



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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3232 Elder Street
P.O. Box 83720
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March 8, 2017

Joe Rudd, Administrator
Life Care Center of Boise
808 North Curtis Road
Boise, ID 83706-1306

Provider #: 135038

Dear Mr. Rudd:

On **February 23, 2017**, a survey was conducted at Life Care Center Of Boise by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 20, 2017**. Failure to submit an acceptable PoC by **March 20, 2017**, may result in the imposition of penalties by **April 12, 2017**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 30, 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 24, 2017**. A change in the seriousness of the deficiencies on **April 9, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **May 24, 2017** includes the following:

Denial of payment for new admissions effective **May 24, 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 22, 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 24, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **March 20, 2017**. If your request for informal dispute resolution is received after **March 20, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

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

PRINTED: 04/14/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/23/2017
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706		
(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 from February 21, 2017 to February 23, 2017. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Brad Perry, LSW Sheila Sizemore, RN Melanie Tatom, RN Abbreviations include: ADON = Assistant Director of Nursing BG = Blood Glucose CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease CPAP = Continuous Positive Airway Pressure DNS = Director of Nursing Services GDR = Gradual Dose Reduction LPN = Licensed Practical Nurse LN = Licensed Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set mg = Milligrams NP = Nurse Practitioner PO = By Mouth PRN = as needed RN = Registered Nurse UTI = Urinary Tract Infection	F 000			
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each	F 241		3/30/17	

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

TITLE

(X6) DATE

Electronically Signed

03/18/2017

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 241	<p>Continued From page 1</p> <p>resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record reviews, and staff interview, it was determined the facility failed to protect residents dignity by covering catheter drainage containers with a privacy bag. This was true for 2 of 3 residents (#1 and #7) observed with indwelling catheters. This created the potential for residents to experience embarrassment and diminished self-esteem. Findings include:</p> <p>1. Resident #1 was admitted to the facility with diagnoses that included end stage multiple sclerosis, quadriplegia, and adult failure to thrive. The resident had an indwelling Foley catheter related to a sacral pressure ulcer.</p> <p>On 2/21/17 at 9:55 am, 12:25 pm, and 2:50 pm, Resident #1's catheter drainage bag was observed hanging from the bed frame without a privacy bag in place.</p> <p>On 2/22/17 at 7:40 am and 3:40 pm, Resident #1's catheter drainage bag was observed hanging from the bed frame without a privacy bag in place.</p> <p>On 2/22/17 at 3:40 pm, the facility's Wound Nurse and CNA #1 were interviewed in Resident #1's room with the exposed catheter drainage bag in view. Both staff members stated Resident #1's catheter drainage bag should have have</p>	F 241	<p>This Plan of Correction required under Federal and State Regulations and statutes applicable to long-term care providers. This Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.</p> <p>Additional Abbreviations: Daily = Monday through Friday (with regard to audits) DX = Diagnosis UM = Unit Manager SDC = Staff Development Coordinator QA = Quality Assurance</p> <p>F 241</p> <p>Corrective Action: 1.Catheter Bag for Resident #1 has been covered. Covers installed on each side of bed. Resident's Care Plan updated for checks of catheter bag cover for being in</p>		

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F 241	Continued From page 2 been covered with a privacy bag. 2. On 2/21/17 at 7:45 am, Resident #7 was observed asleep in bed. From the hallway through the open door an uncovered catheter bag with urine in it was observed on the floor near Resident #7. On 2/21/17 at 7:50 am, RN #1 when shown Resident #7's catheter bag and said the catheter bag was not to be on the floor. RN #1 donned gloves and placed the bag and tubing inside of a privacy bag attached to Resident #7's bed. On 2/23/17 at 2:25 pm, the DNS said the catheter bag should have been inside the privacy bag and not on the floor.	F 241	place and off the floor each shift. 2. Catheter Bag for Resident #7 covered immediately. Resident's Care Plan updated for checks of catheter bag cover being in place and off the floor each shift. Identification: 1. All residents with catheter bags are identified as potentially being affected. 2. 100% of residents with catheter bags have been reviewed to ensure covers are in place. Care Plans also reviewed and updated as needed. Systemic Changes: 1. Inservice provided to LN and CNA staff on Resident Dignity with regard to covering catheter bags and ensuring they are not on the floor. 2. Inservice provided to DNS, Unit Managers, and SDC with regard to Care Plan policy and procedure. Monitor: 1. UM to conduct audit of residents with catheter bags to ensure they are covered and off the floor. 2. Audits to begin on 3/15/2017, and will continue at the following frequencies: Daily x two (2) weeks Weekly x six (6) weeks Monthly x 90 days 3. Administrator to review audits and report findings to QA Committee		
F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	F 252		3/30/17	

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F 252	<p>Continued From page 3</p> <p>(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.</p> <p>§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-</p> <p>(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to ensure the environment was maintained in a clean, comfortable, and home-like manner. This was true for 2 of 2 therapy rooms, 2 of 4 dining rooms, 3 of 3 units (100, 200 and 300), 1 of 2 lounges, 1 of 3 shower rooms, and the front lobby. This deficient practice had the potential to cause harm should the condition of the facility cause residents embarrassment, sadness, depression, or other adverse reactions to a less-than clean and homelike environment.</p>	F 252	<p>F 252</p> <p>Corrective Action: 1. Areas in Front Lobby identified in 2567 have been patched and painted. 2. Paint Splatter from shelf in Room #101 has been removed. 3. Bathroom door in Room #101 has been replaced. 4. Scuff marks on bathroom door in Room #108 have been removed. 5. Buildup of dirt and wax in Room #108</p>		

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F 252	<p>Continued From page 4</p> <p>Findings include:</p> <p>During the initial environmental tour conducted on 2/22/17 at 2:00 pm with the Maintenance Director and the Housekeeping Director, the following concerns were observed:</p> <p>1. In the front lobby, there were three areas of missing paint approximately 8 inches, 6 inches and 2 inches on the wall next to the door.</p> <p>2. In the 100 Unit the bathroom corner shelf in Room 101 was observed with numerous white paint splatters on the shelves, and the bathroom door was scuffed and marred from the door knob to the bottom of the door. In Room 108, the bathroom door had numerous scuff marks on the lower portion of the door, and there was a build-up of dirt and wax in the bathroom entry way. The Housekeeping Director stated a floor tech would remove the wax and dirt build-up. In front of Room 112 were 20 unclean and discolored tiles, of which the Housekeeping Director stated, "We need to strip and wax the floor." Lastly, the wastepaper basket in Room 121's bathroom was overflowing with used toilet paper. The Housekeeping Director said it was a little overflowing.</p> <p>3. In the therapy rooms, the plaster on the wall above the P-tac heater/air conditioner unit had crumbled and fallen into the vent of the P-tac Unit, and the bottom of the adjustable table was unclean and dusty. The Housekeeping Director stated the bottom of the table had not been cleaned.</p> <p>4. In the 200 Unit, the corner of Room 218 was</p>	F 252	<p>has been removed.</p> <p>6. Tiles in front of Room #112 have been stripped and waxed.</p> <p>7. Waste basket in Room #121 was emptied during environmental tour.</p> <p>8. Plaster on walls of Therapy Gym have been patched and painted.</p> <p>9. PTAC unit in Therapy Gym cleaned.</p> <p>10. Adjustable table in Therapy Gym cleaned.</p> <p>11. Dirt build up under sink in Room #218 removed.</p> <p>12. Vent in Room #218 cleaned.</p> <p>13. Floor areas identified as Station 2 exit doors have been cleaned and waxed.</p> <p>14. Kick board identified in 2567 as between Room #206 and Dietary Department office has been refinished.</p> <p>15. Blinds in Room #210 have been cleaned.</p> <p>16. Walls in Room #206 have been cleaned.</p> <p>17. Area in Shower Room identified in 2567 as missing plaster surrounding the shower vent has been patched and painted.</p> <p>18. Vents in 300 Unit restrooms have been replaced.</p> <p>19. Privacy curtain in Room #301 has been replaced.</p> <p>20. Microwave identified as hallway microwave oven has been cleaned.</p> <p>21. Table in 300 Unit Dining Room has been cleaned.</p> <p>22. Two corner cabinets in Main Dining Room identified as missing veneer and chips in the wood have been removed from the facility.</p>		

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F 252	<p>Continued From page 5</p> <p>observed with a build-up of dirt under the sink and the vent in the bathroom was dirty and dusty. The Housekeeping Director stated the type of mop heads used to clean the floors pushed dirt into the corners, and noted he could observe cobwebs on the vent. At Station 2, the exit doors were dirty and scuffed. The Housekeeping Director stated he would place the area on the floor on the tech's list of items to clean every day.</p> <p>Also in the 200 Unit, the kickboard above the cove base between Room 206 and the Dietary Department was missing veneer, which the Maintenance Director acknowledged, and the window blinds in Room 210 were dirty and dusty. The Housekeeping Director stated Room 201 "had been neglected." When shown a brown substance in Room 206 on the wall beside the bed, the Housekeeping Director stated he did not know what it was.</p> <p>5. In the shower room, when shown an area of missing plaster surrounding the shower vent, the Maintenance Director stated, it looked like it needed to be patched and painted.</p> <p>6. In the 300 Unit, when shown a dusty and dirty vent in the women's and men's restrooms, the Housekeeping Director stated both vents should be cleaned by the housekeeping staff. The privacy curtain in Room 301 was soiled with a red substance, and the hallway microwave oven had food splatters on the inside and outside surfaces. The Housekeeping Director stated the microwave was to be checked every day.</p> <p>7. In the 300 Unit Dining Room, the middle table was observed with dried milk splatters over the</p>	F 252	<p>23. Vent in Main Dining Room identified in 2567 as being dusty and dirty has been replaced.</p> <p>24. White substance behind fish tank in 300 Unit has been removed.</p> <p>Identification: 1. All residents are identified as potentially being affected.</p> <p>Systemic Changes / Measures: 1. Inservice provided to facility staff regarding identifying and reporting areas that need cleaning and/or repair, in the resident's physical environment, to the facility Maintenance and Housekeeping departments. 2. Inservice provided to Housekeeping and Maintenance staff regarding facility policy and procedure related to maintaining the resident's environment in a clean, comfortable, and home-like manner.</p> <p>Monitor: 1. Administrator to conduct audit of Housekeeping staff work as noted on their checklists to ensure compliance and note any areas of concern. 2. Administrator to conduct audit of facility environment to ensure compliance and note any areas of concern. 3. Audits to begin on 3/15/2017, and will continue at the following frequencies: Daily (Monday <input type="checkbox"/> Friday) x two (2) weeks. Weekly x four (4) weeks Monthly x 90 days 4. DNS to review audits and report</p>		

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F 252	Continued From page 6 base and the legs of the table. In the Main Dining Room, the two corner cabinets were observed with missing veneer and chips in the wood, which the Housekeeping Director acknowledged. Additionally, the ceiling vent in the Main Dining Room was the dusty and dirty.	F 252	findings to QA Committee		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money	F 278		3/30/17	

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F 278	<p>Continued From page 7 penalty of not more than \$1,000 for each assessment; or</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</p> <p>(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interview, it was determined the facility failed to ensure the resident assessment accurately reflected the resident's status. This was true for 1 of 13 (#6) sampled residents. This failure could result in harm if the resident's vision needs were not addressed due to an inaccurate assessment. Findings include:</p> <p>Resident #6 was readmitted to the facility on 1/20/16, with multiple diagnoses including Type II diabetes mellitus without complications.</p> <p>Resident #6's 5/31/16 physician's note documented, "In speaking with the patient, he states that his right eye is hurting, states that since the cataract surgery he has only been able to differentiate a little bit of light and dark ... Assessment/Plan-2. Blindness. The patient is also being followed by the Commission for the blind."</p> <p>Resident #6's quarterly MDS assessments, dated 6/25/16, 9/25/16 and 12/26/16, documented the resident had adequate vision and could see fine detail such as newspapers and books.</p>	F 278	<p>F 278</p> <p>Corrective Action: 1. MDS for Resident #6 has corrected to reflect current vision deficits.</p> <p>Identification: 1. All residents are identified as potentially being affected. 2. Audit to be completed on 100% of all residents for vision deficits, to ensure the assessment accurately reflects the resident's current vision status.</p> <p>Systemic Changes: 1. MDS nurses inserviced regarding facility policy and procedure concerning accurate vision assessment of a resident for the MDS.</p> <p>Monitor: 1. DNS or designee to conduct audits of Section B of MDS assessments for new admissions and Quarterly Assessments to ensure compliance. 2. Audits to begin on 3/15/2017, and will</p>		

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F 278	Continued From page 8 On 2/21/17 at 9:40 am, and 2/22/17 at 11:30 am, Resident #6 said he had unsuccessful cataract surgeries in the past year, was blind in the right eye and could not see very well out of his left eye because things were blurry. He said due to his vision he used audio books on tape. On 2/23/17 at 1:20 pm, MDS Coordinator #1 said Resident #6's MDS assessments were probably not accurate and she would need to talk with him to determine how much he could see.	F 278	continue at the following frequencies: Weekly x eight (8) weeks Monthly x 90 days 3. Administrator to review audits and report findings to QA Committee		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 280		3/30/17	

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F 280	Continued From page 9 (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 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).	F 280			

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F 280	<p>Continued From page 10</p> <p>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.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure care plans for 2 of 13 sampled residents (#6 & #7) were updated to reflect their current needs. Care plans did not document a resident had vision deficits and a resident used a catheter leg bag. This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in their respective care plans. Findings include:</p> <p>1. Resident #6 was readmitted to the facility on 1/20/16, with multiple diagnoses including Type II diabetes mellitus without complications.</p> <p>Resident #6's 5/31/16 physician's note documented, "In speaking with the patient, he states that his right eye is hurting, states that since the cataract surgery he has only been able to differentiate a little bit of light and dark...Assessment/Plan-2. Blindness. The patient is also being followed by the Commission for the</p>	F 280	<p>F 280</p> <p>Corrective Action:</p> <ol style="list-style-type: none"> Care Plan for Resident #6 has been updated to reflect his current vision status. Care Plan for Resident #7 has been updated to reflect use of catheter leg bag. <p>Identification:</p> <ol style="list-style-type: none"> All residents with vision deficits and/or catheter bags are identified as potentially being affected. Audit to be completed of Resident Care Plans, for residents with vision deficits and/or catheter bags, to ensure those Care Plans reflect the resident's current needs. <p>Systemic Changes:</p> <ol style="list-style-type: none"> LN Staff inserviced regarding facility Care Plan policy and procedure. 		

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F 280	<p>Continued From page 11 blind."</p> <p>Resident #6's current care plan did not reflect his vision loss.</p> <p>On 2/21/17 at 9:40 am, and 2/22/17 at 11:30 am, Resident #6 said he had unsuccessful cataract surgeries in the past year, was blind in the right eye, and could not see very well out of his left eye because things were blurry.</p> <p>On 2/23/17 at 1:20 pm, MDS Coordinator #1 said Resident #6's care plan did not address his vision deficits and should have been updated.</p> <p>2. Resident #7 was admitted to the facility on 10/28/16, with multiple diagnoses including neuromuscular dysfunction of the bladder.</p> <p>Resident #7's February 2017 Physician Orders documented an order, dated 12/27/16, for an indwelling foley catheter for neurogenic bladder.</p> <p>Resident #7's current Urinary Catheter care plan documented she used a foley catheter. The care plan did not document Resident #7 used a catheter leg bag.</p> <p>On 2/21/17 at 7:50 am, and 2/22/17 at 7:55 am and 9:15 am, Resident #7 was observed in bed with catheter tubing and a catheter bag inside the privacy bag attached to the bed. On 2/21/17 at 10:35 am, and 2/22/17 at 10:28 am, 11:25 am, 1:38 pm and 3:40 pm, Resident #7 was observed wearing pants and lying on top of her bed or in her wheelchair; the catheter tubing and/or catheter bag were not visible.</p>	F 280	<p>Monitor:</p> <ol style="list-style-type: none"> DNS or Designee to audit Care Plans of new residents admitted to facility, with vision deficits and / or catheter bags to ensure compliance. Audits to begin on 3/15/2017, and will continue at the following frequencies: Weekly x eight (8) weeks Monthly x 90 days Administrator to review audits and report findings to QA Committee 		

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F 280	Continued From page 12 On 2/22/17 at 10:30 am, CNA #3 said Resident #7 used a catheter leg bag during the day and a regular catheter bag at night.	F 280			
F 323 SS=E	On 2/23/17 at 1:15 pm, MDS Coordinator #1 said she was not aware Resident #7 used a catheter leg bag and said she would update her care plan. 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy	F 323		3/30/17	
			F 323		

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F 323	<p>Continued From page 13</p> <p>review, and record review, it was determined the facility failed to secure treatment supplies that could potentially be harmful if ingested. This was true for 1 of 13 residents (Resident #4) sampled for accident hazards. Additionally, the facility failed to ensure trip hazards were removed from the 300 Unit Resident Lounge. This had the potential to adversely affect any ambulatory resident in that area. These deficient practices placed residents at risk of medical complications, pain, injury, and hospitalization. Findings include:</p> <p>1. Resident #4 was admitted to the facility with diagnoses that included cognitive communication deficit, diabetes mellitus, and right hand osteomyelitis.</p> <p>A 12/9/16 Alteration in Cognition care plan documented Resident #4 was alert and oriented to self and situation, but occasionally experienced confusion, forgetfulness and occasional difficulty with critical thinking.</p> <p>A 5-day MDS assessment, dated 1/18/17, documented Resident #4's cognition was moderately impaired, but she was able to maneuver about her room in a wheelchair.</p> <p>On 2/21/17 at 9:42 am, Resident #4 was observed ambulating in a wheelchair within her room. She had removed the dressing from her dialysis port and LN #2 had come in to replace the dressing. CNA #2 pulled open the third drawer of Resident #4's dresser and removed the gauze and a Kerlix roll. The drawer contained gauze and Kerlix rolls along with three tubes of Santyl ointment (a treatment that debrides wounds) and one bottle of H-Clor 12 Solution (a</p>	F 323	<p>Corrective Action:</p> <ol style="list-style-type: none"> Santyl ointment and H-Chlor 12 was removed from Resident #4's bedside table. Cord for recliner chair identified in 2567 has been rolled up and secured to the back of the chair. <p>Identification:</p> <ol style="list-style-type: none"> All residents with wound treatments requiring prescribed medicated creams are identified as potentially being affected. Audit completed of resident rooms to ensure no medicated creams and/or treatment supplies are left in rooms. With regard to the recliner chair, all residents are identified as potentially being affected. <p>Systemic Changes:</p> <ol style="list-style-type: none"> Nursing Staff inserviced regarding facility Medication Storage policy and procedure. Facility Staff inserviced regarding identifying and correcting trip hazards in the facility. <p>Monitor:</p> <ol style="list-style-type: none"> DNS or Designee to audit rooms of residents with treatment orders to ensure no treatment supplies are stored in those rooms. Housekeeping Supervisor to conduct audit of identified recliner chair cord to ensure compliance. Audits to begin on 3/15/2017, and will 		

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F 323	<p>Continued From page 14 wound wash). The CNA left the drawer open and handed the gauze and Kerlix to the nurse.</p> <p>The warning on the label of the Santyl documented the ointment was harmful if swallowed. The label documented the ointment was to be kept away from children and pets.</p> <p>The warning on the label of the H-Clor 12 Solutions documented they were for external use only and were not to be swallowed.</p> <p>On 2/21/17 at 10:05 am, the ADON stated the wound nurse was not to leave the Santyl and H-Clor 12 Solution in Resident #4's room.</p> <p>On 2/22/17 at 12:00 pm, the Wound Nurse stated the medications and treatment solutions were not to be stored in Resident #4's room.</p> <p>On 2/23/17 at 1:30 pm, the DNS stated the medications and treatment solutions should not have been stored in Resident #4's room.</p> <p>The facility's Medication Storage policy, dated 6/21/06, documented, "Medications must be kept under continuous supervision. Medications for external use must be stored separately from internal medications, and all must be accessible only to authorized personnel..."</p> <p>2. During the environmental tour on 2/22/17 at 2:00 pm, with the Maintenance Director and the Housekeeping Director, an electrical cord was observed on the floor in front of a sit-to-stand recliner in the 300 Unit Resident Lounge. There were six residents in the immediate vicinity within the Lounge at the time of the observation.</p>	F 323	<p>continue at the following frequencies: Weekly x eight (8) weeks Monthly x 90 days 4. Administrator to review audits and report findings to QA Committee</p>		

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F 323	Continued From page 15	F 323			
F 329 SS=D	<p>The Housekeeping Director stated the electric cord should not have been placed in front of the sit-to-stand recliner as it posed a trip hazard to residents, staff, and visitors.</p> <p>483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--</p> <p>(1) In excessive dose (including duplicate drug therapy); or</p> <p>(2) For excessive duration; or</p> <p>(3) Without adequate monitoring; or</p> <p>(4) Without adequate indications for its use; or</p> <p>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--</p> <p>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the</p>	F 329		3/30/17	

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F 329	<p>Continued From page 16 clinical record;</p> <p>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy review, and record review, it was determined the facility failed to ensure psychoactive medications were used only when necessary with adequate monitoring and that non-pharmalogical interventions were initiated prior to administration of psychoactive medications. This is true for 2 of 5 (#4 and #5) residents reviewed who received psychoactive medications. The deficient practice created the potential for residents to receive medications they may not need. Findings include:</p> <p>1. Resident #5 was admitted to the facility on 2/17/16, with multiple diagnoses including depression and history of falls.</p> <p>Resident #5's quarterly MDS assessment, dated 12/16/16, documented Resident #5 had experienced several days of depression.</p> <p>A Physician's Order, dated 1/20/17, documented to decrease Resident #5's Remeron to 15 mg at bedtime for depression per recommendation from a behavior meeting.</p> <p>Resident #5's January 2017 through 2/22/17 behavior monitoring flow sheets, documented no tearful statements or tearfulness behaviors had occurred.</p>	F 329	<p>F 329</p> <p>Corrective Action: 1. Resident #4 discharged from facility on 2/21/2017. 2. Resident #5: a. Behavior Intervention Flow Record has been updated to include additional behaviors that might indicate depression and non-pharmacological interventions for staff to try for each. b. Psychoactive medications prescribed reviewed in monthly Pharmacy Consultant Meeting and in facility weekly Psychoactive Medications Meeting. c. 3/6/2017 – Pharmacist reviewed PRN psychoactive medications. d. 3/21/2017 – Pharmacist reviewed complete Medication Profile. Due to ongoing pain and weight loss issues, reduction of Remeron was not warranted at this time. e. 4/4/2017 – Pharmacist recommended decrease in Melatonin. Physician declined recommendation due to resident's inconsistent sleep of four (4) to seven (7) hours per night. f. 4/4/2017 – Pharmacist recommended decrease in Clonazepam from 1 mg BID</p>		

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F 329	<p>Continued From page 17</p> <p>Resident #5's Nurse's Notes, dated 1/21/17 through 1/27/17, and 1/30/17 through 2/14/17, documented no adverse reaction from the GDR of Remeron.</p> <p>An NP progress note, dated 2/15/17, documented Resident #5 had experienced distress from the GDR of the Remeron on 1/20/17.</p> <p>A Physician's Order, dated 2/15/17, stated to increase Resident #5's Remeron to 30 mg at bedtime for depression with anorexia. The NP indicated this was a failed GDR.</p> <p>On 2/23/17 at 8:50 am, the LSW was unable to provide documentation that supported the failed GDR.</p> <p>On 2/23/17 at 11:30 am, the DNS stated the IDT reviewed Nurse's Notes, Behavior Monitoring flow sheets, and Social Service Notes for failed GDR's. The DNS stated that based on Resident #5's clinical record, the Remeron should not have been increased.</p> <p>2. Resident #4 had multiple diagnoses including diabetes mellitus, foot ulcer, and hypertension.</p> <p>Resident 4's care plan, dated 12/9/16, included a problem of, "Alteration in wellbeing and mood..." Interventions included, "Call by her preferred name, Listen to her feelings, provide support and encouragement, Reassure her she is not a burden on her family and that they care about her, Administer medications and monitor for side effects and efficacy, Review in psychotropic</p>	F 329	<p>PRN to Daily PRN. Physician ordered this recommended reduction. g.4/5/2017 – GDR ordered for Remeron from 30 mg at bedtime to 22.5 mg at bedtime.</p> <p>Identification: 1.All residents with orders for psychoactive medications are identified as potentially being affected.</p> <p>Systemic Changes: 1.Monthly Behavior Intervention Flow Records of residents that have orders for psychoactive medications will be reviewed to identify need for GDR. Those identified will be reviewed by Pharmacist in monthly Pharmacy Consultant Meeting. 2.Nurse Practitioners educated regarding the necessity of meeting with RN Unit Managers to ensure resident behaviors support a change in dosage of psychoactive medications. 3.Nursing Staff inserviced regarding: a.Policy and procedure for GDR documentation. b.Policy and procedure for Behavior Flow Record documentation. c.Using Non-Pharmacological interventions and documentation of such.</p> <p>Monitor: 1.DNS or Designee to audit Behavior Intervention Flow Records of residents with orders for psychoactive medications to ensure compliance with regard to documentation and GDR practices (i.e. Behavior Monitor, Weekly Psychoactive</p>		

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F 329	<p>Continued From page 18 meeting, Observe mood and report changes to the UM (Unit Manager) and SS (Social Services) so it may be addressed as needed, Provide education regarding her diagnoses and realistic expectations, Provide education regarding different ways of coping, Ask her about her family as she is very proud of them, Encourage her family to stay involved."</p> <p>Resident #4's MDS, dated 1/18/17, documented Resident #4 had moderate cognitive impairment. A physician's order, dated, 1/18/17, documented Resident #4 could receive, "Lorazepam (anti-anxiety medication) 0.25 mg PO (by mouth) PRN twice daily as needed for anxiety." Resident #4 received the lorazepam as follows:</p> <p>* The PRN MAR, dated February 2017, documented Resident #4 received the prn lorazepam on 2/4/17. The Nurse's Medication Notes on the back of the PRN MAR documented Resident #4, "c/o (complained of) anxiety" and the medication was "helpful."</p> <p>Resident #4's Behavior/Intervention Monthly Flow Record for February 2017, documented Resident #4 had made "anxious statements" on 2/4/17. The interventions of "Encourage deep breathing" and "Involve family" had been marked as resulting in "improved outcomes."</p> <p>There was a lack of documentation in the Nurses' Notes of the reason Resident #4 received the lorazepam when the interventions above had showed an improved outcome.</p> <p>* The February PRN MAR documented Resident #4 received prn lorazepam on 2/5/17 for "c/o</p>	F 329	<p>Medication Review meeting, and monthly GDR Review at Pharmacy Consultant Meeting).</p> <p>2.Audits to begin on 3/15/2017, and will continue at the following frequencies: Weekly x eight (8) weeks Monthly x 90 days</p> <p>3.Administrator to review audits and report findings to QA Committee</p>		

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F 329	<p>Continued From page 19 anxiety" and the results were "helpful."</p> <p>There was a lack of documentation in the Resident #4's Behavior/Intervention Monthly Flow Record of Resident #4 making anxious statements or of non-pharmacological interventions being used.</p> <p>There was a lack of documentation in the Nurses' Notes on 2/5/17 of Resident #4 being anxious.</p> <p>* The February PRN MAR documented Resident #4 received lorazepam on 2/6/17 for complaints of anxiety.</p> <p>The February Behavior/Intervention Monthly Flow Record lacked documentation of Resident #4 making anxious statements on 2/6/17 or of non-pharmacological interventions being used.</p> <p>There was a lack of documentation in the Nurses' Notes of the reason Resident #4 received lorazepam on 2/6/17.</p> <p>* The February PRN MAR documented Resident #4 received the lorazepam on 2/7/17 for complaints of anxiety.</p> <p>The February Behavior/Intervention Monthly Flow Record lacked documentation of Resident #4 making anxious statements on 2/7/17 or of non-pharmacological interventions being used.</p> <p>There was a lack of documentation in the Nurses' Notes of the reason Resident #4 received lorazepam on 2/7/17.</p> <p>* The February PRN MAR documented Resident</p>	F 329			

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F 329	<p>Continued From page 20</p> <p>#4 received lorazepam on 2/11/17 for complaints of anxiety.</p> <p>The February Behavior/Intervention Monthly Flow Record lacked documentation of Resident #4 making anxious statements on 2/11/17 or of non-pharmacological being used.</p> <p>There was a lack of documentation in the Nurses' Notes of the reason Resident #4 received the lorazepam on 2/11/17.</p> <p>* The February PRN MAR documented Resident #4 received lorazepam on 2/12/17 for complaints of anxiety.</p> <p>The February Behavior/Intervention Monthly Flow Record lacked documentation of Resident #4 making anxious statements on 2/12/17 or of non-pharmacological being used.</p> <p>There was a lack of documentation in the Nurses' Notes of the reason Resident #4 received lorazepam on 2/12/17.</p> <p>* The February PRN MAR documented Resident #4 received lorazepam on 2/15/17 for complaints of anxiety.</p> <p>The February Behavior/Intervention Monthly Flow Record lacked documentation of Resident #4 making anxious statements on 2/15/17 or of non-pharmacological being used.</p> <p>There was a lack of documentation in the Nurses' Notes of the reason Resident #4 received lorazepam on 2/15/17.</p>	F 329		

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F 329	<p>Continued From page 21</p> <p>* The February PRN MAR documented Resident #4 received lorazepam on 2/19/17 for complaints of anxiety.</p> <p>The February Behavior/Intervention Monthly Flow Record lacked documentation of Resident #4 making anxious statements on 2/19/17 or of non-pharmacological being used.</p> <p>There was a lack of documentation in the Nurses' Notes of the reason Resident #4 received lorazepam on 2/19/17. The 2/19/17 Nurses' Notes documented Resident #4 had "no s/sx (signs symptoms) of depression tonight, no tearfulness or negative statements."</p> <p>During an interview on 2/21/17 at 2:55 pm, the ADON said she did not see where non-pharmacologic interventions were being used. The ADON stated she did not see Nurses' Notes specific to the interventions being used.</p> <p>A facility policy, dated 11/17/16, titled Psychopharmacological Medication Management, documented:</p> <p>"Non-pharmacological interventions refers to approaches to care that do not involve medications, generally directed toward stabilizing or improving a resident's mental, physical or psychosocial well-being...Non-pharmacological interventions (such as behavioral interventions) are considered and used when indicated, instead of, or in addition to psychopharmacologic medication...the care plan will reflect non-pharmacological interventions utilized during the gradual dose reduction process and attempts to prevent increase or additional usage of</p>	F 329			

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F 329	Continued From page 22 psychopharmacological medications..."	F 329			
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a	F 441		3/30/17	

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F 441	<p>Continued From page 23 resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to keep a catheter bag and catheter tubing off the floor. This was true for 1 of 3 (#7) residents sampled for catheters. This failure created the potential for more than minimal harm by exposing residents to the risk of infection.</p>	F 441	<p>F 441</p> <p>Corrective Action: 1. Catheter Bag for Resident #7 covered and moved off of the floor immediately during survey. 2. Resident #7's Care Plan updated for</p>		

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F 441	Continued From page 24 Findings include: The facility's revised Indwelling Catheters policy, dated 11/28/16, documented, "Staff must use appropriate infection control practices regarding...tubing, and the collections bag." Resident #7 was admitted to the facility on 10/28/16, with multiple diagnoses including UTI and neuromuscular dysfunction of bladder. On 2/21/17 at 7:45 am, Resident #7 was observed in her bed asleep. Resident #7's uncovered catheter bag with six-inches of catheter tubing was observed on the floor. On 2/21/17 at 7:50 am, when shown Resident #7's catheter bag and tubing, RN #1 said the catheter bag and tubing should not be on the floor. RN #1 donned gloves and placed the bag and tubing inside of the privacy bag attached to the resident's bed. On 2/23/17 at 2:25 pm, the DNS said the catheter bag and tubing should not be left on the floor.	F 441	checks of catheter bag cover and off the floor each shift. Identification: 1. All residents with catheter bags are identified as potentially being affected. Systemic Changes: 1. Nursing staff inserviced regarding the facility Infection Control policy and procedure related to catheter bag care. Monitor: 1. DNS / Designee conduct audit of resident's catheter bags to ensure compliance. 2. Audits to begin on 3/15/2017 and will continue at the following frequencies: Daily for two (2) weeks Weekly x six (6) weeks Monthly x 90 days 3. Administrator to review audits and report findings to QA Committee		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 514		3/30/17	

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F 514	Continued From page 25 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interview, it was determined the facility failed to ensure complete and accurate clinical records were maintained for 2 of 13 sampled residents (#6 & #12). This deficient practice increased the risk for care decisions to be based on incomplete or inaccurate information and increased the risk for complications due to inappropriate care or interventions. Findings include: 1. Resident #6 was readmitted to the facility on 1/20/16, with multiple diagnoses including Type II	F 514	F 514 Corrective Action: 1. Diagnosis List of Resident #6 has been updated to reflect current vision deficits. 2. MAR for resident #12 was corrected to reflect the administration of the medications to the resident on dates noted in 2567. Identification: 1. All residents are identified as		

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F 514	<p>Continued From page 26</p> <p>diabetes mellitus without complications.</p> <p>Resident #6's 5/31/16 physician's note documented, "In speaking with the patient, he states that his right eye is hurting, states that since the cataract surgery he has only been able to differentiate a little bit of light and dark...Assessment/Plan-2. Blindness. The patient is also being followed by the Commission for the blind."</p> <p>Resident #6's Facesheet and Diagnosis list did not include Resident #6's vision impairments.</p> <p>On 2/21/17 at 9:40 am, and 2/22/17 at 11:30 am, Resident #6 said he had unsuccessful cataract surgeries in the past year, was blind in the right eye, and could not see very well out of his left eye because things were blurry.</p> <p>On 2/23/17 at 1:35 pm, the Health Information Management Director said she knew Resident #6 had experienced vision impairments, but had not updated his diagnosis list.</p> <p>2. Resident #12's Mood Care Plan, dated 7/18/16, documented a history of anxiety and use of psychotropic medications. The Care Plan directed staff to administer medications as ordered by the physician.</p> <p>Resident #12's Physician Telephone Orders, dated 12/14/16, documented the resident was to receive Klonopin 0.5 mg at 6:00 am, 2:00 pm, and 10:00 pm.</p> <p>The January 2017 MAR documented Resident #12's Klonopin 0.5 mg tablet was scheduled</p>	F 514	<p>potentially being affected.</p> <p>Systemic Changes:</p> <ol style="list-style-type: none"> 1. Nursing staff inserviced regarding facility policy and procedure for Medication Administration. 2. Nursing Staff and Medical Records Staff inserviced regarding facility policy and procedure for diagnosis documentation in Resident Clinical Record. <p>Monitor:</p> <ol style="list-style-type: none"> 1. DNS / Designee to conduct audit of all MAR and TAR to ensure compliance. 2. DNS / Designee to conduct audit of resident Diagnosis List to ensure compliance. 3. Audits to begin on 3/17/2017 and will continue at the following frequencies: Weekly x eight (8) weeks Monthly x 90 days 4. Administrator to review audits and report findings to QA Committee 		

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F 514	<p>Continued From page 27</p> <p>every 8 hours at 6:00 am, 2:00 pm, and 10:00 pm. Eight of the 31 boxes for the 10:00 pm Klonopin administrations in January 2017 were blank. There was no explanation provided on the MAR for those 10:00 pm administrations that were blank on 1/4/17, 1/9/17, 1/10/17, 1/15/17, 1/16/17, 1/22/17, 1/27/17, and 1/28/17.</p> <p>Resident #12's Count Sheets for 12/5/16, 1/8/17, and 1/16/17 documented that counts signed by oncoming shift nurses confirmed that the 10:00 pm doses of Klonopin were dispensed on 1/4/17, 1/9/17, 1/10/17, 1/15/17, 1/16/17, 1/22/17, 1/27/17, and 1/28/17.</p> <p>On 2/23/17 at 1:10 pm, the DNS said the facility typically conducted a weekly audit of the MARs to ensure documentation was complete. The DNS said the January 2017 MAR audits were not completed due to viral outbreaks in the facility. The DNS stated the controlled medication count sheets completed on each shift showed the medication was dispensed.</p>	F 514			