IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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March 3, 2017

Candice Durham, Administrator
Prestige Care & Rehabilitation - The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

Dear Ms. Durham:

On **February 10, 2017**, a survey was conducted at Prestige Care & Rehabilitation - The Orchards 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 an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 13, 2017**. Failure to submit an acceptable PoC by **March 13, 2017**, may result in the imposition of penalties by **April 7, 2017**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;

- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and

- Include dates when corrective action will be completed <u>in column (X5)</u>.

  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 17, 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 **May 11, 2017**. A change in the seriousness of the deficiencies on **March 27, 2017**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 11, 2017** includes the following:

Denial of payment for new admissions effective **May 11, 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 **August 9, 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 **May 11, 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

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 13, 2017**. If your request for informal dispute resolution is received after **March 13, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135103		02/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE & REHABILITATION - THE ORCHARDS	1014 BURRELL AVENUE LEWISTON, ID 83501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility February 6, 2017 to February 10, 2017. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Ophelia McDaniels, RN Brenda Cross, RN, BSN Acronyms include: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CDM = Certified Dietary Manager cm = Centimeters CNA = Certified Nursing Assistant DNS = Director of Nursing Services F = Fahrenheit LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = milligram ml = milliliter PRN = As Needed RCM = Resident Care Manager RD = Registered Dietician TAR = Treatment Administration Record 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,	F 157		3/17/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 03/13/2017

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

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

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F 157	Continued From page 2 (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 and staff interview, it was determined the facility failed to ensure a resident's physician was notified of significant changes in the resident's clinical condition. This was true for 1 of 14 (#6) sampled residents and had the potential for more than minimal harm when the facility failed to notify Resident #6's physician when the resident developed three Stage II pressure ulcers. Findings include: Resident #6 was readmitted to the facility on 11/11/13, with multiple diagnoses including peripheral vascular disease, a history of left leg above the knee amputation, and an open wound to the right buttock. Resident #6's Skin Grid documented on 12/27/16 the resident developed three Stage II pressure ulcers to the right and left buttocks. Resident #6's clinical record did not document the resident's physician was notified when the pressure ulcers developed. On 2/9/17 at 3:35 pm, RCM #2, with the DNS and Regional Support Nurse present, said she could not determine if the physician was notified of the pressure ulcers prior to 1/5/17 when the facility asked for a treatment order.	F 157	What corrective action will be accomplished for those residents found to have been affected by the deficient practice For resident #6, the physician has been notified of the significant change in resident□s clinical condition How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Current residents who have developed a pressure wound while residing in the facility have the potential to be affected by the deficient practice; facility will review residents who currently have in-house developed wounds to verify that the physician was notified regarding significant changes in the resident□s clinical condition What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur DNS or designee will complete pressure wound audit weekly to ensure physician notification of significant changes in resident□s clinical condition; LN□s will be in-serviced regarding physician notification of significant changes in a	

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F 157	Continued From page 3	F 157	resident□s clinical condition How will the corrective action be monitored to ensure the deficient practice is corrected and compliance sustained DNS or designee weekly audits will be reviewed by facility QAPI Committee Monthly x3 months to ensure physician notification of significant changes in resident□s clinical condition and develop further action plan if required Date the deficient practice correction will be completed 3/17/17 Individual responsible for correction of the deficient practice The Administrator is responsible for correction of the deficient practice	
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. 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 1 of 14 sampled residents (#5) was served lunch and given time to eat it prior to leaving the facility for a previously	F 246	What corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #5 was offered a sack lunch	3/17/17

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F 246	Continued From page 4 scheduled doctor's appointment. The facility also failed to accommodate food preferences and offer a requested substitute food for 1 of 14 sampled residents (#15). These deficient practices had the potential to adversely effect residents' nutritional health and create feelings of loss of control over their environment. Findings include: 1. Resident #5 was admitted to the facility 4/4/16 with diagnoses that included muscle weakness, angiodysplasia of the stomach and duodenum, depression, dementia and Vitamin D deficiency. The 10/11/16 MDS assessment documented Resident #5 required supervision and setup help only with her meals. On 2/7/17 at 12:35 pm, staff were observed placing Resident #5's meal on the dining room table in front of her. The resident was informed the bus bus to take her to a physician's appointment had arrived and the resident was offered a sandwich, which she refused. At 12:40 pm, a maintenance staff member pulled Resident #5 away from the table in her wheelchair as he told her she had to leave for the physician's appointment. Resident #5 was not allowed to eat her meal and was not provided with a "sack" lunch. 2. Resident #15 was admitted to the facility on 12/16/16 with diagnoses that included heart failure. A 1/13/17 MDS assessment documented the resident ate independently and required setup help only with her meals. The resident's	F 246	upon leaving the facility and declined it; Resident #5 did accept 2 cookies for the road upon leaving the facility; Resident #15 no longer resides at the facility How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents who are being transported to appointments during meal time have the potential to be affected by the deficient practice; the facility will review appointments in the morning meeting to ensure meal served timely (early meal) and/or sack lunch provided; residents who have listed dislikes on their meal card have the potential to be affected by the deficient practice; the facility Director of Nutritional Services has verified residents likes vs. dislikes and updated resident meal cards accordingly What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur The facility will review appointments in the morning meeting to ensure meal served timely and/or sack lunch provided; staff will be in-serviced regarding offering sack lunch or early meal when residents are leaving for appointments; dietary staff will be in-serviced regarding upholding residents likes vs. dislikes when serving meals How will the corrective action be	

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F 246	Continued From page 5 physician's order directed staff to provide her with a consistent carbohydrate regular diet. On 2/6/2017 at 6:00 pm, Resident #15 summoned a surveyor to her table and stated, "Look at this." Resident #15 then pointed to her meal card and stated it was "clearly written on the meal card that [I] dislike zucchini." Zucchini was observed on the resident's plate at this time. The resident stated she had requested a substitute for the zucchini, but by 6:40 pm Resident #15 had not received the requested substitute.	F 246	monitored to ensure the deficient practice is corrected and compliance sustained Designated Orchard Angels will interview residents weekly x3 then monthly x3 to ensure dietary needs and preferences are being met; results of interviews will be reviewed by facility QAPI Committee Monthly x3 with further action plan if required Date the deficient practice correction will be completed 3/17/17 Individual responsible for correction of the deficient practice The Administrator is responsible for correction of the deficient practice	
F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 252		3/17/17

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F 252	Continued From page 6 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure residents were provided a safe and clean environment. This was true for 11 of 18 resident rooms (Rooms 301, 303, 305, 307, 309, 312, 313, 314, 316, 317, and 318) observed and had the potential to cause harm should the condition of the facility cause residents embarrassment, sadness, depression, or experience other adverse reactions to a less-than clean and homelike environment. Findings include: During a tour of the facility conducted with maintenance staff on 2/9/17 at 9:00 am, the following was observed: * A 7-inch by 1-inch wide area of the door panel of Room 305 had separated and was missing from the bottom of the door. There was an 8-inch separation at the top of the door. * Rooms 312, 313 and 314 had chipped paint on both sides of the door trim and 38-inches above the bottom of the door. * There were 5 nail holes on the left wall over the resident's dresser in Room 318; 4 nail holes in the wall 10 inches apart on the left wall in Room	F 252	What corrective action will be accomplished for those residents found to have been affected by the deficient practice The 7inch by 1inch wide area of the door panel and the 8inch separation at the top of the door of Room 305 has been repaired; the chipped paint on both sides of the door trim and 38inches above the bottom of the door in room 312, 313, and 314 has been repaired; the 5 nail holes on the left wall over the resident□s dress in Room 318 have been repaired; the 4 nail holes in the wall 10inches apart on the left wall in Room 307 have been repaired; the 4 holes in the left wall in Rooms 303 and 307 have been repaired; the rug outside Room 317 with the white stain 16 inches wide and 4.5 inches long has been shampooed / deep cleaned; the rug outside room 316 with the dark brown stain 11 inches wide and 16 inches long has been shampooed / deep cleaned; the closets in Rooms 303, 307, and 309 the black marks, scratches and deep gouges have been repaired ; the wall behind the first bed in resident Room 301 with several 6inch long and 1inch wide gouges	

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F 252	Continued From page 7 307; and 4 holes in the left wall in Rooms 303 and 307. * The rug outside Room 317 had a white stain 16 inches wide and 4.5 inches long. The rug outside Room 316 had a dark brown stain 11 inches wide and 16 inches long. * The closets in Rooms 303, 307, and 309 had black marks, scratches and deep gouges. On 2/9/17 at 9:00 am, during the environmental tour, the maintenance staff member stated he would make the necessary repairs as soon as possible. 2. On 2/7/17 at 9:45 am, the wall behind the first bed in resident Room 301 was observed with several six-inch long and one-inch wide gouges which exposed the drywall. There were also several scratches in the wall near the door, which also exposed the dry wall. On 2/7/17 at 11:00 am, the Maintenance Director said the gouges behind the bed occurred when the bed was pushed into the wall and the scratches near the door appeared to have been caused by a wheelchair. He said both areas needed to be repaired.	F 252	which exposed the drywall have been repaired; the scratches in the wall near the door in Room 301 which exposed the drywall have been repaired; How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All resident rooms have the potential to be affected by the deficient practice; the facility Maintenance Director has completed an audit of all resident rooms and developed a schedule of maintenance based on that audit to repair/paint scratches in walls, repair nail holes in walls, repair exposed drywall in walls, repair door panels, and door trims; facility has shampooed / deep cleaned carpet in all resident area halls What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur Facility Administrator has provided 1:1 in-service to Maintenance Director regarding his role in ensuring a safe, clean, comfortable, home-like environment; Maintenance Director will review progress of developed maintenance schedule to address the deficient practice weekly x3 months with the Administrator to ensure on-schedule repairs of scratches in walls, nail holes in walls, exposed drywall in walls, door panels, door trims, and carpets are deep cleaned	

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F 252	Continued From page 8	F 252	How will the corrective action be monitored to ensure the deficient practice is corrected and compliance sustained Maintenance Director will review developed schedule of maintenance to address the deficient practice in the facility QAPI Committee monthly x6 months with further action plan if required Date the deficient practice correction will be completed 3/17/17 Individual responsible for correction of the deficient practice The Administrator is responsible for correction of the deficient practice	
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 includes measurable objectives and timeframes	F 279		3/17/17

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F 279	Continued From page 9 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 - (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 (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). (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. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 279		

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F 279	Continued From page 10 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and record review, it was determined the facility failed to develop a comprehensive care plan that included specialized treatments (dialysis) for 1 of 14 sampled residents (Resident #1). This had the potential to cause more than minimal harm if facility staff were to provide inappropriate dialysis-related care to Resident #1, who did not have a care plan for dialysis services. Findings included: Resident #1 was admitted to the facility on 11/15/16 with diagnoses that included End Stage Renal Disease (ESRD) and dependence on renal dialysis. The admission MDS assessment, dated 11/22/16, documented Resident #1 received dialysis before- and after admission to the facility. On 2/6/17 at 5:25 pm, Resident #1 said she had a 'rough day' at dialysis and was tired. On 2/7/17 at 2:30 pm, LN #6 said Resident #1 left the facility for dialysis three times a week. On 2/9/17 at 9:20 am, MDS Coordinator #2 said there was no care plan for Resident #1's dialysis. On 2/10/17 at 9:05 am, LN #5 said she had not assessed Resident #1's dialysis shunt because it did not appear on her computer screen (electronic record) as an intervention she needed to complete.	F 279	What corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #1 no longer resides at facility How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Other facility residents who receive dialysis have the potential to be affected by the deficient practice; all residents who are currently receiving dialysis have had their plan of care updated accordingly to include no blood draws on access arm, no blood pressure readings on access arm, non-toothed clamp at bedside, routine weight assessment per MD order, and coordination with the outside provider□s stated needs, goals, and interventions; all residents who currently receive dialysis have been place on electronic record for the intervention of assessing the dialysis shunt accordingly; What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur LN□s have in-serviced to ensure electronic documentation of shunt	

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F 279	Continued From page 11 The facility's Hemodialysis Care and Provision of Care by Outside Providers policies, each revised January 2016, documented care plan interventions should be individualized to the specific resident and included the following: * No blood draws on access arm * No blood pressure readings on access arm * Non-toothed clamp at bedside * Routine weight assessment per MD order * A plan of care shall be established in coordination with the outside provider * The facility shall maintain its' own plan of care and incorporate the outside provider's stated needs, goals and interventions.	F 279	assessment and care plan interventions specific to each resident currently receiving dialysis How will the corrective action be monitored to ensure the deficient practice is corrected and compliance sustained DNS or designee will perform audit weekly x3 then monthly x3 to ensure implementation of individualized plan of care regarding dialysis, coordination of plan of care with outside provider, and LN assessment of shunt per electronic record; audits will be reviewed in facility QAPI Committee monthly x3 to ensure compliance with plan of correction and develop further action plan if required Date the deficient practice correction will be completed 3/17/17 Individual responsible for correction of the deficient practice The Administrator is responsible for correction of the deficient practice	
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	F 280		3/17/17

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F 280	Continued From page 12 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 planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 280		

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F 280	Continued From page 13 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a resident's care plan was revised to reflect current needs. This was true for 1 of 14 (#6) sampled residents and had the potential to cause harm if residents did not receive appropriate care and interventions due to lack of direction on the care plan. Findings include:	F 280	What corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #6□s Skin Breakdown Plan of Care has been updated to reflect appropriate care and interventions for the three pressure ulcers	

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F 280	Continued From page 14 Resident #6's Skin Grid documented on 12/27/16 that the resident developed three Stage II pressure ulcers to the right and left buttocks. Resident #6's numerous progress notes between 12/29/16 to 2/9/17 documented the resident had three pressure ulcers. Resident #6's Skin Breakdown care plan did not document the resident had the three pressure ulcers. On 2/9/17 at 2:30 pm, a surveyor and LN #3 observed Resident #6's pressure ulcers. Wound #1 to the right buttock measured 5.5 (length) X 3.0 (width) cm and appeared bloody. Wound #2 to the left buttock measured 1.5 X 1 cm with a pink clean wound bed. Wound #3 to the left buttock measured 0.5 X 0.5 cm with a pink clean wound bed. Wound depth was not measured. On 2/9/17 at 3:35 pm, with the DNS with RCM #2 and the Regional Support Nurse present, said the care plan was not updated to reflect the new pressure ulcer development.	F 280	How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Other facility resident with developed pressure ulcers have the potential to be affected by the deficient practice; the facility has completed an audit of care plans for residents with pressure ulcers to ensure appropriate care and interventions are reflected What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur Licensed Nurses will be provided further education / in-service regarding their role in ensuring Skin Breakdown Plan of Care reflects appropriate care and interventions for residents with pressure wounds; DNS or designee will audit weekly x 4 then monthly x3 to ensure compliance How will the corrective action be monitored to ensure the deficient practice is corrected and compliance sustained DNS or designee will audit weekly x 4 then monthly x3 to ensure compliance; audits will be reviewed in facility QAPI Committee monthly x4 to evaluate for further plan of action if required Date the deficient practice correction will be completed 3/17/17	

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F 280	Continued From page 15	F 280	Individual responsible for correction of the deficient practice The Administrator is responsible for correction of the deficient practice	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such	F 309		3/17/17

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F 309	Continued From page 16 services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, record review, and policy review, it was determined the facility failed to communicate assessments and coordinate care between dialysis providers and residents, complete a dialysis care plan, and/or assess the dialysis shunt for 2 of 14 sampled residents (Resident #1 and Resident #10) who received hemodialysis outside the facility. Resident #1's care related to dialysis was not care planned by the facility and the facility failed to assess and monitor the resident's dialysis shunt. Additionally, the facility failed to communicate with Resident #1's and Resident #10's dialysis provider. Findings include: The facility's Dialysis - Provision of Care by Outside Providers and Hemodialysis Care policies, each revised January 2016, documented: * The resident's plan of care was to be established in coordination with the outside provider * The facility would maintain its' own plan of care and incorporate the outside provider's stated needs, goals and interventions * Communication would occur between the dialysis clinic and the facility that resulted in an interchange of information that was useful and necessary for the care of the resident * The resident's shunt site would be assessed for bruit and thrill each shift while the resident was	F 309	What corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #1 no longer resides at facility; for Resident #10, the facility is completing dialysis communication form prior to the resident leaving for dialysis&including resident□s pre-dialysis weight, communication is occurring between the facility and the dialysis clinic resulting in an interchange of information that is useful and necessary for the care of the resident; resident #10□s shunt site if being assessed for bruit and thrill each shift while the resident is awake How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken There are no other current residents receiving dialysis What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur LN□s will be provided education / in-service regarding their role in completing dialysis communication form prior to the resident leaving for	

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F 309	Continued From page 17 awake * Nurses would complete the Dialysis Center Communication Form prior to the resident leaving for dialysis. This communication would include the resident's pre-dialysis weight 1. Resident #1 was admitted to the facility on 11/15/16 with diagnoses that included End-Stage Renal Disease (ESRD) and dependence on renal dialysis. The admission MDS assessment, dated 11/22/16, documented Resident #1 received dialysis before- and after admission to the facility. Resident #1's clinical record did not include evidence of communication between the facility and the dialysis provider, nor did it include documentation that the resident's care plan addressed dialysis services. On 2/7/17 at 2:30 pm, LN #6 said Resident #1 left the building for dialysis three times a week. On 2/9/17 at 1:50 pm, LN #6 said a list of medications for Resident #1 was faxed to the dialysis center weekly and medication changes would be faxed immediately. LN #6 said no other information was sent to the dialysis provider. On 2/9/17 at 3:30 pm, the medical records clerk provided Resident #1's dialysis communication forms that did not include the time of the resident's last meal, last weight and date, medications given in the immediate 4 hours prior to dialysis, or any problems since the last resident's last dialysis treatment. The medical records clerk stated the facility had not provided	F 309	dialysis&including resident□s pre-dialysis weight, communication between the facility and the dialysis clinic to facilitate an interchange of information that is useful and necessary for the care of the resident, and assessing shunt site for bruit and thrill each shift while the resident is awake; DNS or designee will complete audit weekly x4 then monthly x4 to ensure compliance How will the corrective action be monitored to ensure the deficient practice is corrected and compliance sustained DNS or designee will audit weekly x 4 then monthly x4 to ensure compliance; audits will be reviewed in facility QAPI Committee monthly x5 to evaluate for further plan of action if required Date the deficient practice correction will be completed 3/17/17 Individual responsible for correction of the deficient practice The Administrator is responsible for correction of the deficient practice	

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F 309	Continued From page 18 this information to the dialysis provider since 11/16/16 to the present time. Resident #1's clinical record did not include any documentation that the resident's dialysis shunt had been assessed post-dialysis care. On 2/10/17 at 8:55 am, the medical records clerk said she was not aware until 2/9/17, following questioning by the surveyor, that Resident #1's electronic health record did not include documentation related to assessments of the resident's dialysis shunt. On 2/10/17 at 9:05 am, LN #5 said she had not assessed Resident #1's dialysis shunt because it did not appear on her computer screen (electronic record) as an intervention she needed to complete. 2. Resident #10 was readmitted to the facility on 10/16/16 with multiple diagnoses, including end stage renal failure. Resident #10's current Dialysis care plan documented the resident received hemodialysis on Monday, Wednesday and Friday at a local dialysis center. Resident #10's clinical record included 39 Dialysis Communication Forms forms with date ranges from 11/2/16 to 2/6/17. The forms, which were from Resident #10's dialysis center, contained clinical information regarding Resident #10's dialysis treatments; however, each of the 39 forms' "To Be Completed by Skilled Nursing Care Facility" sections were blank.	F 309		

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F 309	Continued From page 19 Resident #10's progress notes documented the facility contacted the dialysis center on three occasions between 11/2/16 and 2/6/17 regarding the resident's clinical status. On 2/9/17 at 8:50 am, Resident #10 said the facility did not send paperwork with her when she went to dialysis, but the dialysis center sent paperwork back with her to the facility. On 2/9/17 at 9:00 am, RCM #1 said the facility communicated with the dialysis center via fax or phone if any issues arose that needed to be communicated to the dialysis center. Documentation of this faxed communication was requested, but not provided by the facility. On 2/9/17 at 2:30 pm, the DNS said the facility should send communication to the dialysis center either with the resident or fax it to the center.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and clinical record review, it was determined the facility failed to: * Ensure residents were provided nutritional care and assistance with meals consistent with their assessed needs. This was true for 2 of 14 sampled residents (#3 and #9) reviewed for nutritional and dietary concerns and had the potential for more than minimal harm should	F 312	F312 □ D What corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #17 has been provided with oral hygiene, a shower, shaved, and all his clothing has been laundered; For resident #9, staff have been educated / in-serviced	3/17/17

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F 312	Continued From page 20 residents experience unplanned weight loss of comprosed nutritional status. * Provide necessary grooming, as well as personal and oral hygiene, for Random Resident #17, who could have experienced more than minimal harm from embarassment or rejection by others due to his appearance and/or personal odor. Findings include: 1. Resident #9 was readmitted to the facility on 6/20/14 with diagnoses that included abnormal weight loss. A quarterly MDS assessment, dated 11/23/16, documented Resident #9 was cognitively impaired and required supervision and the assistance of one staff for meals. Resident #9's current Care Plan documented she was at risk for weight loss, recieved a "regular" diet, consumed 75-percent or less of "most" meals and ate in the independent dining room, but required "PRN" [as needed] staff cueing and encouragement to eat. On 2/6/17 at 6:15 pm, Resident #9 was observed with ham, potatoes, bread, and zucchini in a round plate with dividers that separated each item. LN #2, who stood next to Resident #9, cut the ham into small pieces. Neither LN #2 nor other staff in the dining room provided cueing or encouragement to the resident, who sat alone eating the bread and drinking the milk from a pre-packaged container. Resident #9 had not eaten any of the other food items when she left the dining room for toileting. Resident #9 returned to the table a short time later, but staff had already removed her meal. LN #2 stated that	F 312	to provide encouragement and cueing at meal time; offer substitute if resident appears disinterested in meal served, and her plan of care has been updated to reflect her affinity for bread and milk; resident□s physician has been notified of current weight status, dietician has reviewed for possibility of further nutritional intervention in mgmt of resident□s weight; Resident #3□s plan of care has been updated to reflect Speech Therapist□s recommendations, deviation of care as signed, and staff encouragement; staff have been provided education / in-service regarding Resident #3□s plan of care regarding Speech Therapists recommendations How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents who require assistance with oral hygiene, showering and shaving have the potential to be affected by the deficient practice; facility□s Orchard Angels provided audit/observation of facility residents to ensure adequate grooming, as well as personal and oral hygiene care Residents who are at risk for weight loss have the potential to be affected by the deficient practice; residents at risk for weight loss are reviewed per schedule by facility NAR Committee with care plan updated if required to reflect assistance required during meal time, Speech Therapists recommendations,	

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F 312	Continued From page 21 she would get her "something else" to eat. On 2/7/17 at 12:30 pm, Resident #9 was observed sitting alone at the same small table in the dining room eating bread and drinking milk from a pre-packaged container of milk. Staff did not provide encouragement or cueing and at 1:00 pm she left the table without eating any of the meal. On 2/8/17 at 12:40 pm, Resident #9 was observed sitting alone at a small table in the dining room, where she had been served salad, lasagna, garlic bread, and mixed fruit. She ate the bread and drank a container of milk. Staff did not provide her with encouragement or cueing. 2. Resident #3 was admitted to the facility on 5/18/15, with diagnoses that included dysphagia and gastroesophageal reflux disease without esophagitis. A quarterly MDS assessment, dated 11/24/16, documented Resident #3 was independent with daily decision making, short- and long-term memory were intact, and the physical assistance of one staff was required for meals. A 12/1/15 Speech Therapy Evaluation and Plan of Treatment documented Resident #3 was to use "general swallow techniques/precautions, straws in beverages and distant supervision." An "Informed Consent Identifying Risks for Deviation in the Recommended Plan of Care," dated 2/9/17, documented Resident #9 chose "to eat items not on her prescribed diet, eat in her room and eat in her bed."	F 312	encouragement and cueing if required, deviation of care if appropriate, and Dietician recommendations What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur Care staff will be provided education / in-service regarding their role in the provision of adequate grooming, as well as ensuring personal and oral hygiene care is provided to residents as outlined in plan of care and facility procedure for re-approaching resident two times, documenting and involving the RN if resident refuses shower; DNS or designee will complete shower audit weekly x3 months to ensure compliance; designated Orchard Angels will monitor residents weekly x3 weeks, then monthly x3 for adequate grooming and oral hygiene to ensure compliance Staff will be provided with education / in-service to provide encouragement and cueing at meal time; offer substitute if resident appears disinterested in meal served, Speech Therapist□s recommendations, and deviation of care if signed; Assigned Dining Room Monitor will review / audit weekly x 3 months to ensure compliance with providing encouragement and cueing at meal time and offering substitute if resident appears disinterested in meal served; Residents at risk for weight loss will be reviewed by facility NAR Committee ongoing for further interventions and care plan	

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F 312	Continued From page 22 The current Care Plan directed staff to encourage Resident #9 to dine in the facility dining room and to follow ordered dietary food and fluid textures. The Care Plan did not include the Speech Therapist's recommendations noted in the 2/9/17 Informed Consent recommendation. On 2/6/17 at 6:05 pm, Resident #3 was observed eating whipped potatoes, and "mechanical soft" zucchini and chopped ham with her hands. Staff was observed putting a spoon in the resident's hand at 6:30 pm. Resident #3 drank juice and tea without a straw; each liquid was observed flowing from Resident #3's mouth and down both cheeks. 3. Resident #17 was admitted to the facility on 11/26/16 with diagnoses that included heart failure and muscle weakness. A 12/3/16 MDS assessment documented Resident #17 required the physical assistance of one staff for transfers. Resident #17's current Care Plan directed staff to provide assistance with oral hygiene upon rising and at bedtime. Staff were also to provide regularly scheduled and "as needed" showers. On 2/6/17 at 2:50 pm, Resident #17 was observed lying in bed watching television and wearing a blue shirt, gray jogging pants and a black jacket. There was a yellow crusted area on the resident's right cheek approximately 2 centimeters in width and length and yellow crust in the inner corner of both eyes and eyelashes. Resident #17 was unshaven with beard and mustache hair growth of approximately 0.5	F 312	revision as needed How will the corrective action be monitored to ensure the deficient practice is corrected and compliance sustained Audits completed by the DNS (or designee) and observations noted by Orchard Angels will be reviewed by the facility QAPI Committee monthly x3 to ensure compliance and develop further plan of action if required DNS or designee will review residents at risk for weight loss, NAR Recommendations, and Dining Room Monitor audits with facility QAPI Committee monthly x3 to ensure compliance with plan and development of further action plan of required Date the deficient practice correction will be completed 3/17/17 Individual responsible for correction of the deficient practice The Administrator is responsible for correction of the deficient practice	

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F 312	Continued From page 23 centimeters. The resident was noted with a foul body and mouth odor. The resident's black jacket was observed with white stains on both sleeves and front panels ranging from 1 to 4 centimeters in width and length, and the right wrist area had a white crusted area. The gray pants were soiled with yellow crusted areas on both knees. The front of the blue shirt was observed with white and yellow stains ranging from 1 to 4 centimeters. Resident #17 ' s black shoes had multiple white stains and three used tissues were observed on the room's floor. When asked about his appearance, Resident #17 stated, "I haven't had a shower in over a week. I would like to be shaved and have a shower." Shower schedules from 1/26/17 to 2/5/17 documented Resident #17, who was to be bathed twice weekly, received one shower (2/1/17) from 1/26/17 to 2/5/17. The shower schedule documented Resident #17 refused some staff offers to bathe, however, there was no explanation given or whether the resident was reapproached at a later time. On 2/9/17, the DNS stated, "If a resident refuses a shower he is to be re-approached two times. If the resident is cognitive, the resident should sign on the shower sheet [that he/she refused to bathe]. If not, two staff members are to sign the shower sheet. The RN is to chart [refusals to bathe] in the Progress Notes." The DNS stated the facility did not have a policy regarding baths or showers.	F 312		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		3/17/17

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F 314	Continued From page 24 (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 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (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: Based on observation, record review, resident and staff interviews, and policy review, it was determined the facility failed to ensure: *Pressure ulcers did not develop, *Pressure ulcers did not redevelop after they were healed, *Interventions were implemented after pressure ulcers developed, *Assessments of pressure ulcers were completed timely, and *A pressure ulcer was identified. This was true for 2 of 4 (#4 and #6) residents sampled for pressure ulcers. Resident #6 was harmed when he developed two Stage II pressure ulcers, a Stage II pressure ulcer redeveloped, interventions were not implemented in a timely manner, and assessments were not completed in a timely manner. Resident #4 was	F 314	What corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #4 no longer resides at facility; for Resident #6, facility has updated plan of care including interventions and education for resident upon refusal to off-load and/or lay down between meals; resident is provided air mattress in bed and Roho cushion when up in w/c; resident□s skin grid is updated; facility has met with resident and RP providing education and updated deviation of care form How will the facility identify other residents having the potential to be affected by the same deficient practice	

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F 314	Continued From page 25 at risk for harm related to the facility's failure to assess a stage I pressure ulcer. Findings include: The facility's Skin at Risk/Skin Breakdown policy, dated January 2016, documented nursing staff will: *Notify the physician and obtain treatment orders for new skin impairments, *Implement interventions and document interventions on the resident's care plan, and *Assess, measure and document weekly on the Skin Grid. 1. Resident #6 was readmitted to the facility on 11/11/13, with multiple diagnoses including peripheral vascular disease, a history of left leg above the knee amputation, and an open wound to the right buttock. Resident #6's 9/28/12 physician's x-ray report documented, "Shrapnel is present in the soft tissues overlying the left obturator foramen and stump." Resident #6's 10/22/12 physician's progress note documented: -"This has come back showing some shrapnel in the obturator foramen on the left side. There is no evidence of any shrapnel in the sacral gluteal area on the right side." -"Look into a tilting wheelchair. This would be very favorable in terms of getting him off of this pressure area...cannot off-weight when he is up in the chair and does not want to spend all day in the bed."	F 314	and what corrective action will be taken Current residents who have developed a pressure wound while residing in the facility have the potential to be affected by the deficient practice; facility will review residents who currently have in-house developed wounds to verify that the physician was notified regarding significant changes in the resident□s clinical condition, plan of care has been updated timely to reflect new interventions and education for resident upon refusal to off-load and/or lay down between meals, skin condition is assessed and documented on skin grid timely, and deviation of care is updated and in place if appropriate What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur LN□s will be provided with education / in-service regarding their role in preventing the development of pressure ulcers, completing the weekly full body skin audit, physician notification of any new skin problem or worsening skin problem, care plan provision and revision timely with new interventions, timely assessment of pressure wounds and skin grid documentation of such, and the provision resident education in times of non-compliance or refusal of cares; C.N.A.□s will be provided education / in-service regarding the documentation of specific care instructions for residents; DNS or designee will audit weekly	

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F 314	Continued From page 26 Resident #6's current care plan documented on 10/9/12 a Risk for Skin breakdown due to mobility limitations and a history of shrapnel in the right buttock. The care plan documented the following interventions: *10/9/12-Utilize air mattress on bed, monitor right buttock where shrapnel exits, and Roho cushion to wheelchair, and *11/29/16-Resident is noncompliant with orders and encouragement to lay down between meals and staff to continue to encourage resident to off load. Resident #6's 5/17/16 and 8/17/16 quarterly, and 11/12/16 annual MDS assessments documented, he did not have an unhealed pressure ulcer and required two-person extensive assistance for transfers. Resident #6's 11/12/16 annual MDS assessment documented he was cognitively intact, with a BIMS of 14 and that he did not reject cares. Resident #6's 11/29/16 Braden Scale assessment documented the resident was "chairfast" and had "very limited" mobility. Resident #6's Skin Grid documented the resident had a Stage II pressure ulcer on his right buttock which developed on 6/17/16 and was healed on 8/9/16. Resident #6's December 2016 TAR documented an order, dated 6/21/16, to apply Silvadene cream and cover with Mepilex dressing to the right buttock every 3 days. The TAR documented the treatments had been completed.	F 314	x3months then monthly x3 months to ensure compliance How will the corrective action be monitored to ensure the deficient practice is corrected and compliance sustained Audits will be reviewed by facility QAPI Committee monthly for development of further plan of action of required Date the deficient practice correction will be completed 3/17/17 Individual responsible for correction of the deficient practice The Administrator is responsible for correction of the deficient practice	

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F 314	Continued From page 27 Resident #6's Skin Grid documented on 12/27/16 the resident developed three Stage II pressure ulcers to the right and left buttocks. -Wound #1-Right buttock: *12/27/16- Stage II, 5.0 (length) X 2.5 (width) X 0.1 (depth) cm, red/pink, *1/8/17- 5.5 X 4.0 X 0.2 cm, Note: This assessment was completed 12 days after the pressure ulcer was discovered. *1/19/17- 4.0 X 3.0 X 0.1 cm, bloody drainage, Note: This assessment was completed 11 days after the previous assessment. *1/21/17- 5.75 X 3.5 X 0.1 cm, slowly healing. There were no more documented assessments of the wound until 2/9/17. -Wound #2-Left buttock: *12/27/16- Stage II, 5.5 X 5.5 X 0.3 cm, red/pink, *1/8/16- 5.5 X 2.5 cm, This assessment was completed 12 days after the pressure ulcer was discovered. *1/19/17- 4.5 X 2.0, bloody drainage, This assessment was completed 11 days after the previous assessment. *1/27/17- 4.0 X 0.5, almost closed. There were no more documented assessments of the wound until 2/9/17. -Wound #3-Left buttock: *12/27/16- Stage II, 1 X 1 X 0.3 cm, pink/red, *1/8/17- 2.75 X 1.5 X 0.2, The assessment was completed 12 days after the pressure ulcer was discovered. *1/19/17- 2.0 X 1.0 cm, small amount of blood, This assessment was completed 11 days after the previous assessment. *1/21/17- 0.5 X 0.5 cm, almost closed.	F 314		

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F 314	Continued From page 28 There were no more documented assessments of the wound until 2/9/17. Resident #6's care plan did not include new interventions after the three pressure ulcers developed. Resident #6's progress notes documented, *1/3/17- "Wounds to both buttocks, cleansed, Silvadene applied and non-adhere foam dr[essin]g to both." No order was found for treatment of the left buttock wounds until 1/8/17. *1/4/17- "Wounds to R/L [right/left] buttocks, cleansed, applied Silvadene and non-adhesive foam." Resident #6's fax to the physician dated 1/5/16, documented: "Both of [Resident #6]'s butt cheeks are breaking down again. I have orders for his Right Buttock, but not the left, and the order I have is for Silvadene and to cover with Mepilex. Anything with even a slight adhesive is pulling skin off. Can we have an order as stated below instead?" The physician's order section, dated 1/6/17, documented, "Buttock Wounds: Gently clean with saline, pat dry, apply Silvadene and cover with a non-adhesive foam dressing daily and PRN until resolved." The physician documented, "OK." The facility nurse order review section was signed on 1/8/17. Resident #6's January and February 2017 TARs document a 1/8/17 order, "Buttock Wounds: Gently clean with saline, pat dry, apply Silvadene	F 314		

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F 314	Continued From page 29 and cover with a non-adhesive foam dressing daily and PRN until resolved." On 2/7/17 at 8:45 am and 10:55 am, on 28/8/17 at 8:50 am and 1:40 pm, and on 2/9/17 at 8:40 am, Resident #6 was observed in his room and in his wheelchair with a Roho cushion. On 2/8/17 at 8:50 am, Resident #6 was in his wheelchair in his room and said staff did not ask him to lay down after breakfast and said he might lay down if they had asked him. He said he did not remember if staff had ever educated him about the importance of laying down between meals. At 4:35 pm, Resident #6 was in his wheelchair at the dining room table and said he had been up in his wheelchair all day and he did not remember if staff ever offered to lay him down that day. He said since dinner was coming up, there was no reason to lay down until after dinner. On 2/9/17 at 8:45 am, LN #7 said Resident #6 did not always want to lay down when asked, but was not sure if the refusals were documented. On 2/9/17 at 2:30 pm, a surveyor and LN #3 observed Resident #6's pressure ulcers. LN #3 said wound #1 to the right buttock measured 5.5 (length) X 3.0 (width) cm and appeared bloody. LN #3 said wound #2 to the left buttock measured 1.5 X 1 cm with a pink clean wound bed. LN #3 said wound #3 to the left buttock measured 0.5 X 0.5 cm with a pink clean wound bed. Resident #6's 2/9/17 Skin Grid documented wound #1 measured 5.0 X 3.0 cm and wound #3 measured 0.3 X 0.3 cm.	F 314		

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F 314	Continued From page 30 On 2/9/17 at 3:35 pm, the DNS and RCM #2, with the Regional Support Nurse present, said the pressure ulcers most likely developed because Resident #6 was up in his wheelchair too long and he did not always like to lay down. The DNS said the care plan did not direct staff to educate the resident if he refused to lay down and Resident #6's medical record did not document where education to the resident had been provided and could not find documentation of Resident #6's refusals. The Regional Support Nurse asked RCM #2 if the facility had implemented a deviation of care for Resident #6's refusals and RCM #2 said she had not. RCM #2 said the physician was not notified of the pressure ulcers until the fax on 1/5/17. The DNS said there were no interventions implemented after the breakdown until the 1/8/17 order for wound dressings was initiated and no other interventions were put into place. RCM #2 said the last measurement of the pressure ulcers was completed on 1/21/17 and said progress notes documented the wounds were improving, but the notes did not include characteristics of the ulcers. The DNS said the assessments were not completed timely to make sure the ulcers were healing properly or if new interventions needed to be tried. On 2/9/17 at 5:30 pm, the DNS provided the surveyor a document titled "Informed Consent Identifying Risks For Deviation In The Recommended Plan Of Care" which was signed by Resident #6 and dated 11/5/12. The consent documented Resident #6's buttock wound might not resolve and could worsen if he did not lay down between meals. The DNS said the form had not been updated or revised because	F 314		

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F 314	Continued From page 31 nothing had changed since then. The DNS said Resident #6 redeveloped a Stage II pressure ulcer to the right buttock. The facility failed to ensure Resident #6 did not develop two Stage II pressure ulcers and did not redevelop a Stage II pressure ulcer. Resident #6 had not been educated on the importance to lay down to relieve pressure. Interventions were not implemented in a timely manner after the pressure ulcers developed and assessments were not completed timely to determine if the plan of care needed to be altered. 2. Resident #4 was admitted to the facility on 9/7/15, with diagnoses including congestive heart failure. Resident #4's quarterly MDS assessment, dated 12/18/16, a BIMS score of 7 out of a possible score of 15, indicating she was severely cognitively impaired. Resident #4 required extensive assistance of one staff person with bed mobility, transfer, dressing, toilet use and personal hygiene. The assessment documented Resident #4 was, "at risk for pressure ulcers." No unhealed pressure sores were identified. During the tour with the SDC on 2/6/2017 at 2:10 pm, Resident #4 was observed to have labored breathing and was non-responsive to the SDC. When queried regarding the care and services being provided to Resident #4, the SDC responded that Resident #4 "declined. I don't know what's being done for her. Her mouth is dry and we've been trying to keep it moist." Resident #4 was observed on 2/7/17 at 10:30 am during incontinence care provided by CNA #3 and CNA #4. She was observed to have redness	F 314		

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F 314	Continued From page 32 and excoriation from the anus expanding 2 inches to both buttocks and covering all areas within the 2 inches. At the time of the observation CNAs #3, #4 and #5, who were responsible for providing care for Resident #4, stated they did not have "specific care instructions for Resident #4." They said they were "turning and repositioning her every 2 hours." According to the CNAs, they were not aware of the excoriated areas to Resident #4's buttock. Resident #4's Skin Grid for All 'Other' Skin Problems did not include documentation of the reddened and excoriated anal area and buttocks. During an interview with LN #3 at 3:30 pm, LN #3 stated, "There are no other skin sheets for her. She does not have a pressure ulcer. We are not putting anything on her buttocks. There is nothing on the TAR." Resident #4's current Care Plan did not include documentation of the reddened and excoriated anal area and buttocks. An Approach with the start date 12/11/12 documented, "Report any signs of skin breakdown (sore, tender, red or broker areas)." Resident #4's Physician Order Report included an order with a start date of 9/10/15, for "Weekly Skin Checks." The Report did not include an order for Resident #4 addressing the redness and excoriated anal area and buttocks. On 2/8/17 at 2:50 pm, Resident #4's skin was observed in the presence of the DNS. There was white cream covering the reddened excoriation on Resident #4's anal area and buttocks. The DNS stated she did not know what the white	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135103		02/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE & REHABILITATION - THE ORCHARDS	1014 BURRELL AVENUE LEWISTON, ID 83501

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F 314	Continued From page 33 cream was as she did not put it on. The DNS said Resident #4's anal and buttocks area was getting better. At 4:50 pm on 2/9/17, LN #3 was asked about the white cream on Resident #4's reddened and excoriated anal area and buttocks. She stated she had looked at the area with a flashlight on 2/8/17, and there was no reddened area or excoriation. A Progress Note, dated 2/8/17 at 10:42 by LN #3, documented Resident #4's skin was intact no open or red areas were noted to the buttocks or peri area." At 5:00 pm on 2/9/17 the DNS said she did not know the physician was notified of Resident #4's the red and excoriated area or if orders were received to treat the area. On 2/9/17 5:20 pm, the DNS provided a copy of a request for a physician's order for "barrier cream after each noted incontinent episode and PRN," dated 2/8/17, to be faxed to the attending physician. The facility's Policy and Procedure on "Skin at Risk/Skin Breakdown," dated 1/2016, documented, "A full body skin audit will be completed weekly by the LN. Completion of the skin audit will be documented on the Treatment Administration Record (TAR) with their initials..."	F 314		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free	F 323		3/17/17

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PRESTIGE CARE & REHABILITATION - THE ORCHARDS	1014 BURRELL AVENUE LEWISTON, ID 83501

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F 323	Continued From page 34 from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (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, and resident and staff interviews, it was determined the facility failed to ensure resident rooms were as free from accident hazards as possible. The facility failed to ensure resident rooms were free from trip hazards in 5 of 19 rooms in the 300 hallway (Rooms 301, 303, 307, 309 and 319). This had the potential for physical harm if holes in the floors and anti-trip strips were not repaired. Findings include: On 2/7/17 at 9:00 am and 9:45 am, the following resident rooms were observed: *Room 301 had a nine-inch long by three-inch	F 323	The 9inch long by 3inch wide by a quarter inch deep hole in the floor between the first bed and the wall in Room 301 has been repaired; the peeled up rubber anti-trip strips on the floor in front of a recliner in Room 303 have been removed/ repaired; the 4inch section of cracked floor linoleum in the center of Room 307 has been repaired; the 2inch long by 3inch wide by a quarter inch deep hole in the floor near the bed in Room 309 has been repaired; the cracked linoleum on the floor in Room 319 has been repaired	

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F 323	Continued From page 35 wide by a quarter-inch deep hole in the floor between the first bed and the wall, *Room 303 had peeled-up rubber anti-trip strips on the floor in front of a recliner, *Room 307 had a four-inch section of cracked floor linoleum in the center of the room, *Room 309 had a two-inch long by three-inch wide by a quarter-inch deep hole in the floor near the bed, and *Room 319 had cracked linoleum on the floor. On 2/7/17 at 9:45 am, Resident #6 was observed in Room 301 in a wheelchair with the hole in front of the left front wheel. Resident #6 said he did not have a concern with the hole in his floor as long as he backed into the area between the wall and the bed, so when he left he would have enough momentum to roll over the hole with his wheelchair. On 2/7/17 at 11:00 am, the Maintenance Director said the flooring in rooms 301, 307, 309 and 319 needed to be repaired and the anti-trip strip in room 303 needed to be tacked down.	F 323	How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All resident rooms have the potential to be affected by the deficient practice; the facility Maintenance Director has completed an audit of all resident rooms and developed a schedule of maintenance based on that audit to repair holes in flooring/linoleum, peeled up rubber anti-trip strips, and cracked linoleum What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur Facility Administrator has provided 1:1 in-service to Maintenance Director regarding his role in ensuring a safe, clean, comfortable, home-like environment as free from accident hazards as possible; Maintenance Director will review progress of developed maintenance schedule to address the deficient practice weekly x3 months with the Administrator to ensure on-schedule repairs of holes in linoleum, cracks in linoleum, and peeled up rubber anti trip strips How will the corrective action be monitored to ensure the deficient practice is corrected and compliance sustained Maintenance Director will review developed schedule of maintenance to address the deficient practice in the	

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F 323	Continued From page 36	F 323	facility QAPI Committee monthly x6 months with further action plan if required Date the deficient practice correction will be completed 3/17/17 Individual responsible for correction of the deficient practice The Administrator is responsible for correction of the deficient practice	
F 364 SS=E	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interviews, test tray evaluation and staff interviews, it was determined the facility failed to serve food at a palatable temperature. This affected 1 random resident (#18) and 2 residents who wished to remain anonymous, and had the potential to affect all residents who dined in the facility. This failed practice created the potential to negatively affect residents' nutritional status and psychosocial well-being related to unpalatable food. Findings include: Resident Council minutes, dated 1/30/17,	F 364	What corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #18 no longer resides at facility How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All facility residents have the potential to be affected by the deficient practice; Cook #3 was provided 1:1 in-service regarding	3/17/17

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F 364	Continued From page 37 documented a concern with the temperature of hot foods. On 2/6/17 at 5:15 pm, a resident who wished to remain anonymous said the food was "not very good," hot foods were not always served hot, tater tots and french fries were cold and toast was not always toasted. On 2/7/17 at 9:00 am, a resident who wished to remain anonymous said food was not always served hot and was not flavorful. On 2/7/17 at 10:15 am, Resident #18 said the coffee was lukewarm, hot foods were cold and the food had "no flavor." On 2/8/17 during the tray line observation from 12:14 pm to 12:24 pm, the CDM was observed removing 15 heated metal plate pellets from the pellet warmer and place them, uncovered, inside a plastic plate holder, which were then placed on meal trays inside an opened metal tray cart. Meals were plated by Cook #3, placed on the metal pellets, and then covered with a plastic cover. At 12:22 pm, one of the uncovered pellets was not warm to the touch. On 2/8/17 at 1:25 pm, a lunch meal test tray was evaluated by two surveyors with the CDM and RD present. The test tray included coffee, lasagna, garlic bread, tater tots, salad, and mixed fruit. The lasagna had a temperature of 124.5-degrees F. The RD and CDM said "the lasagna could have been hotter." The tater tots had a temperature of 104-degrees F. The CDM said the tater tots could be "crispier." The RD said the garlic bread could have been hotter. It	F 364	the proper use of plate warmer What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur DSM has provided education / in-service to all dietary personnel regarding the proper use of plate warmer and their responsibility in providing food that is palatable, attractive, and at a safe and appetizing temperature How will the corrective action be monitored to ensure the deficient practice is corrected and compliance sustained DSM or designee will audit weekly to ensure compliance with plate warmer procedure in the serving of meals; assigned Dining Room Monitor will audit test tray weekly to ensure food is palatable and flavorful; designated Orchard Angels will interview assigned residents monthly x3 to assess for meal satisfaction and palatability; DSM will review all audits with the facility QAPI Committee monthly x3 to ensure compliance and develop further plan of action if required Date the deficient practice correction will be completed 3/17/17 Individual responsible for correction of the deficient practice The Administrator is responsible for correction of the deficient practice	

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F 364	Continued From page 38 was determined the lasagna was not hot enough, the tater tots were mushy and not hot, the garlic bread was not toasted enough and the food was not palatable. On 2/9/17 at 12:03 pm, the metal plate pellets were observed in a similar fashion as the previous day's observation, with the RD and CDM present. The RD touched one of the pellets located inside the plastic plate holder on a tray in the tray cart and said the pellet was not hot. Five plates were observed out of the plate warmer, stacked on top of each other and sitting on the counter next to Cook #3, who then used those plates to serve meals one at a time. At 12:10 pm, this was brought to the attention of the RD and CDM and the RD said the plates should be taken out of the plate warmer one at a time and just prior to plating each meal. The CDM said cooks would burn their hands if they took pellets out one at a time and Cook #3 said he typically took out several plates at the same time, rather than one at a time.	F 364		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility;	F 425		3/17/17

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F 425	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and record review, it was determined the facility failed to obtain from the pharmacy correct medication dosages for 1 of 10 residents (Resident #11) observed during medication pass. This deficient practice created the potential for more than minimum harm if residents received either excessive or inadequate dosages of physician-ordered medications. Findings include: February 2017 Physician Orders documented Resident #11 was to receive Albuterol Sulfate solution for nebulization, 0.63 mg/3 ml three times a day. On 2/7/17 at 4:16 pm, LN #4 was observed administering Albuterol Sulfate 2.5 mg/3 ml solution via nebulizer to Resident #11. On 2/8/17 at 4:22 pm, LN #4 stated the Albuterol Sulfate 2.5 mg/3 ml was available and administered via nebulizer to Resident #11 rather than the physician-ordered 0.63 mg/3 ml Albuterol Sulfate, which was not available in the facility. LN #4 said she was unaware the Albuterol Sulfate was not the correct dosage and had not notified the pharmacy or reported the wrong dosage had been administered to Resident #11.	F 425	What corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #11 is now receiving the correct dosage of Albuterol Sulfate solution for nebulization; physician and pharmacy were notified How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents who currently are prescribed Albuterol Sulfate solution for nebulization have the potential to be affected by the deficient practice; facility completed audit of residents who receive Albuterol Sulfate solution for nebulization to ensure correct dose being administered; no further issues noted What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur LN□s have been provided education / in-service regarding the proper dosing and administration of Albuterol Sulfate solution for nebulization and pharmacy notification if required dosage is not available How will the corrective action be monitored to ensure the deficient practice is corrected and compliance sustained	

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F 425	Continued From page 40	F 425	DNS or designee will complete audit weekly x4 then monthly x3 to ensure compliance with dosage , administration, and pharmacy notification if required for Albuterol Sulfate solution for nebulization; audits will be reviewed with facility QAPI Committee monthly x4 to ensure compliance and develop further plan of action if required Date the deficient practice correction will be completed 3/17/17 Individual responsible for correction of the deficient practice The Administrator is responsible for correction of the deficient practice	
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview and policy review, it was determined staff were not able to describe what steps they would take to safely assist residents from the facility in the event of a fire. This was true for 2 of 4 staff interviewed (CNA #4 and LN #3) on emergency preparedness and had the potential to harm resident in the facility requiring the assistance of these two staff members in an emergency situation involving fire. Findings include:	F 518	What corrective action will be accomplished for those residents found to have been affected by the deficient practice Staff has been provided education / in-service regarding what steps to take to safely assist residents from the facility in the event of a fire How will the facility identify other	3/17/17

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F 518	Continued From page 41 The facility's undated "Fire" policy directed staff to take the following steps in the event of fire: Rescue residents, contain the area of the building in which there was fire, evacuate residents, "or" extinguish the flames and relocate residents. On 2/9/17, when asked, "What would you do if there was fire in Room 310?" CNA #4 stated she was unable to name where facility fire alarms were located, and LN #3 responded, "They never really told us what to do with the residents."	F 518	residents having the potential to be affected by the same deficient practice and what corrective action will be taken All facility residents have the potential to be affected by the deficient practice; Staff has been provided education / in-service regarding what steps to take to safely assist residents from the facility in the event of a fire What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur Administrator has provided 1:1 education to facility Safety Coordinator and facility Staff Developer regarding their role in the ongoing education of staff regarding fire policy and ensuring staff aware of steps they would take to safely assist resident from the facility in the event of a fire; facility Safety Coordinator and facility Staff Developer will work together in the continued provision of monthly fire drills, staff education upon hire, during fire drills, and annually to ensure staff awareness of fire policy and procedures to minimize potential for resident harm in event of a fire emergency How will the corrective action be monitored to ensure the deficient practice is corrected and compliance sustained Facility Safety Coordinator and facility Staff Developer will perform audits / random employee interviews weekly x 3 then monthly x3 to ensure staff awareness of fire policy and procedures	

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PRESTIGE CARE & REHABILITATION - THE ORCHARDS	**1014 BURRELL AVENUE** **LEWISTON, ID 83501**

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F 518	Continued From page 42	F 518	to minimize potential for resident harm in event of a fire emergency; facility Safety Coordinator and/or Staff Developer will review audits with facility QAPI Committee monthly x3 to develop further plan of action if required Date the deficient practice correction will be completed 3/17/17 Individual responsible for correction of the deficient practice The Administrator is responsible for correction of the deficient practice	

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
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April 21, 2017

Candice Durham, Administrator
Prestige Care & Rehabilitation-- The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

Dear Ms. Durham:

On **February 10, 2017**, an unannounced on-site complaint survey was conducted at Prestige Care & Rehabilitation - The Orchards. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted February 6, 2017 to February 10, 2017.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007329

ALLEGATION:

The Reporting Party said the facility made residents remove their personal refrigerators from their rooms.

FINDINGS:

Several residents' personal refrigerators were observed throughout the facility.

Resident Council minutes for July 2016 documented a concern over refrigerators had been resolved. A July 2016 letter from the facility Administrator to residents and families regarding personal refrigerators documented personal refrigerators were allowed and did not need to be removed as indicated in a previous letter.

Several residents with personal refrigerators were interviewed and said once they let staff know they wanted to keep their refrigerators, they were allowed to keep them in their rooms and staff continued to clean them and record temperatures. Several residents in the Group meeting said they had no concerns regarding refrigerators issues. The Administrator said the facility had trouble in the past maintaining cleanliness and proper temperature of the refrigerators and the facility already had refrigerators on each unit, which residents could use. The Administrator said the facility initially sent out letters to residents and family members regarding the removal of personal refrigerators, but when residents complained the facility rescinded the plan and residents were able to keep their personal refrigerators in their rooms.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

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

DS/lj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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April 24, 2017

Candice Durham, Administrator
Prestige Care & Rehabilitation-- The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

Dear Ms. Durham:

On **February 10, 2017**, an unannounced on-site complaint survey was conducted at Prestige Care & Rehabilitation - The Orchards. Three investigators conducted an onsite investigation from February 6, 2017 February 10, 2017. Fourteen residents were reviewed in the sample. Numerous observations were made throughout the facility. Interviews were conducted with four residents, the Ombudsman, ten staff members, and three family members. Resident Council Minutes for the previous six months were reviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007301

ALLEGATION #1:

The facility failed to ensure Physical Therapy and Occupational Therapy services were provided as ordered.

FINDINGS:

The investigation determined the resident was admitted with orders for Physical Therapy and Occupational Therapy services and was promptly evaluated and provided these services. Current residents with orders for therapies were receiving services as needed.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility failed to ensure timely and appropriate incontinent care was provided.

FINDINGS:

The investigation determined the resident was offered toileting assistance on several occasions by staff. The resident said staff were available when she needed them and they assisted her to the bathroom. The resident voiced no complaints about the care she received. No incontinent episodes were noted during this investigation for this resident. Current residents were observed with no odors or concerns noted with incontinent care provided by staff.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility failed to ensure an identified resident was fed despite the resident's wishes not to eat.

FINDINGS:

The investigation determined the resident ate most meals in the dining room with set-up assistance only. On one occasion the resident wanted to eat in her room and her meal was provided to her in her room. The resident said she could eat in her room when she wanted and in bed or in her chair. She voiced no complaints about staff treatment. Current residents were observed during three meal services with no concerns.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility failed to provide baths more than once a week.

FINDINGS:

The investigation determined the resident was satisfied with her baths/showers and hygiene requirements were to her preferences. Staff interviews and bathing documentation for this resident revealed she refused baths/showers on most occasions, but would accept a bath/shower every one to two weeks. Staff said the resident allowed them to cleanse her with no rinse soap on a wash cloth several times a week. The resident's preferences were honored. Although the allegation could not be substantiated for the resident named in the complaint, the allegation was substantiated for another resident in the sample and deficiencies were written.

The facility was cited with deficient practice F312. Please refer to Federal 2567 Report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

The facility failed to ensure corrects diet were served.

FINDINGS:

The investigation determined the resident had an ostomy and that she believed she was diabetic. Review of the clinical record, including physician orders, progress notes, and laboratory results, did not support a diagnosis of diabetes. Nursing staff said the resident exhibited no signs/symptoms of diabetes although she and her family member said she was diabetic. The resident was currently on a low-residual diet, which the dietician said was required due to the resident's history of issues with her ostomy. The resident received half portions at lunch and dinner due to unwanted weight gain. The dietician said there were multiple diet changes for this resident at the resident's request. The resident did not eat 100% of any meal, but stated she always had enough to eat. She voiced no complaints about her diet. Current residents were observed during three meal services with no concerns about their diets.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The facility failed to ensure residents' uneaten food was removed from their rooms.

FINDINGS:

The investigation determined the resident should not have nuts on a low residual diet, but could have candy. The resident said she could not eat nuts, but did occasionally have a bite size candy that the nurses kept for her. A nurse was observed offering the resident a bite size candy after a meal and the resident refused. There were no nuts or candy visible in the resident's room. There was documentation in the chart of an incident in which the resident's family member visited and two cans of nuts were discovered in the resident's room afterward. The nuts were removed and returned to family. Current residents voiced no complaints related to staff honoring their request.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The facility failed to ensure there was proper space between residents' beds.

FINDINGS:

The investigation determined there was more than the required square footage in the resident's room. The resident voiced no complaint about the arrangement of her room. The roommate had a fall mat beside her bed, which was not near the identified resident's bed. Staff said the roommate had the floor mat due to a history of falls, but no recent falls had occurred from bed. Staff said the roommate did not sleep on the mat. Current residents were provided required living space in their rooms.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

The facility failed to ensure living areas were kept clean and sanitary.

FINDINGS:

The investigation determined the resident's room and bathroom were clean and no feces was observed. The resident's toiletries, including deodorant and denture cup, were in a plastic basket in her room and appeared clean. The resident said her room was clean and had no complaints. Current resident rooms were clean and no complaints were voiced related to housekeeping services.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #9:

The facility failed to ensure residents were dressed in clean rather than soiled clothing.

FINDINGS:

The investigation determined the resident had clean clothes available and was groomed with no odors. The resident said the facility did her laundry and that she was satisfied with the arrangement. Staff said when the resident was admitted the family was to do laundry, but other arrangements were made when the resident did not have clean clothes to wear. The resident's clothes were sent to the facility laundry and the family became upset. At this time the family was not allowed at the facility due to a restraining order. Current residents were observed well-groomed and wearing clean clothes.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION#10:

The facility failed to ensure the roof did not leak during rain storms.

FINDINGS:

The investigation determined the facility had a leaking roof in May 2016. Staff said the building was old and the flat roof sloped to the center and flooded interior hallways. Roof repair were begun the previous summer and were completed except over one hall that required more extensive work and which was currently closed to residents. No leaks were noted during survey, during which snow and rain fell. Residents did not express any concerns related to the roof leaks.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #11:

The facility failed to ensure residents had access to the doctor and/or dentist of their choice.

FINDINGS:

The investigation determined the resident visited a physician outside the facility during survey. The resident said the appointment was only an introductory meeting and that she had a tooth pulled recently by a dentist she liked. Staff said residents could choose the doctor or dentist they wanted as long as the doctor/dentist agreed to treat them. Staff said there was a doctor retiring soon and letters had been sent to resident/family, who could choose a new doctor. The medical director would assume care of residents until a new physician had been selected by the resident or interested party. Current residents voiced no complaints related to physician choice during this investigation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #12:

The facility failed to ensure an identified resident was provided with ostomy-appropriate food, which caused the resident to reguritate.

FINDINGS:

The investigation determined the resident had an ostomy and experienced three episodes of vomiting in one day in May 2016. The physician was notified and antiemetic medication was administered. The resident was placed on a liquid diet for one week and solid foods were slowly reintroduced. There were no other issues involving the ostomy at this time, nor was there documentation of the resident vomiting fecal matter. The resident was on a low-residual diet, which the dietician said was equired due to a history of problems with the ostomy. Current residents were receiving physician-ordered and appropriate diets.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #13:

The facility failed to transfer a resident to the emergency room when the resident was experiencing vomiting from a blockage.

FINDINGS:

The investigation determined the resident had an ostomy and three episodes of vomiting in one day of May 2016. The physician was notified and antiemetic medication was administered. The resident was

placed on a liquid diet for one week and solid foods were slowly reintroduced. There were no other issues involving the ostomy at this time. There was no documentation of the resident having physician orders to transfer to the emergency room or a need to go to the hospital. Current residents were sent to the hospital as ordered by the physician and/or as needed.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #14:

The facility failed to allow family member to transport an identified resident to external medical appointments.

FINDINGS:

The investigation determined the facility refused to allow a family member to transport the resident to medical appointments at the request of the resident's physician. In July 2016, the resident had a court appointed guardian who was not the family member. At this time the family member was no longer allowed to come to the facility. The resident reported to facility staff and counseling services that this family member was abusive toward her. Current residents voiced no complaints related to medical appointments.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #15:

The facility failed to ensure the identified resident's toileting needs were met.

FINDINGS:

The investigation determined the resident was offered toileting assistance on several occasions by staff. The resident said staff were available when she needed them and they assisted her to the bathroom. She voiced no complaints about the care she received. No incontinent episodes were noted during this investigation for this resident. Current residents were observed with no odors and assisted as needed.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #16:

The facility failed to ensure a court-appointed guardian was making decisions for the resident.

FINDINGS:

The investigation determined the resident's family member was the guardian when the resident was admitted. This status changed, however, with the court appointing a guardian for the resident in July 2016. The family member in who had been the guardian was no longer allowed at the facility at this time. The court-appointed guardian made decisions for the resident, but the facility had no control over from whom the guardian sought input on matters affecting the resident. Current residents were able to make their own choices with assistance of family/guardians.

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,

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

DS/lj