



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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March 10, 2017

Gary "Paul" Arnell, Administrator
Life Care Center of Treasure Valley
502 North Kimball Place
Boise, ID 83704-0608

Provider #: 135123

Dear Mr. Arnell:

On **February 24, 2017**, a survey was conducted at Life Care Center of Treasure Valley 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 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, 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 "David Scott". The signature is written in a cursive style and is positioned above the typed name.

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: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2017
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from February 22, 2017 February 24, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Teresa Kobza, RDN/LD, Team Coordinator Candy Shugars, RN Ophelia McDaniels, RN Jackie Copas, RN</p> <p>ABBREVIATIONS:</p> <p>ADL = Activities of Daily Living ADON = Assistance Director of Nursing AFO = Ankle-foot Orthosis am = morning BID = Twice a Day CKD = Chronic Kidney Disease CNA = Certified Nursing Assistant DM = Diabetes Mellitus DON = Director of Nursing GERD = Gastroesophageal Reflux Disease HS = Hours of Sleep / Before Bed HTN = Hypertension hx = History LN = Licensed Nurse MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set mg = milligram mL = milliliter NPO = Nothing by Mouth OFM = Out for Meals oz = ounce pm = evening</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/17/2017
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 PRN = as needed R = Refused RAR = Residents at Risk RD = Registered Dietitian RN = Registered Nurse ST = Skin Tear UTI = Urinary Tract Infection	F 000			
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review it was determined the facility failed to ensure licensed nurses adhered to professional standards of practice related to medication management and administration. This was true for 1 of 8 residents (#18) reviewed for use of psychotropic medications. These failed practices created the potential for diversion of medication. Findings include: Resident #18 was admitted to the facility on 1/1/17, with a diagnosis of malignant terminal cancer with hospice care in place. Resident #18 died in the facility on 1/10/17. Resident #18's January 2017 Physician's Orders documented he was to receive 1 mg tablet of Ativan every 6 hours PRN, by mouth, for end of life anxiety, ordered 1/1/17.	F 281	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 the 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 constitute a deficiency, or that the scope and severity of the deficiencies cited are correct applied. F 281 SPECIFIC RESIDENT Resident #18 no longer in facility. OTHER RESIDENT Residents currently receiving hospice	3/29/17	

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F 281	Continued From page 2 Resident #18's January 2017 MAR documented a 1 mg tablet of Ativan was administered on 1/3/17. Resident #18's 1/6/17 Hospice Visit Report Form completed by the hospice RN documented, "Activated Lorazepam [Ativan] 0.5 mg liquid [every] 2 [hours] if needed for anxiety/restlessness...from preapproved orders - fax to follow." Resident #18's January 2017 MAR did not contain orders for liquid Ativan. Resident #18's Drug Destruction Log for January 2017, documented the facility administered 0.25 mL of liquid Ativan on 1/7/17. The faxed verbal order for the liquid Ativan was received in the facility and noted by nursing on 1/10/17. The physician had signed the order on 1/9/17. On 2/24/17 at 9:35 am, the DON stated the nurse gave the 0.25 mL of liquid Ativan without a physician's order. She stated the RN must have gotten the Ativan from the Pyxis. [A decentralized medication distribution system.] She stated because there was no order it was not included on the MAR. In addition, she said since it was not on the MAR the nurse did not sign the MAR. According to Potter, Perry & Ostendorf (2014), Clinical Nursing Skills & Techniques, 8th ed., safe medication administration is obtained in accordance with the six rights of medication administration: right medication; right dose; right	F 281	services are at risk for deficient practice. All hospice residents will be audited on or before 3/29/2017 to ensure current orders are in place and appropriately documented. ROOT CAUSE Licensed nurse failed to obtain appropriate order for medication before administration. SYSTEMIC CHANGE Education to be provided by Staff Development Coordinator on or before 3/29/2017 regarding appropriate implementation of physician orders prior to administration. MONITOR Director of Nursing or designee will monitor all new hospice orders to ensure orders are implemented prior to administration. Hospice chart audits will be conducted weekly x 4, and monthly x 3. Additional education will be provided as necessary. Results of audits will be reported to PI to ensure ongoing compliance. Plan to be updated as indicated. DATE OF COMPLIANCE: 03/29/2017		

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F 281	Continued From page 3 patient; right route; right time; and right documentation. Record medications immediately after administration. These standards were not followed.	F 281			
F 325 SS=D	<p>The facility failed to ensure a physician's order was received prior to the administration of the liquid Ativan on 1/7/17, the MAR contained an order for liquid Ativan, and the RN signed the MAR after administering the liquid Ativan.</p> <p>483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-</p> <p>(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;</p> <p>(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, it was determined the facility failed to ensure 1 of 3 residents (#7) sampled for weight loss was weighed and her intake of a liquid nutritional supplements was monitored. Resident</p>	F 325	<p>F 325</p> <p>SPECIFIC RESIDENT Resident #7 was assessed by Certified Dietary Manager and Registered Dietician</p>	3/29/17	

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F 325	<p>Continued From page 4</p> <p>#7 had the potential for harm when she experienced an 11.2% weight loss in 4 months. Findings include:</p> <p>Resident #7 was admitted to the facility on 3/16/16, with diagnoses including back pain, DM, macular degeneration, osteoporosis, CKD stage 3, fall history, and UTI.</p> <p>Resident #7's admit MDS assessment, dated 3/23/16, documented her weight was 123 pounds. Resident #7's quarterly MDS assessment, dated 6/14/16, documented her weight was 125 pounds and she was on a physician prescribed weight gain diet. Resident #7's quarterly MDS assessment, dated 12/1/16, documented her weight was 108 pounds. The MDS documented she had a moderate cognitive impairment and was dependent on staff for all cares except eating and drinking. She needed "Set Up" only for eating and drinking.</p> <p>Resident #7's February 2017 Physicians' Orders included:</p> <ul style="list-style-type: none"> * Resident #7 was to receive Ensure [liquid nutritional supplement] 1 can BID between the hours of 6-10 am and 3-6 pm, ordered on 10/3/16. <p>Resident #7's Nutrition Care Plan, dated 3/16/16, documented a goal of offering her food and fluids of her choosing. Interventions included:</p> <ul style="list-style-type: none"> * Nutritional supplements of Med-pass and Ensure to increase her calories with weight loss. * Staff was to observe and report to the physician when Resident #7 experienced significant weight 	F 325	<p>on 3/1/2017 to ensure appropriate interventions are in place. Resident continues to show stable weights and IDT determined weekly weights to be appropriate.</p> <p>OTHER RESIDENT Residents who trigger for significant weight loss and are on a liquid nutritional supplement are at risk for deficient practice. All residents at risk will be audited to ensure interventions are in place and timely on or before 3/29/2017.</p> <p>ROOT CAUSE Certified Dietary Manager failed to update weekly weights as an intervention for resident #7 from 9/7/2016 thru 10/3/2016.</p> <p>SYSTEMIC CHANGE Education to be provided by Staff Development Director to Certified Dietary Manager and licensed nursing staff on or before 3/29/2017 regarding Resident at Risk (RAR) policy, specifically on ensuring designated interventions are implemented timely as well ensuring liquid nutritional intakes are monitored.</p> <p>MONITOR Director of Nursing or designee will monitor all residents triggering for weight loss to ensure interventions are in place and timely as well as ensuring liquid nutritional intakes are monitored. Audits will be conducted weekly x 4, and monthly x 3. Additional education will be provided as necessary. Results of audits will be reported to PI to ensure ongoing compliance. Plan to be updated as indicated.</p>		

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F 325	<p>Continued From page 5</p> <p>loss.</p> <ul style="list-style-type: none"> * Staff was to provide her with a regular diet with regular textures as ordered by her physician. * Resident #7 was reviewed in the facility's Residents at Risk [RAR] for weight loss meetings. * Staff was to provide and observe Resident #7's intake of diet/fluids and encourage her to consume 50-75% of most meals. * Staff was to provide Resident #7 with a protein snack before bed. * Staff was to provide Resident #7 with small portions at breakfast and provide enhanced cereal at breakfast. * Staff was to weigh Resident #7 and record her weights weekly. <p>Resident #7's 3/16/16 through 1/30/17 Weight History Report documented:</p> <ul style="list-style-type: none"> * On 3/16/16 and 3/21/16, Resident #7's weight was 123 pounds. * On 6/6/16 and 7/1/16, Resident #7's weight was 125 pounds. * On 8/1/16, Resident #7's weight was 118 pounds. * On 8/8/16, Resident #7's weight was 117 pounds. * On 8/15/16, Resident #7's weight was 118 pounds. * On 8/22/16, Resident #7's weight was 121 pounds. * On 8/29/16, Resident #7's weight was 120 pounds. * On 9/2/16, Resident #7's weight was 116 pounds. * On 10/3/16, Resident #7's weight was 113 pounds. 	F 325			

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F 325	<p>Continued From page 6</p> <p>* On 11/7/16, Resident #7's weight was 107 pounds.</p> <p>* On 11/14/16, Resident #7's weight was 106 pounds.</p> <p>* On 11/21/16 and 11/28/16, Resident #7's weight was 108 pounds.</p> <p>Resident #7's 12/1/16 through 2/22/17 MAR did not document how much Ensure Resident #7 was consuming.</p> <p>Resident #7's RD Note, dated 6/7/16, documented she gained some weight [125 pounds] which was desirable to reach her admit weight. The note documented a goal of maintaining her weight at [125 pounds] vs gaining.</p> <p>Resident #7's Dietary Note, dated 8/3/16, documented the facility requested 1 can of Ensure daily. [Her weight was 118 pounds which was down 7 pounds from 6/7/16.]</p> <p>Resident #7's Dietary Note, dated 8/10/16, documented weekly weights were added, in addition to, the Ensure one time daily. [Her weight was 117 pounds which was down 8 pounds 6/7/16.]</p> <p>Resident #7's Dietary Note, dated 8/17/16, documented her intake had increased and she had gained weight to 118 pounds. The note documented they would weigh her in one month and review her status.</p> <p>Resident #7's Dietary Note, dated 9/7/16, documented her weight decreased by 4 pounds and her intake decreased to 59% from 75%. The</p>	F 325			

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F 325	<p>Continued From page 7</p> <p>note documented she was eating in her room due to isolation precautions. In addition, the note documented Resident #7 continued to get Ensure one time daily and the facility would be continuing the weekly weights. The weight history report above documented the next weight was attained on 10/3/16. Weekly weights were not obtained and monthly weights remained in place. In addition, the facility did not monitor the amount of Ensure Resident #7 consumed.</p> <p>Resident #7's Dietary Note, dated 9/14/16, documented her intake was around 35%. No weight was taken.</p> <p>Resident #7's Dietary Note, dated 10/5/16, documented her intake was around 25% and she was down another 3 pounds. Ensure 1 can BID and PRN was ordered on 10/3/16. In addition, Resident #7 was discharged from the RAR for weight loss meetings. Monthly weights remained in place.</p> <p>Resident #7's MD Note, dated 10/6/16, documented she had developed anorexia due to an infection.</p> <p>Resident #7's Dietary Note, dated 11/9/16, documented she triggered for weight loss, with a weight of 107 pounds, and the RD recommended Med-pass 2 ounce BID. In addition, the facility would be reviewing her weekly in the RAR of weight loss meetings. [Her weight was down 18 pounds from 6/7/16.]</p> <p>Resident #7's RD Notes on 9/3/16, 11/8/16, 11/15/16, 11/29/16, 12/6/16, and 2/7/17 documented Resident #7 had triggered for weight</p>	F 325			

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F 325	<p>Continued From page 8</p> <p>loss multiple times to include significant weight loss. The documentation included interventions when the RD was notified of weight concerns. There were no RD Notes between 6/8/16 through 9/12/16, and 9/14/16 through 11/7/16, documenting Resident #7's weight loss. In addition, the documentation did not include how the staff was to assess the effectiveness of the Ensure when the order change from one can daily to one can BID and PRN on 10/3/16. Resident #7's RD notes documented Resident #7's weight continued a downward.</p> <p>On 2/21/17 at 12:48 pm, Resident #7 was observed sitting in the dining room not eating until a family member arrived and requested food from the kitchen.</p> <p>On 2/23/17 at 9:10 am, the DON stated the facility implemented one intervention at a time to see if it was working, such as placing a resident on the list of residents to be reviewed at the RAR of weight loss meetings, which included monitoring weights weekly. She stated when a resident was followed by the RAR of weight loss group, weights were taken weekly, usually for 4 weeks, and after the 4th week the resident was assessed to determine if interventions in place were working. She stated the facility's practice was to monitor the resident's weights to assess the effectiveness of interventions [Ensure] put in place.</p> <p>On 2/23/17 at 12:00 pm, the RD showed a timeline of events outlined above. She stated Resident #7's weight was stable from 12/5/16 to 1/30/17 at 110-113 pounds and stated that was Resident #7's baseline weight. When asked how</p>	F 325			

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704		
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F 325	Continued From page 9 she determined the baseline weight, she stated it was because Resident #7's weight was in that range most of the time she had been in the facility, Resident #7 had a history of breast cancer, and Resident #7 was of advanced age.	F 325			
F 364 SS=F	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of menus and policies, it was determined the facility failed to ensure recipes were followed, food provided was in the appropriate form and nutritive content as prescribed by a physician, and food was seasoned and palatable and served at an appetizing temperature. This was true for each of the 96 residents living in the facility who received food prepared by the kitchen. These deficient practices created the potential for residents to experience health complication if foods served were inconsistent	F 364	F364 SPECIFIC RESIDENT All residents currently residing in facility are affected by deficient practice. OTHER RESIDENT All residents currently residing in facility are affected by deficient practice. ROOT CAUSE: Cook #1 did not use designated recipes to prepare food and was not consistent in preparing foods for altered textured diets. SYSTEMIC CHANGE	3/29/17	

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F 364	<p>Continued From page 10</p> <p>with their diets. It also placed residents at risk of weight loss if they found the food unpalatable, and at risk of psychosocial harm if they felt an ongoing lack of control over the quality of food available to them. Findings include:</p> <p>1. Residents participated in a Group Interview on 2/21/17 at 3:30 pm. Residents' complaints included the following: "Cold food, no flavor, tolerable but bland, meat too tough, no variety for people with allergies and colostomies."</p> <p>The dinner menu for 2/22/17 included the following foods: Baked Glazed Ham, Sweet Potatoes, and Seasoned Asparagus. Zucchini and tomatoes was one of the alternate food items. Observations of the preparation of the dinner meal include:</p> <p>* Cook #1 observed preparing the sweet potatoes on 2/22/17 at 2:40 pm, did not follow the facility's Production Recipe. She sprayed a pan with "pan coating concentrate" and poured 6 pounds of 14 ounce cans of "sweet potatoes in syrup" into a cooking pan. She sprinkled the sweet potatoes with an unknown amount of a mixture from a 10 ounce aluminum shaker with a hand written label - "Cinnamon and Sugar mixed 11/16/16." She poured an unknown amount of Marshmallows from a 2 pound bag over the sweet potatoes. She placed the pan in the oven.</p> <p>The Food Service Manager (FSM), in the presence of the Dietary Manager, was interviewed on 2/22/17 at 3:50 pm. The FSM said the mixture in the aluminum shaker was "equal parts cinnamon and sugar - half and half."</p>	F 364	<p>Education to be provided by Certified Dietary Manager on or before 3/29/2017 to all kitchen staff assigned to prepare food regarding policy on using designated recipes, served at appetizing temperatures and providing more palatability with altered textured diets.</p> <p>MONITOR</p> <p>Registered Dietician will monitor food preparation and delivery to ensure meals are prepared according to recipe and served at appetizing temperatures. Audits will be conducted weekly x 4, and monthly ongoing. Additional education will be provided as necessary. Results of audits will be reported to PI to ensure ongoing compliance. Plan to be updated as indicated.</p> <p>DATE OF COMPLIANCE: 03/29/2017</p>		

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F 364	<p>Continued From page 11</p> <p>The Production Recipe for "Cut Canned Yams" (no syrup indicated) specified 1 pound 9 ounces of brown sugar, 2 cups of water and 8 ounces of margarine were to be mixed and heated to a boiling point then poured over the sweet potatoes. Seasonings for sweet potatoes were "Allspice, Cardamom, Cinnamon, Cloves or Nutmeg," not the unknown amount and mixture used by Cook #1.</p> <p>* During observation of Cook #1's preparation of the Glazed Ham on 2/22/17 at 3:00 pm, she removed the outer skin of pre-cooked "boneless ready to serve" hams. Cook #1 sliced the hams and placed them in a shallow pan. She poured an unknown amount of brown sugar from a 2 pound bag over the ham. She sprinkled an unknown amount of cinnamon and sugar mixture from the aluminum shaker described in number 1 above. Cook #1 poured a 32 ounce pitcher of water over the ham slices.</p> <p>The Production Recipe for Baked Glazed Ham required that the ham be baked at 325 degrees Fahrenheit (F) for 2.5 hours until the internal temperature reached 155 degrees F. The ham was to be removed from the oven and scored ¼ inches deep in diamond pattern and covered with glaze. Then the ham was to be returned to oven and baked until the internal temperature reached 155 degrees F for 15 seconds.</p> <p>The ingredients for the glaze was to be prepared by combining 8 ounces of light brown sugar, 2 tablespoons of cornstarch, ½ cup of light corn syrup and ¼ cup & 1 tablespoon of pineapple juice.</p>	F 364			

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F 364	<p>Continued From page 12</p> <p>Following the above observations the Dietary Manager stated recipes should always be followed. When queried regarding the effect of unknown amounts of syrup, marshmallows, and sugar on residents receiving therapeutic diets, particularly for diabetic residents, she stated the residents should have received smaller servings.</p> <p>* Cook #1 was observed preparing the seasoned asparagus and she did not follow the facility's Production Recipe. She boiled frozen asparagus, drained the asparagus, and subsequently placed it on the steam table. The Production Recipe indicated 1 cup of margarine or butter was to be poured over the cooked asparagus.</p> <p>For the alternate vegetable, zucchini and tomatoes, the Production Recipe required that margarine, salt, and black pepper be added. Cook #1 did not include these items, or the canned diced tomatoes. Instead, tomato soup and pureed tomatoes were prepared.</p> <p>* Cook #1 was observed at 4:05 pm, preparing pureed sweet potatoes. The sweet potatoes were taken directly from the can and placed in the food processor. After processing the sweet potatoes they were placed in a silver container and put on the steam table. The Production Recipe indicated that pureed sweet potatoes were to be prepared according to the regular recipe and then placed in the processor until smooth. After processing, the sweet potatoes were to be reheated to a minimum temperature of 165 F or higher for 15 seconds.</p> <p>* Cook #1 was observed at 4:15 pm, removing ham from the walk-in refrigerator. It was in a 6 x</p>	F 364			

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F 364	<p>Continued From page 13</p> <p>6 inch silver container covered with clear plastic wrap. The ham was cut in slices. Cook #1 placed the ham in the food processor. After processing the ham it was placed in the silver container and put on the steam table. The Production Recipe indicated that the pureed ham was to be reheated to a minimum temperature of 165 degrees F or higher for 15 seconds.</p> <p>On 2/22/17 at 7:10 pm, the Dietary Manager was asked about Cook #1 using ham taken from the refrigerator. She stated that Cook #1 told her that the ham was "dated 2/21/17." She used it because it was "already cut up and ready."</p> <p>2. Test trays were requested and received at 6:55 pm, for Regular, Mechanical Soft and Pureed diet and textures. Food items on the regular diet test tray that were below the appetizing and safe range of 135 - 140 degrees F were sweet potatoes 120.2 degrees and ham 130.1 degrees F.</p> <p>Food items on the Mechanical Soft diet test tray that were below the appetizing and safe range of 135 - 140 degrees F were asparagus 127 degrees F and ham 128.3 degrees F.</p> <p>The ham on the Pureed test tray was extremely salty. The asparagus and sweet potatoes were bland. All items were warm and unappetizing. This was acknowledged by the Dietary Manager who took the temperatures and also tasted the food items for palatability.</p> <p>During an interview with the Director of Nursing on 2/23/17 at 2:00 pm, regarding the effect of unknown amounts of syrup, marshmallows, and</p>	F 364		

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F 364	Continued From page 14 sugar on residents receiving therapeutic diets, she stated, "Diabetic residents are on Consistent Carbohydrate Diet. Residents should have received smaller portions. Recipes should be followed." The Dietary Manager provided blank copies of the following documents, "Dining Service Review, Food and Nutrition Services Department Review, RD Monthly Facility Visit Report, and Test Tray Audit Form." Evidence in the manner of completed forms was requested. These were not provided. In addition, none of the blank documents provided included observation of cooks preparing meals. The facility's policy and procedures for "Food Preparation, Revised 11/11/2016" documented, "The Cook is responsible for food preparation. Menu items are prepared according to the menu, production sheets and recipes. Food is seasoned appropriately and acceptable to the residents. Food is prepared in a manner and form that meets each resident s needs...Food and drinks are palatable, attractive and at a safe and appetizing temperature."	F 364			
F 367 SS=D	483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State	F 367		3/29/17	

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F 367	<p>Continued From page 15</p> <p>law. 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 1 of 2 sampled residents (Resident #13) with physician orders for thickened liquids received and consumed beverages in the appropriate form as prescribed by the physician. This deficient practice placed Resident #13 at risk of aspiration and subsequent medical complications, including aspiration pneumonia. Findings include:</p> <p>Resident #13 was admitted to the facility on 2/2/12 with diagnoses that included dementia and muscle weakness. Resident #13's quarterly MDS assessment, dated 1/27/17, documented she had short and long term memory problems and modified independence in making decisions regarding tasks of daily life. She required extensive physical assistance from one staff person with eating.</p> <p>On 11/14/16, the attending physician ordered a regular puree diet with nectar thick liquids. Resident #13's care plan documented a problem of, "At risk for alteration in Nutrition/Hydration" with an initiation date of 2/2/12 and a target date of 5/3/17. Approaches included: "Needs increased assist from staff can be dependent at times."</p> <p>During the Kitchen/Food Service observation initiated on 2/21/17 at 7:10 am, the entrance and exit kitchen doors which lead to an adjacent dining area were always open. Posted on the wall between the 2 doors at the entrance and exit</p>	F 367	<p>F367 SPECIFIC RESIDENT Resident #13 was assessed to include lung sounds and vitals with no noted issue or adverse effect. Resident #13 was also assessed by speech therapy for appropriate diet textures. Family member was educated concerning administration of thickened fluid and acknowledged understanding of facility policy.</p> <p>OTHER RESIDENT Any resident with need for thickened fluids are at risk by deficient practice if assisted by anyone other than facility staff. Staff provided education to ensure door to beverage serving area outside of kitchen remains closed when not in use and all others aside from facility staff are redirected to ask for assistance.</p> <p>ROOT CAUSE: Staff failed to redirect family member from entering beverage area and preparing resident #13's coffee.</p> <p>SYSTEMIC CHANGE Education to be provided by Staff Development Coordinator on or before 3/29/2017 to all staff regarding beverage serving area policy and thickened liquid protocols.</p> <p>MONITOR Certified Dietary Manager or designee will monitor preparation and serving of thickened liquids to designated residents to ensure appropriate diet texture is provided. House wide audit will be</p>		

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F 367	<p>Continued From page 16</p> <p>to the kitchen was a sign "Employees Only." Staff of all disciplines in the facility were observed accessing an area in the kitchen near the door where beverages were located. Family members were also observed accessing the area during meal times. The area included coffee, tea, milk and hot chocolate. In addition, there was an 8 ounce can of "Instant Food Thickener" on the counter of the beverage area.</p> <p>During an observation on 2/22/17 at 5:30 pm, a male family member entered the beverage area, put coffee into a coffee cup and poured an unknown amount of thickener from the can on the counter in the beverage area into the coffee cup. The DM was apprised of the occurrence. She went to the dining table where Resident #13 and her Family Member, who put the thickener into the cup, were sitting. Resident #13 had already consumed the contents of the cup.</p> <p>Following the above, the DM stated, "The beverage area is for dietary aides. Family members should not be in the kitchen. The thickener is on the counter for dietary aides to use."</p> <p>During interview with the DON on 2/23/17 at 11:55 am, she stated she spoke with Resident #13's Family Member regarding "appropriate interventions for family members, Resident #13's physician was notified, Resident #13's lungs were assessed and vitals signs monitored, and an incident report was completed.</p> <p>The DM provided an undated policy and procedure titled Unauthorized Persons in the Food and Nutrition Services Department. The</p>	F 367	<p>provided to ensure all at-risk residents reviewed for appropriate diet texture on or before 3/29/2017. Audits will be conducted weekly x 4, and monthly x 3. Additional education will be provided as necessary. Results of audits will be reported to PI to ensure ongoing compliance. Plan to be updated as indicated.</p> <p>DATE OF COMPLIANCE: 03/29/2017</p>		

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F 367	Continued From page 17 policy documented, "Because we must prepare and serve food under sanitary conditions, it is necessary to allow only authorized individuals to enter the Food and Nutrition Services department."	F 367			
F 368 SS=E	483.60(f)(1)-(3) FREQUENCY OF MEALS/SNACKS AT BEDTIME (f) Frequency of Meals (f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. (f)(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. (f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, policy review, and record review, it was determined the facility failed to ensure bedtime snacks were offered to all residents. This was true for 5 of 11 anonymous residents in a Resident Group Interview, 20 of 21 (#1 - #4, #6 - #17, and #21 - #24) sampled residents residing in the facility,	F 368	F368 SPECIFIC RESIDENT All residents currently residing in facility are affected by deficient practice. OTHER RESIDENT All residents currently residing in facility are affected by deficient practice.	3/29/17	

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F 368	<p>Continued From page 18</p> <p>and all other residents in the facility who did not fall into a special category of residents who were provided bedtime snacks. The failure created the potential for more than minimal harm if residents experienced hunger between dinner and breakfast and/or did not receive adequate nutrition to support healing or prevent weight loss. Findings include:</p> <p>The facility's Therapeutic Diets, Snack and Supplements Policy and Procedure, dated 12/06/07, documented the facility was responsible for offering a night snack to all residents whose diet allowed a snack.</p> <p>1. Resident Group Interview Summary included:</p> <p>* On 2/21/17 at 3:00 pm, during the Resident Group interview with 11 residents, 5 residents said they were not offered bedtime snacks. The residents stated they did not realize a snack was to be offered to them at bedtime. They stated if they asked for a snack they could have one. One resident said they knew of other residents with diabetes who did receive bedtime snacks.</p> <p>2. Sampled Residents Summary's included:</p> <p>The key for facility ADL Flow-sheets included:</p> <p>* NPO = Nothing by Mouth * 0%/R = Refused * OFM = Out for Meals</p> <p>a. Resident # 4 was admitted to the facility on 5/26/16, with diagnoses which included HTN, stage 4 pressure ulcer, UTI and osteomyelitis.</p>	F 368	<p>ROOT CAUSE: Nursing staff designated to pass HS snacks did not offer 100% of residents a snack at HS.</p> <p>SYSTEMIC CHANGE Education to be provided by Staff Development Coordinator on or before 3/29/2017 to all nursing staff regarding facility policy on offering and passing HS snacks.</p> <p>MONITOR Director of Nursing or designee will monitor HS snack pass to ensure nursing staff is offering to residents. Random audits will be conducted weekly x 4, and monthly x 3. Additional education will be provided as necessary. Results of audits will be reported to PI to ensure ongoing compliance. Plan to be updated as indicated.</p> <p>DATE OF COMPLIANCE: 03/29/2017</p>		

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F 368	<p>Continued From page 19</p> <p>Resident #4's 2/18/17 through 2/23/17 HS snack record documented:</p> <ul style="list-style-type: none"> * "100%" one time. * "0%/R" four times. * Left blank one time. <p>b. Resident #8 was readmitted to the facility on 7/8/16, with diagnoses which included anxiety, hemiplegia and hemiparesis affecting the right side, depression, history of UTI, GERD, and obesity.</p> <p>Resident #8's 2/18/17 through 2/23/17 HS snack record documented:</p> <ul style="list-style-type: none"> * "100%" one time. * "0%/R" five times. <p>c. Resident #23 was admitted to the facility on 1/19/15, with diagnoses which included anemia, osteoarthritis, and HTN.</p> <p>Resident #23's 2/18/17 through 2/23/17 HS snack record documented:</p> <ul style="list-style-type: none"> * "0%/R" six times. <p>d. There were similar findings for Residents #1-#3, #6, #7, #9-#17, #21, #22, and #24 regarding the facility's failure to consistently offer HS snacks.</p> <p>3. Unit by Unit Summary included:</p> <p>Rooms 101-124 February 18, 2017 through February 23, 2017 HS snack records, minus those on tube feeding, documented:</p>	F 368			

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F 368	<p>Continued From page 20</p> <ul style="list-style-type: none"> * "100%" twenty-one times. * "25%" two times. * "0%/R" one-hundred and seven times. * Left blank eight times. <p>Rooms 125-149 February 18, 2017 through February 23, 2017 HS snack records, minus those on tube feeding, documented:</p> <ul style="list-style-type: none"> * "100%" thirty-four times. * "25%" one time. * "0%/R" two-hundred and eight times. * Left blank three times. <p>Rooms 201-209 February 18, 2017 through February 23, 2017 HS snack records, minus those on tube feeding, documented:</p> <ul style="list-style-type: none"> * "0%/R" twenty-seven times. * Left blank twenty-one times. <p>Rooms 301-312 February 18, 2017 through February 23, 2017 HS snack records documented:</p> <ul style="list-style-type: none"> * "100%" ten times. * "50%" two times. * "0%/R" one-hundred and seven times. * Left blank one time. <p>During an interview with LN #3 on 2/24/17 at 2:00 pm, she stated every evening dietary delivered snacks that were labeled for 'certain people' and nursing staff handed them out. If the resident refused the snack staff would remove the label and then discard the snack. When questioned, she stated 'certain people' could be diabetics,</p>	F 368			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2017
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F 368	Continued From page 21 residents with weight losses or anyone the doctor or dietician ordered as needing a snack. She stated there were extra snacks placed in the refrigerator in case other residents requested a snack, however, they were not routinely offered. On 2/24/17 at 2:05 pm, CNAs #2 & #3 stated residents were offered HS snacks depending on dietary requirements and preferences. They stated not every resident was scheduled to receive an HS snack. They stated if someone did not eat well at dinner they would offer an HS snack to that resident. On 2/24/17 at 2:14 pm, the Administrator stated he was not aware that snacks were not being offered to all residents.	F 368			
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	F 441		3/29/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2017
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F 441	Continued From page 22 limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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.	F 441			

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F 441	<p>Continued From page 23</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, staff interview, and policy review, it was determined the facility failed to ensure staff completed hand hygiene and cleaned resident-use equipment consistent with current standards of practice. These deficient practices directly impacted 2 of 17 sampled residents (#5 and #9) and had the potential to negatively impact all 54 residents who were serviced by the same nursing station as Resident #5. These deficient practices placed residents at risk of developing infections. Findings include:</p> <p>The facility's "Infection Control Policies and Procedures", dated 12/22/16, documented:</p> <p>Policy Title: Standard Precautions:</p> <p>- Purpose: to reduce the risk of transmission of infection. Standard precautions apply to all residents in all situations, regardless of diagnosis or presumed infection status. The required elements of standard precautions include: (1) adequate hand hygiene at all times, (2) appropriate use of personal protective equipment (PPE), including...gloves...(3) disinfection of surfaces and equipment between resident use...</p> <p>Replace gloves if torn, punctured, or contaminated...follow hand hygiene</p>	F 441	<p>F441 SPECIFIC RESIDENT Resident #9 and #5 were assessed for infection secondary to failed infection control practices with no findings. OTHER RESIDENT All residents currently residing in facility are affected by deficient practice. ROOT CAUSE: LN #1 and CNA #1 failed to follow facility infection control policies. SYSTEMIC CHANGE Education to be provided by Staff Development Coordinator on or before 3/29/2017 to LN#1, all nursing and therapy staff regarding appropriate infection control procedures for wound care, stethoscopes, blood pressure cuffs, and pulse oximeters. MONITOR Director of Nursing or designee will monitor wound care and infection control protocols for equipment. Random audits will be conducted weekly x 4, and monthly x 3. Additional education will be provided as necessary. Results of audits will be reported to PI to ensure ongoing compliance. Plan to be updated as indicated.</p>		

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

PRINTED: 03/30/2017
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 24</p> <p>recommendations immediately after removal of gloves.</p> <p>Policy Title: Cleaning and Disinfection of Non-Critical Patient Care Equipment:</p> <p>- Purpose: To establish a process for the cleaning and disinfection of non-critical, reusable patient care equipment (NCRPCE). The Centers for Disease Control (CDC) defines NCRPCE as items that come in contact with intact skin but not mucous membranes. Examples of NCRPCE include stethoscopes, blood pressure cuffs...and pulse oximeters etc. NCRPCE is to be cleaned daily and before and after use.</p> <p>These policies were not followed. Examples include:</p> <p>1. On 2/21/17, at 10:30 am, while observing application of a wound vac dressing on Resident #9, wound care nurse LN #1 removed the adhesive liner of the wound vac and threw it in the trash can. Then, with her gloved right hand, she lifted the lid to the trash can with her finger tips on the underside of lid and pulled the trash can closer to her. Without removing her gloves or washing her hands, she turned back to snap the two ends of the vac tubing together then pushed the start button to the machine.</p> <p>On 2/23/17, at 12:35 pm, LN #2, the Infection Control Nurse, was interviewed. LN #2 stated LN #1 reported her actions to her immediately after the 2/21/17 wound vac dressing change was completed. LN #2 stated LN #1 should have removed her gloves, sanitized her hands, then re-donned gloves prior to touching the tubing or</p>	F 441	DATE OF COMPLIANCE: 03/29/2017		

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F 441	<p>Continued From page 25 the wound vac machine.</p> <p>2. On 2/22/17, at 10:15 am, CNA #1 was observed entering Resident #5's room to obtain vital signs. From a blue plastic equipment tote he removed a pulse oximeter (a devise used to determine respiratory status by measuring oxygen saturation) placing the finger probe on a finger on Resident #5's right hand and laying the measurement device on Resident #5's bed next to the pillow under his head. After the reading was obtained, CNA #1 returned the device to his tote. He then applied a blood pressure cuff to Resident #5's right arm placing the bell of the stethoscope on the inner elbow area of the resident. After completed, CNA #1 returned the stethoscope and cuff to the tote. CNA #1 washed his hands, picked up the tote, carried it back to nurses' station where he placed it in a cabinet under the desk, shut the cabinet door, and left the nurses' station. CNA #1 did not return to the tote at nurses' station during the following hour of observation.</p> <p>On 2/23/17 at 12:35 pm, during interview, LN #2, the Infection Control Nurse, stated she expected the policy to be followed and the pulse oximeter disinfected with Sani Cloth AF3 (referred to as Purple wipes). However, she had no issue with the lack of disinfection of the blood pressure cuff since "it is not an invasive piece of equipment." She was asked to provide the facility policy regarding her statement. She returned approximately an hour later correcting her 12:35 pm statement, pointing out the above stated policy Cleaning and disinfection of Non-Critical Patient Care Equipment.</p>	F 441			

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F 441	Continued From page 26 On 2/24/17, at 2:10 pm, CNA #1 stated that during the 2/22/17 observation he forgot, but normally he cleaned the pulse oximeter with probe and blood pressure cuff with the disposable Sani Cloth AF3 to prevent the spread of infection.	F 441			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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May 17, 2018

Gerald Bosen, Administrator
Life Care Center of Treasure Valley
502 North Kimball Place
Boise, ID 83704-0608

Provider #: 135123

Dear Mr. Bosen:

On **February 24, 2017**, an unannounced on-site complaint survey was conducted at Life Care Center of Treasure Valley. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007443

ALLEGATION #1:

The Reporting Party stated the facility failed to ensure an identified resident's indwelling catheter was patent and draining as ordered.

FINDINGS #1:

An onsite complaint investigation was conducted at the facility from February 21, 2017 through February 24, 2017. Observations were conducted on four residents with indwelling catheters, and interviews were conducted with five residents, two family members, and three staff members. A resident group interview involving ten residents was conducted and three residents with indwelling catheters were interviewed. There were no concerns related to catheter care voiced by residents.

The clinical records of those residents with indwelling catheters, including the identified resident, documented foley care was performed per physician order and care plan. The identified resident's

clinical record documented the indwelling catheter was draining clear yellow urine the day prior to the resident's discharge to a hospital. The clinical record also documented that in late December 2016 the identified resident's urine was noted to be brown. The resident's physician was contacted by facility nursing staff, who requested orders to change the catheter, however the physician instead ordered an immediate transfer to the hospital, where he/she was diagnosed with bladder and renal stones. All residents observed during survey received appropriate catheter care, including cleaning and flushing as ordered. Urinary drainage bags were observed with urinary output on all days of the survey.

Although the allegation that the catheter was fully obstructed was substantiated, the facility was not cited with deficient practice given the presence of the renal stones as probable cause of the blockage.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #2:

The Reporting Party stated the facility failed to ensure an identified resident was not injured by use of an indwelling urinary catheter.

FINDINGS #2:

The clinical record documented the identified resident was admitted to the facility with an "eroded" meatus (opening through which urine is expelled from the body). The indwelling urinary catheter was later changed to a suprapubic catheter.

Although the allegation that the resident's meatus exhibited signs of "chronic tearing" from an indwelling catheter, this resident was admitted to the facility in this condition and the facility was not cited with deficient practice.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #3:

The Reporting Party stated the facility failed to ensure nursing staff managed a wound drainage system according to acceptable standards of practice and the system failed to suction the wound as designed.

FINDINGS #3:

In late December 2016, the identified resident was sent to a hospital on an emergent basis per physician order that did not include removing the wound vac. Two written witness statements documented emergency response personnel asked to remove the wound vac machine due to concern for cost and damage prevention. The facility's policy for wound vac care was consistent with the manufacturer's guidelines that the wound vac dressing could be left in place without vacuum for up to two hours. The hospital was located 2.5 miles from the facility. The Director of Nursing stated it was the facility's practice to send and receive residents without a wound vac pump to prevent loss of equipment and routinely exchanged residents to- and from the hospital without vac pumps in place.

The wound vac tubing was attached to the resident at the time of admission to the Emergency Room, but the wound vac itself was not attached to the tubing. The allegation could not be substantiated and the facility was not cited for deficient practice.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility failed to ensure an identified resident's skin was regularly assessed and managed, which resulted in injuries to the resident's feet.

FINDINGS #4:

Observations were conducted on four residents receiving care in the facility. All residents observed received appropriate foot care and seventeen other residents in the facility were observed receiving grooming care.

The identified resident was assessed with skin care needs upon admission to the facility. The identified resident's clinical record documented identified interventions, including compression stockings and pressure relieving assistive devices, were provided as physician ordered and care planned.

The allegation was not substantiated due to a lack of evidence.

CONCLUSIONS:

Gerald Bosen, Administrator
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Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The facility failed to ensure residents were provided with routine personal hygiene care.

FINDINGS #5:

Staff were observed providing appropriate pericare to the identified resident and three other residents, as well as appropriate personal hygiene and grooming care to seventeen residents observed for such care during the complaint investigation of February 21, 2017 through February 24, 2017.

The identified resident's clinical record and those of other residents reviewed for personal hygiene care did not document staff failure to provide this type of care and the allegation was not substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The facility failed to ensure residents were provided appropriate bowel care.

FINDINGS #6:

Four residents were observed receiving appropriate bowel care during the complaint investigation with no concerns identified.

The identified resident's clinical record documented two bowel movements the day prior to his/her transfer to a hospital, and that he/she had physician orders for the application of a topical agent to the peri-rectal area, which Treatment Administration Records documented staff applied each shift. Staff interviewed during the investigation stated the identified resident received per-care prior to his/her transfer to the hospital.

Based on observation, record review and interview, this allegation was not substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The facility failed to ensure an new early stage ulcer was properly assessed.

FINDINGS #7:

Six residents with pressure ulcers were observed receiving appropriate preventative- and curative care. These six residents stated they had no concerns regarding the care they received for these pressure ulcers.

The identified resident's clinical record documented a wound to the resident's coccyx had improved. Investigation revealed the facility employed a Licensed Nurse that served as their full time Certified Wound Care Nurse. For the named resident, the investigation revealed wound care measurements had improved greatly since his admission to the facility such that he no longer required the wound vac. Measurements at admission, on 12/16/16, were 3 centimeters (cm) x 3cm x 1 cm. On 2/19/17 measurements were documented as 1 cm x 1.5 cm x 1 cm. The resident's care plan and Admission Assessment, dated 12/16/16, noted 'scars' of buttocks due to healed pressure ulcers. A hospital wound care nurse assessed the resident on 12/29/16 and documented the ischial ulcer but, stated the rest of the coccyx and buttocks areas were pink in color from what appeared to be healed pressure ulcers. The hospital physician recorded three contrasting descriptions for the appearance of resident's buttock area.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #8: The identified resident had a bruise on his left arm.

Findings #8:

During the survey five individual resident were interviewed, two family members were interviewed, and three staff members were interviewed. A resident group interview which consisted of 10 residents was also conducted. There were no concerns related to unexplained bruises or abuse. All incident reports for the preceeding six months were reviewed to determine proper facility investigation of any unexplained bruising.

The investigation revealed on review of the named resident's Admission Assessment, dated 12/16/16, noted preexisting bruising to the left arm. The resident's plan of care on the same date documented potential skin issues that included, "Be aware: May spontaneously bruise and or tear due to aspirin and steroid therapy and not necessarily the result of trauma." There was a witness statement when paramedics arrived, four people transferred the resident onto the gurney to send

Gerald Bosen, Administrator
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to the ER, on 12/28/16. The resident was transferred on his left side and during the process his left arm hit the gurney. The resident's right arm kept sliding off off of the gurney The witness statement documented the transfer was not smooth but did not recall any skin integrity issues to the resident's arms.

The allegation was unsubstantiated due to a lack of sufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have questions, comments or concerns regarding our investigation, please contact Debby Ransom, RN, RHIT at (208) 334-6626, option 5. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "Debby Ransom". The signature is written in a cursive, flowing style.

Debby Ransom, R.N., R.H.I.T., Chief
Bureau of Facility Standards

DR/lj