



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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March 10, 2017

Rick Holloway, Administrator
Idaho State Veterans Home -- Boise
PO Box 7765
Boise, ID 83707-1765

Provider #: 135131

Dear Mr. Holloway:

On **February 24, 2017**, a survey was conducted at Idaho State Veterans Home-- 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 an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

After each deficiency has been answered and dated, the administrator should sign the Form

Rick Holloway, Administrator
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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, 2016**. Failure to submit an acceptable PoC by **March 20, 2016**, may result in the imposition of penalties by **April 14, 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 31, 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 25, 2017**. A change in the seriousness of the deficiencies on **April 10, 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 25, 2017** includes the following:

Denial of payment for new admissions effective **May 25, 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 23, 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 25, 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, 2016**. If your request for informal dispute resolution is received after **March 20, 2016**, 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: 03/30/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2017
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 320 COLLINS ROAD, 83702-4519 BOISE, ID 83707		
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility February 21, 2017 to February 24, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Presie Billington, RN Marcia Mital, RN Lesley Davis, RN</p> <p>Abbreviations:</p> <p>BPH = Benign Prostatic Hyperplasia CNA = Certified Nursing Assistant C/O = Complaint of DON = Director of Nursing COPD = Chronic Obstructive Pulmonary Disease D/T = Due to ER = Emergency Room Hx = history LN = Licensed Nurse LPM = Liters Per Minute MAR = Medication Administration Record MDS = Minimum Data Set NC = Nasal Cannula NSU = Non-secured Unit O2 = Oxygen O2 Sat = Oxygen Saturation POST = Physician Order for Scope of Treatment PRN = As Needed Res = Resident RNM = Registered Nurse Manager SCU = Secured Care Unit S/S = Signs and Symptoms SOB = Shortness of Breath TV = Television</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

03/17/2017

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

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F 000	Continued From page 1 VAMC = Veterans Affairs Medical Center w/c = wheelchair	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 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: Based on observation, staff interview, and record review, it was determined the facility failed to ensure urinary drainage bags were in privacy bags for 2 of 6 sample residents (#4 and #19) reviewed for use of indwelling urinary catheters. The failure created the potential for Resident #4 and #19 to experience embarrassment or diminished self-esteem when their urinary drainage bags and their contents were visible to others. Findings include: 1. Resident #19 was admitted to the facility in 2014, and readmitted on 2/22/16, with multiple diagnoses including obstructive and reflux uropathy [urine flow reverses direction due to a blockage in the tube that carries urine from the kidneys to the bladder] and urinary retention. Resident #19's care plan included an indwelling urinary catheter as a focus area, which was initiated 2/22/16 and revised 11/9/16. Interventions included, "Monitor placement of my catheter bag frequently as I have a hx. of letting bag drag on floor and be outside of privacy sleeve.	F 241	This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The 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. SPECIFIC RESIDENT Resident # 4: expired during the survey; no correction possible. Resident # 19: urinary drainage bag has been replaced with a bag that has an attached privacy flap. A basin has been placed at his bed side for him to put his urinary bag in when self-transferring. Placement of his bag is being monitored	3/27/17	

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F 241	<p>Continued From page 2</p> <p>Resident #19's active physician orders included a 1/3/17 order for an indwelling urinary catheter and a 3/1/16 order for a urinary drainage bag.</p> <p>On 2/23/17 at 1:45 pm, Resident #19 was observed laying in bed watching TV. Resident #19's uncovered urinary drainage bag was on the floor to the left of the bed, which faced the opened door to the room. An empty urinary privacy sleeve was suspended at the left side of the bed frame.</p> <p>On 2/23/17 at 3:15 pm, Resident #19 was again observed laying in bed watching TV and the uncovered urinary drainage bag was on the floor by the bed.</p> <p>On 2/23/17 at 3:20 pm, RNM #1 accompanied the surveyor to Resident #19's room. The RNM said the urinary drainage bag should not be on the floor. She said that CNA's do rounds every 2 hours and the shift change occurred at 2:00 pm. The RNM said the expectation is that CNA's go into resident rooms during shift change to ensure things, such as call lights and needed items, are within reach; and in Resident #19's case, to ensure the urinary drainage bag is off the floor in the privacy sleeve.</p> <p>2. Resident #4 was admitted to the facility on 9/8/16, with multiple diagnoses including acute kidney failure and benign prostrate hyperplasia [enlarged prostate].</p> <p>Resident #4's current Care Plan, initiated on 9/14/16, documented, "I have an indwelling catheter...Ensure that my catheter bag is fully</p>	F 241	<p>during rounds.</p> <p>OTHER RESIDENTS</p> <p>Residents that require a urinary drainage bag are provided urinary bags with the attached privacy flap, and the bags will be kept off of the floor.</p> <p>SYSTEMIC CHANGES</p> <p>Staff were in-serviced on ensuring catheter bags have a privacy cover and residents' dignity, is maintained at all times.</p> <p>Department Head room rounds have been implemented bi-weekly to observe for dignity issues.</p> <p>Unit Managers will observe for catheter bags privacy & placement during daily rounds. This will occur Monday through Friday.</p> <p>MONITOR</p> <p>Unit Managers, Department Heads or designee, will monitor for compliance through their rounds weekly for 3 months then as needed once the Quality Assurance Committee deems compliance is being maintained.</p> <p>Administrator and DON will monitor during daily walking rounds, Monday through Friday.</p>		

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F 241	Continued From page 3 covered in a protective catheter cover. Ensure that my catheter tubing is not touching the floor." Resident #4's February 2017 recapitulated Physician's orders included an order for an indwelling catheter. On 2/21/17 at 11:50 am, Resident #4 was observed in his room, sitting in his recliner with his uncovered catheter bag on his right side, placed on top of a folded towel on the floor. The bag could be seen from the hallway through the opened doorway. On 2/22/17 at 8:55 am, Resident #4 was observed to have an uncovered urinary catheter bag on the floor while he was seated in his power wheelchair inside his room. On 7/22/17 at 11:43 am, the MDS Nurse said the urinary catheter bag should be covered.	F 241	Results of rounds will be taken to the daily Stand-Up meeting and addressed as indicated. Any ongoing concerns will be taken to the monthly Quality Assurance meetings for review and adjustments made as indicated.		
F 252 SS=D	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	F 252		3/27/17	

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F 252	<p>Continued From page 4</p> <p>environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a resident's bed was made and his recliner was clean. This was true for 1 of 19 residents' room observed (Room 127) and impacted 1 of 22 sampled residents (#4). This had the potential to cause harm if Resident #4 experienced embarrassment or sadness due to a less than a clean and homelike environment. Findings include:</p> <p>Resident #4 was admitted to the facility on 9/8/16, with multiple diagnoses including COPD and heart failure.</p> <p>Resident #4's 10/10/16 Significant Change MDS assessment documented he received hospice care services.</p> <p>Resident #4's Respiratory Care Plan, initiated 9/8/16, documented, "Elevate the head of my bed or assist me to rest in a recliner with my head/chest elevated when I have SOB or difficulty of breathing."</p>	F 252	<p>SPECIFIC RESIDENT</p> <p>Resident # 4: expired during the survey; his recliner has been removed from the facility.</p> <p>OTHER RESIDENTS</p> <p>Resident's personal furniture was observed for cleanliness and condition and measures to clean the furniture were taken if necessary.</p> <p>SYSTEMIC CHANGES</p> <p>Department Head room rounds have been implemented twice per week to observe for environmental issues including soiled furniture and unmade beds.</p> <p>Unit Managers will observe for unmade beds and soiled furniture during daily rounds. This will occur Monday through Friday.</p>		

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F 252	Continued From page 5 Resident was observed in his room [Room 127] sitting in his recliner on 2/21/17 at 11:50 am and 3:35 pm, with his bed unmade. On 2/22/17, Resident #4 was observed in his room, sitting on his power wheelchair at 8:55 am and 10:55 am, with his bed unmade. On Resident #4's bed was found the following: three pillows, a hot plate cover, and a zip lock plastic bag with condiments. Resident #4's recliner was observed with food crumbs on it. On 2/22/17 at 11:30 am, CNA #2 said Resident #4 preferred to his sleep on his recliner and seldom used the bed. The MDS Nurse present asked CNA #2 to clean Resident #4's recliner and make his bed.	F 252	MONITOR Unit Managers, Department Heads or designee, will monitor for compliance through their rounds weekly for 3 months then as needed once the Quality Assurance Committee determines compliance is being maintained. Administrator and DON will monitor during daily walking rounds, Monday through Friday. Results of rounds will be taken to the daily Stand-Up meeting and addressed as indicated. Any ongoing concerns will be taken to the monthly Quality Assurance meetings for review and adjustments made as indicated.		
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	F 279		3/27/17	

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

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F 279	Continued From page 7 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and clinical record and policy review, it was determined the facility failed to ensure a comprehensive, person-centered care plan was developed for 1 of 22 sample residents (#11). The failure created the potential for more than minimal harm if facility staff were to provide inappropriate care or violate Resident #11's right to smoke cigarettes from lack of direction in the care plan about smoking. Findings included: Resident #11 was admitted to the facility on 6/27/16 with multiple diagnoses, including chronic ischemic heart disease, atherosclerotic heart disease, diabetes mellitus and peripheral vascular disease. Resident #11's admission MDS assessment, dated 7/3/16, documented intact cognition with a BIMS score of 15 and tobacco use. Resident #11's clinical record contained 3 smoking assessments, dated 6/27/16, 11/18/16 and 12/21/16. The assessment instructions included, "Care Plan will be developed to reflect the assessment, classification, and other appropriate interventions related to the residents smoking activities." All three of the assessments documented Resident #11 was safe to smoke without supervision and could keep her smoking materials with her.	F 279	SPECIFIC RESIDENT Resident # 11: care plan has been reviewed and updated to include her occasional smoking and storage of her cigarettes and lighter. OTHER RESIDENTS Residents who smoke: care plans have been reviewed and updated as indicated. SYSTEMIC CHANGES License Nurses have been in-serviced on maintaining and individualizing care plans to provide effective patient centered care. This included ensuring care plans are written for residents who smoke or who have insomnia. MONITOR DON, Unit Managers or designee will perform 3 care plan audits on each unit weekly for 3 months, then as needed once the Quality Assurance Committee deems compliance is being maintained. Results of audits will be taken to the monthly Quality Assurance meetings for		

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F 279	Continued From page 8 On 2/22/17 at 10:55 am, Resident #11 was observed in her wheelchair by her bed with an overbed table in front of her. Resident #11 said she was a smoker and that she kept her cigarettes and a lighter out of sight and safe from other residents. Resident #11 moved a magazine on the overbed table which exposed a pack of cigarettes, then she opened the cigarette pack which exposed a lighter in with the remaining 5 cigarettes. At 1:00 pm, Resident #11 was again observed in her room with her pack of cigarettes on the overbed table and covered by a magazine. Resident #11's current care plan did not address smoking or where the cigarettes and lighter would be kept. On 2/23/17 at 7:45 am, the DON provided the facility's smoking policy. The policy documented that residents who were assessed to smoke without supervision would be allowed to keep cigarettes and matches/lighters "in a safe area. This area must be in a location so that other residents will not have access to them." The policy also documented the residents' care plans, "will be developed or adjusted to reflect their smoking assessment and classification, along with other related smoking interventions." On 2/23/17 at 2:30 pm, RNM #1 reviewed Resident #11's care plan and said she did not find a care plan for smoking.	F 279	review and adjustments made as indicated.		
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	F 280		3/27/17	

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F 280	<p>Continued From page 9</p> <p>(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:</p> <p>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.</p> <p>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.</p> <p>(iv) The right to receive the services and/or items included in the plan of care.</p> <p>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.</p> <p>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--</p> <p>(i) Facilitate the inclusion of the resident and/or resident representative.</p> <p>(ii) Include an assessment of the resident's strengths and needs.</p> <p>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.</p> <p>483.21</p>	F 280			

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F 280	Continued From page 10 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 280			

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F 280	<p>Continued From page 11</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure care plans for 1 of 22 sampled residents (#12) were updated to reflect their current needs. Resident #12's care plan was not updated to include insomnia and the use of an antidepressant medication to assist with sleep. This had the potential to result in harm if Resident #12 did not receive appropriate care related to insomnia. Findings include:</p> <p>Resident #12 was admitted to the facility on 3/16/16, with diagnoses including insomnia and Alzheimer's disease.</p> <p>A physician's order, dated 4/21/16, documented, "Trazodone (an antidepressant medication)...Give 100 mg (milligrams) by mouth at bedtime for insomnia."</p> <p>Resident #12's care plan, dated 3/22/16 and updated 12/12/16, did not include insomnia and the use of Trazodone to assist with sleep.</p> <p>During an interview on 2/22/17 at 3:40 pm, the Social Service Director stated Resident #12 should have a care plan for insomnia and the use of Trazodone to treat it.</p>	F 280	<p>SPECIFIC RESIDENT</p> <p>Resident # 12: care plan has been reviewed and updated to include insomnia and the use of an antidepressant.</p> <p>OTHER RESIDENTS</p> <p>Residents who require the use of medication for sleep: care plans have been reviewed and updated as indicated</p> <p>SYSTEMIC CHANGES</p> <p>Licensed Nurses have been in-serviced on maintaining and individualizing care plans to provide effective patient centered care. This included ensuring care plans address smoking and insomnia.</p> <p>MONITOR</p> <p>DON, Unit Managers or designee will perform 3 care plan audits on each unit weekly for three months, then as needed once the Quality Assurance Committee deems compliance is being maintained.</p> <p>Results of audits will be taken to the monthly Quality Assurance meetings for review and adjustments made as indicated.</p>		
F 328 SS=D	<p>483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility</p>	F 328		3/27/17	

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F 328	<p>Continued From page 12 and good foot health, the facility must:</p> <p>(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and</p> <p>(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments</p> <p>(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.</p> <p>(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.</p> <p>(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.</p> <p>(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal</p>	F 328			

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F 328	<p>Continued From page 13</p> <p>suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure oxygen therapy was administered consistent with physician orders. This was true for 1 of 3 sampled residents (#4) reviewed for oxygen use. This deficient practice created the potential for harm if Resident #4's respiratory needs were not met. Findings include: Resident #4 was admitted to the facility on 9/8/16, with multiple diagnoses including COPD and heart failure. Physician orders, dated 10/4/16, directed staff to provide Resident #4 with oxygen at the rate of 3 liters per minute [3 LPM] via nasal cannula, and if oxygen saturation falls below 88 percent the LN may increase the oxygen up to 6 LPM using the smallest amount possible. The physician order also directed staff to notify the physician if Resident #4's O2 blood saturation rate could not be maintained at or above 88 percent on 6 LPM.</p>	F 328	<p>SPECIFIC RESIDENT</p> <p>Resident # 4: expired during survey. No correction possible.</p> <p>OTHER RESIDENTS</p> <p>Residents who require oxygen: liter flow will be checked every shift and documented on the TAR.</p> <p>SYSTEMIC CHANGES</p> <p>Staff was in-serviced on ensuring oxygen liter flow is maintained as ordered.</p> <p>Oxygen liter flow has been added to the TAR.</p> <p>MONITOR</p> <p>DON, Unit Managers and or designee will</p>		

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F 328	Continued From page 14 Resident #4's Respiratory Care Plan, initiated on 9/8/16, documented, "Assess my breath sounds PRN S/S [signs and symptoms] of respiratory distress. Alert MD to changes PRN. Assist/encourage me to wear my oxygen, and to switch between my concentrator and oxygen companion as needed." Resident #4 was observed in his room receiving oxygen via nasal cannula at 8 LPM on 2/21/16 at 11:50 am, and 3:35 pm. While the surveyor was inside the resident's room, CNA #1 entered the room, and asked Resident #4 if he needed anything. The CNA was not observed to check how much oxygen Resident #4 was receiving. On 2/22/16 at 10:55 am, Resident #4 was observed in his room sitting on his power wheelchair receiving oxygen via nasal cannula at 7 LPM. The MDS Nurse then entered Resident #4's room and was informed of the observation. The MDS Nurse checked the order and said the O2 should be set at 6 LPM.	F 328	perform audits comparing TAR to visualized actual liter flow weekly for 3 months and then as needed once the Quality Assurance Committee deems compliance is being maintained. Results of audits will be taken to monthly Quality Assurance meetings for review and adjustment made as indicated.		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible	F 356		3/27/17	

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F 356	Continued From page 15 for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of posted information, and staff interview, it was determined	F 356	SPECIFIC RESIDENT		

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F 356	<p>Continued From page 16</p> <p>the facility failed to ensure the posted staffing information was complete and readily accessible for 2 of 4 units in the facility (Secured Care Unit [SCU] and Non-Secured Unit [NSU]). The facility also failed to ensure the posted staffing information was completed for 4 of 4 facility units (SCU, NSU, 1 West, and 2 West). These failures had the potential to affect all 106 residents residing in the facility, their family members, and/or visitors who wanted or needed the information to be uninformed. Findings include:</p> <p>On 2/22/17 at 11:30 am, the Staffing Coordinator showed the surveyor where the Daily Staff Posting information was located on each unit. The posted information for 1 West and 2 West was on a wall near each of the nurses' stations. The posted information for the Secured Care Unit [SCU] and Non-Secured Unit [NSU] was on a narrow wall inside the doorway into the SCU nurses' station from the adjacent small NSU nurses' station. The posted staffing information was not visible from the NSU nurses' station or hallway and there was no signage to direct residents or visitors to the posted information inside the SCU.</p> <p>In addition, the posted staffing information for all 4 of the units was missing the resident census (number of residents) and the total number of hours for each discipline (RN, LPN and CNA) for all three shifts. The Staffing Coordinator said they did not include the number of hours for each discipline in the posted staffing information and that the resident census information had been removed awhile back.</p> <p>On 2/23/17 at 4:35 pm, the DON said she was</p>	F 356	<p>No Residents cited</p> <p>OTHER RESIDENTS</p> <p>No Residents cited</p> <p>SYSTEMIC CHANGES</p> <p>The posted nursing staffing signage has been move to the front lobby and it includes the daily census and the total number of hours worked by each nursing discipline on each shift.</p> <p>MONITOR</p> <p>Administrator, DON or designee will monitor through direct observations of the posted daily staffing sheets.</p> <p>Results of observations will be taken to monthly Quality Assurance Meetings for review and adjustment made as indicated.</p>		

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F 356	Continued From page 17 aware of the issue regarding the posted staffing information and that they were going to move the SCU and NSU information to a different place.	F 356			
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (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-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431		3/27/17	

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F 431	<p>Continued From page 18 applicable.</p> <p>(h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure 1 of 2 vials of Tubersol (a medication used to test for tuberculosis) in 1 of 4 medications rooms (Secured Care Unit [SCU] medication room) was dated after opened. This deficient practice had the potential to compromise the efficacy of tuberculosis tests. Findings include: During an observation on 2/23/17 at 8:12 am, an opened undated vial of Tubersol was observed in the refrigerator of the medication room in the SCU. During an interview, at the time of the observation, LN #1 stated the vial was not dated. He said there was not a label on the vial to put a date so they did not date the vials when opening. The manufacturer's insert for the Tubersol</p>	F 431	<p>SPECIFIC RESIDENT</p> <p>The vial of Tubersol was destroyed.</p> <p>OTHER RESIDENTS</p> <p>All multi use vials where inspected to ensure that they were dated when opened. No other vials were found.</p> <p>SYSTEMIC CHANGES</p> <p>License Nurses were in-serviced on basic nursing standards related to multi use vials and labeling.</p> <p>MONITOR</p>		

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F 431	Continued From page 19 documented, "A vial of TUBERSOL which has been entered and in use for 30 days should be discarded ...Do not use after expiration date." During an interview on 2/24/17 at 9:07 am, the Director of Nursing (DON) said it was the facility's policy to date the vials. During an interview on 2/24/17 at 11:00 am, the DON said the facility did not have a policy for the dating of the Tubersol.	F 431	DON, Unit Managers or designee will perform medication room and medication cart audits weekly for 3 months then as needed once the Quality Assurance Committee deems compliance is being maintained. Results of medication audits will be taken to the monthly Quality Assurance meeting for review and adjustments made as indicated.		
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;	F 441		3/27/17	

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F 441	Continued From page 20 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their	F 441			

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F 441	<p>Continued From page 21 program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure urinary catheter bags and tubing were off the floor. This was true for 2 of 6 (#4 and #19) residents reviewed for urinary catheters. This failure created the potential for more than minimal harm by exposing residents to the risk of infection. Findings include:</p> <p>1. Resident #4 was admitted to the facility on 9/8/16, with multiple diagnoses including acute kidney failure and benign prostatic hyperplasia [enlarged prostate].</p> <p>Resident #4's current Care Plan, initiated on 9/14/16, documented, "I have an indwelling catheter...Ensure that my catheter bag is fully covered in a protective catheter cover. Ensure that my catheter tubing is not touching the floor."</p> <p>The 2009 Catheter-associated Urinary Tract Infection Toolkit found on the www.cdc.gov website, includes the following UTI prevention guidance, "Keep the collecting bag below level of bladder at all times (do not rest bag on floor)."</p> <p>Resident #4's February 2017 recapitulated Physician's orders included an order for an indwelling catheter.</p> <p>On 2/21/17 at 11:50 am, Resident #4 was observed in his room, sitting on his recliner with his uncovered catheter bag on his right side, placed on top of a folded towel on the floor.</p>	F 441	<p>SPECIFIC RESIDENT</p> <p>Resident # 4: expired during the survey; no correction possible.</p> <p>Resident # 19: urinary drainage bag has been replaced with a bag that has an attached privacy flap. A basin has been placed at his bed side for him to put his urinary bag in when self-transferring. Placement of his bag is being monitored during rounds.</p> <p>OTHER RESIDENTS</p> <p>Residents that require a urinary drainage bag are provided urinary bags with the attached privacy flap, and the bags will be kept off of the floor.</p> <p>SYSTEMIC CHANGES</p> <p>Staff were in-serviced on ensuring catheter bags are covered and kept off the floor.</p> <p>Department Head room rounds have been implemented twice per week to observe for placement of catheter bags.</p> <p>Unit Managers will observe for catheter bags privacy & placement during daily rounds. This will occur Monday through Friday.</p>		

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F 441	<p>Continued From page 22</p> <p>On 2/22/17 at 8:55 am, Resident #4 was observed to have an uncovered urinary catheter bag on the floor, and part of the tubing was touching the floor, while he was seated in his power wheelchair inside his room.</p> <p>On 7/22/17 at 11:43 am, the MDS Nurse said the urinary catheter bag was not to be on the floor.</p> <p>2. Resident #19 was admitted to the facility in 2014 and readmitted on 2/22/16 with multiple diagnoses, including obstructive and reflux uropathy [urine flow reverses direction due to a blockage in the tube that carries urine from the kidneys to the bladder] and urinary retention.</p> <p>Resident #19's care plan included an indwelling urinary catheter as a focus area, initiated 2/22/16 and revised 11/9/16. Interventions included, "Monitor placement of my catheter bag frequently as I have a hx. of letting bag drag on floor..."</p> <p>Resident #19's active physician orders included a 1/3/17 order for an indwelling urinary catheter and a 3/1/16 order for a urinary drainage bag.</p> <p>On 2/23/17 at 1:45 pm, Resident #19 was observed in bed watching TV and his uncovered urinary drainage was bag on the floor to the left of the bed.</p> <p>On 2/23/17 at 3:15 pm, Resident #19 was again observed in bed watching TV and the uncovered urinary drainage bag was on the floor by the bed.</p> <p>On 2/23/17 at 3:20 pm, RNM #1 accompanied the surveyor to Resident #19's room. The RNM said the urinary drainage bag should not be on</p>	F 441	<p>MONITOR</p> <p>Unit Managers, Department Heads or designee, will monitor for compliance through their rounds weekly for 3 months then as needed once the Quality Assurance Committee deems compliance is being maintained.</p> <p>Administrator and DON will monitor during daily walking rounds, Monday through Friday.</p> <p>Results of rounds will be taken to the daily Stand-Up meeting and addressed as indicated. Any ongoing concerns will be taken to the monthly Quality Assurance meetings for review and adjustments made as indicated.</p>		

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F 441	Continued From page 23 the floor. She said CNA's do rounds every 2 hours and shift change occurred at 2:00 pm and the expectation is that CNA's go into resident rooms to ensure things, such as call lights and needed items, are within reach. The RNM said that in Resident #19's case, the CNAs are to ensure the urinary drainage bag is off the floor.	F 441			
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (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;	F 514		3/27/17	

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F 514	<p>Continued From page 24</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure clinical records for each resident were complete and accurate. This was true for 2 of 3 residents (#20 and #22) whose closed records were reviewed. This deficient practice created the potential for Resident #22 to experience complications at the hospital if critical information was not sent with him at the time of transfer, and a lack of clarity of the events that occurred at the time of, and immediately after, Resident #20's death. Findings include:</p> <p>1. Resident #22 was admitted to the facility on 5/19/16, with diagnoses that included pneumonia.</p> <p>Resident #22's 2/20/17 progress notes documented:</p> <p>*At 4:35 am, Resident #22 approached the LN at 2:06 am and complained of shortness of breath. The LN administered PRN nebulization with little relief. Upon auscultation of Resident #22's chest, LN heard crackles all throughout. The Physician was notified and ordered Resident #22 be sent to the hospital. Paramedics were contacted but Resident #22 stated, "I'm not going to the [hospital name]." Paramedics offered another hospital but Resident #22 continued to refused to go to the hospital.</p>	F 514	<p>SPECIFIC RESIDENT</p> <p>Resident # 20 and 22: both were closed records. No correction possible.</p> <p>OTHER RESIDENTS</p> <p>Medical records for expired residents will include appropriate documentation: nursing notes identifying time of death, family, physician notification and orders received.</p> <p>Residents transferred from the facility medical records will include appropriate documentation: records or documents sent on transfer.</p> <p>SYSTEMIC CHANGES</p> <p>Nurses were in-serviced on appropriate documentation on residents who are transferred and/or expire.</p> <p>Written communications to and from the physician will be attached to nursing notes to ensure complete documentation was submitted.</p> <p>MONITOR HIM and or designee will perform</p>		

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F 514	<p>Continued From page 25</p> <p>*At 8:48 am, "...unable to take medication responds to verbal stimuli but unable to keep his eyes open or swallow medication, lung sounds with wheezing O2 sat at 88% on 5 per NC...MD called gave order to send resident to [hospital name] ER even if resident refuses, called family unable to reach at this time will try again. Called [Family Member] unable to reach her at this time."</p> <p>At 9:33 am, Resident #22 was sent to the hospital ER at 9:15 am. Resident #22's record did not include documentation of the records sent with him to the hospital.</p> <p>On 2/24/17 at 10:05 am, the DON said they would usually send the resident's face sheet, POST, MAR, physician orders, history and physical, with the resident upon transfer. She said the LN should have made notations about what documents were sent with Resident #22 when he left for the hospital.</p> <p>2. Resident #20 was admitted to the facility on 9/28/16, with diagnoses including end stage renal disease and advanced dementia. He subsequently passed away in the facility 10/18/16.</p> <p>A progress note, dated 10/19/16 at 8:15 am, documented "(Resident #20) passed away yesterday ...LMSW (Licensed Medical Social Worker) spoke with nursing staff, who reported they attempted to get ahold of (Resident #20's) wife to inform her that (Resident #20's) condition was not well. Resident's wife arrived at the (facility) after (Resident #20) had passed with a</p>	F 514	<p>documentation audits on residents who expire or transfer for 3 months and then as needed once the Quality Assurance Committee deems compliance is being maintained.</p> <p>Result of the documentation audits will be taken to the monthly Quality Assurance meeting for review and adjustments made as indicated.</p>		

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F 514	Continued From page 26 friend. Staff provided support..." A progress note, dated 10/18/16, lacked documentation of the resident's passing or of his wife and physician being notified. During an interview on 2/23/17 at 4:03 pm, the Director of Nursing said she was unable to find documentation in Resident #20's record of his passing or notification of the physician and Resident #20's wife. She said the nurse should have documented these events.	F 514		