of residents' rooms and common areas. Throughout the survey, thirteen individual residents and all residents in general were observed for Quality of Life and Quality of Care concerns. Call lights were observed throughout the survey.

The clinical record of the identified resident was reviewed with twelve other residents' records for Quality of Care concerns. The facility's Grievance files, Resident Council minutes, Incident and Accident reports, and Allegation of Abuse reports from May 2016 were reviewed.

Several residents, Certified Nursing Aides, nurses, and the Director of Nursing were interviewed regarding Quality of Care concerns. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007445

ALLEGATION #1:

An identified resident was admitted to the hospital with urosepsis.

FINDINGS #1:

Based on record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F315.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The Power of Attorney had concerns about the identified resident being admitted to the hospital and requested a care conference with the facility.

FINDINGS #2:

The facility's Grievance file documented that in November 2016, the social services designee and Power of Attorney met and resolved the concerns.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

When the identified resident was readmitted to the facility, s/he had orders for physical therapy, which s/he did not receive.

FINDINGS #3:

Upon readmission to the facility, the identified resident was evaluated for Physical Therapy services, but as the resident was at baseline from the previous admission, Occupational Therapy

services were provided from November 4, 2016 through November 23, 2016.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The identified resident's bed is against the wall on the right side, which is his/her functional side. This prevents the identified resident from consuming fluids without assistance.

FINDINGS #4:

Thirteen individual residents and all residents in general were observed with water at bedside and staff offering fluids throughout survey.

Thirteen individual residents and several residents in the Group meeting were interviewed and did not have concerns receiving fluids by staff. Several Certified Nursing Aides and Nurses said they made sure residents had fluids throughout the day and evening.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The identified resident's call light is often not accessible and when the identified resident does activate the call light it takes fifteen to twenty minutes for staff to answer.

FINDINGS #5:

Based on record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F353.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #6:

The identified resident was transferred to the Emergency Room for tests when the facility found a bruise to the resident's leg, which the Reporting Party said was caused by the facility being under staffed.

FINDINGS #6:

Based on record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F353.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #7:

The identified resident had an Urinary Tract Infection with agitation for which family members requested medication to lessen the resident's agitation and encourage food and fluid intakes. The identified resident was admitted to a hospital with a diagnosis of dehydration.

FINDINGS #7:

Based on record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F315.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #8:

The identified resident's teeth were caked with filth and did not appear to have been brushed for a long time.

Chase Gunderson, Administrator
May 31, 2017
Page 5

FINDINGS #8:

Thirteen individual residents and residents in general were observed for ADLs, including oral hygiene throughout the survey.

The identified resident's clinical record was reviewed for the provision of oral hygiene.

Several Certified Nursing Aides said part of their job duties included oral hygiene twice daily and as needed. The Director of Nursing Services said Certified Nursing Aides assist residents in the morning by assisting them out of bed, as well as with dressing, grooming, and brushing their teeth. Assistance with grooming, including oral hygiene, is provided to residents at bedtime, the Director of Nursing stated.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

A handwritten signature in blue ink that reads "D. Scott".

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

DS/lj

Chase Gunderson, Administrator

May 31, 2017

Page 6



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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E-mail: fsb@dhw.idaho.gov

January 12, 2018

Chase Gunderson, Administrator
Meadow View Nursing and Rehabilitation
46 North Midland Boulevard
Nampa, ID 83651

Provider #: 135076

Dear Mr. Gunderson:

On **January 30, 2017**, an unannounced on-site complaint survey was conducted at Meadow View Nursing And Rehabilitation. The complaint was investigated in conjunction with the facility's federal recertification and State licensure survey conducted January 23, 2017 to January 30, 2017.

Immediately upon entering the facility, the survey team conducted a general tour of residents' rooms and common areas. Throughout the survey, thirteen individual residents and all residents in general were observed for Quality of Life and Quality of Care concerns. Staff responses to call lights were also observed throughout the survey.

The clinical record of the identified resident and twelve other residents' records were reviewed for Quality of Care concerns. The facility's Grievance files, Resident Council minutes, Incident and Accident reports, staffing schedules and records of actual hours worked, and Investigations of allegation of abuse files from May 2016 through January 2017 were also reviewed.

Several residents, Certified Nursing Aides, nurses, and the Director of Nursing Services were interviewed regarding Quality of Care concerns. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007409

ALLEGATION #1:

The facility did not have a Registered Nurse to administer intravenous medications for an identified resident. This occurred on a daily basis.

FINDINGS:

Based on observations, interviews and review of nursing schedules and hours worked, a Registered Nurse was on duty twenty-four hours every day and the allegation was not substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

An identified resident was not consistently provided with Benadryl and Zofran when it was requested because, the facility contended, those medications were not available from the pharmacy. The resident suffered nausea and vomiting as a result of not receiving the medications, which resulted in the resident's physician ordering Triamcinolone acetonide cream for the resident's stomas, however the resident, who requested the ointment daily, was informed by the facility that this medication also was not available. When the resident was discharged, the facility provided a full tube of Triamcinolone acetonide that was dated with the same date as the resident's admission. A nurse "tried" to mix microlipids in the resident's intravenous (IV) fluids rather than for administration through his/her feeding tube and extended release Wellbutrin was crushed and put through the resident's feeding tube.

FINDINGS:

Per review of the identified resident's clinical record, the allegations could not be definitively substantiated. However, based on observation, record review and staff interview, other residents did not receive their medications and/or treatments as ordered; the allegation was substantiated and the facility was cited at F 281. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

An identified resident's microlipids for tube feeding were ordered, but not administered for more than a month. The resident asked daily for the microlipids, but was told they were not available. When the microlipids became available, a nurse attempted to mix them in the resident's intravenous fluids for administration, rather than the feeding tube solution.

FINDINGS:

The identified resident's closed clinical record contained documented evidence that microlipids were not administered as ordered. Deficient practice was identified and the facility was cited at F 322. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

An identified resident was left in her/his wheelchair in the television room from 9:30 pm until 3:00 am, then was told s/he would have to sleep in the television room because his/her roommate was ill. A nurse used a mechanical lift to place the resident on the couch, where he/she slept until 7:00 am.

FINDINGS:

The identified resident's clinical record did not contain evidence that supported the allegation. Based on observations, resident and staff interviews, and record reviews during the survey, there was no evidence discovered that would have substantiated the allegation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

An identified resident did not have his/her Continuous Positive Airway Pressure (CPAP) or oxygen one night.

FINDINGS:

There were no observed, voiced or written complaints by residents or staff, or documentation of issues or concerns in residents' clinical records regarding oxygen and/or Continuous Positive Airway Pressure use. There was a lack of evidence necessary to substantiate this allegation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

One morning, the facility provided an identified resident with a bed in a different room after the resident's roommate "went ballistic" from a drawer that was closed too loudly. The identified resident's room assignment was changed four other times without explanation, except on one occasion when he/she was told the facility needed his/her room for a new resident being admitted to the facility.

FINDINGS:

Based on review of the identified resident's clinical record and staff interviews, the identified resident requested and/or approved the room transfers. This allegation was not substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

A nurse prepared medications for intravenous (IV) administration, which he/she then set directly on an identified resident's blanket. The resident's stoma had leaked gastric fluid on the blanket and there should have been a chux pad or other barrier between the syringe and the blanket. The facility did not assist the resident with hand hygiene or accessing gloves for measuring the contents of his/her bed pan, administering his/her own IV medications, or for performing other personal cares despite a recent surgery the resident had to his/her hand.

FINDINGS:

This allegation could not be substantiated for the identified resident due to a lack of evidence, however facility staff were observed consistently not practicing standard infection control

measures and the allegation was substantiated for other residents. Please refer to citation F 441 on the federal 2567 report for details.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

An identified resident admitted to the facility after surgery on his/her hand was told because he/she was responsible for administering his/her own intravenous (IV) medications at home then he/she would be expected to do the same in the facility. The resident had difficulty administering IV medications because of functional use of only one hand. Additionally, due to post-operative pain medications, the resident should have had increased supervision with this task.

FINDINGS:

Based on resident and staff interviews and observations of interactions between residents and nursing staff, including medication administrations by nurses, it was determined resident choices were honored and residents were assisted with or provided needed care and services. Additionally, a review of clinical records belonging to the identified resident and several other residents, as well as a review of the facility's policies and grievance files, no evidence was found that would have substantiated this allegation.

This allegation was not substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #9:

An identified resident used a drop-arm commode chair before admission to the facility, but the facility provided only a standard commode chair the resident could not use. The facility did not provide the necessary equipment and the resident had to use a bedpan instead of a commode chair.

FINDINGS:

The identified resident's clinical record did not contain historical information or physician orders for a drop-arm commode chair and the resident was care planned to use a bedpan per his/her

preference. During survey, there were no concerns voiced about inadequate or insufficient equipment when residents, interested parties, and staff were interviewed. There were no written concerns about equipment contained within clinical or facility records.

This allegation was not substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #10:

An identified resident was told by the facility he/she must measure his/her own intake and output amounts. Additionally, the identified resident developed a urinary tract infection.

FINDINGS:

The identified resident's clinical record did not document how his/her intake/output was measured. Staff interviewed during the investigation stated the resident was not responsible for measuring his/her own intake and output. Deficient practice was identified, however, for another resident who developed a urinary tract infection and the facility was cited at F315. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #11:

The facility documented an identified resident received Benadryl as a pain relief medication.

FINDINGS:

The identified resident's clinical record documented Benadryl was ordered and administered as needed for itching when requested by the resident.

The allegation was not substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #12:

An identified resident did not routinely receive Physical Therapy nor any Occupational Therapy services after admitting to the facility following hand surgery.

FINDINGS:

The clinical record documented the identified resident was able to make his/her own decisions and that Physical Therapy was provided when agreed to by the resident. When the resident refused to participate in Physical Therapy, the clinical record documented alternate times and/or days were offered. Staff confirmed in interviews that the clinical record accurately documented efforts to provide the identified resident with Physical Therapy services. The clinical record also documented Occupational Therapy was not ordered for the identified resident. This allegation was not substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #13:

The facility Administrator and Regional Vice President were not responsive to concerns regarding an identified resident.

FINDINGS:

The clinical record documented the identified resident was able to make his/her own decisions and desired to do so. A review of facility investigations and interview of staff did not produce any concerns of abuse and/or neglect of residents. Concerns identified in this allegation were investigated by the facility and reported directly to the identified resident. This allegation was not substantiated for lack of evidence.

ALLEGATION #14:

A bedpan was left under an identified resident for extended periods of time.

FINDINGS:

Based on observations, resident and staff interviews, and record reviews, including the clinical records of the identified resident and twelve other residents, as well as the facility's grievance files and investigations of allegations of abuse/neglect, there were no voiced or written concerns

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that residents were left on bedpans longer than necessary. Additionally, the identified resident was documented as able to make his/her needs known and asked to be left on the bedpan at times.

This allegation was not substantiated for lack of evidence.

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 "David Scott". The signature is written in a cursive style and is positioned above the typed name of the sender.

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

DS/lj