



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

April 7, 2017

Corrected letter

Briar Hesler, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Ms. Hesler:

On **March 9, 2017**, a survey was conducted at Bridgeview Estates 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.

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 **April 12, 2017**. Failure to submit an acceptable PoC by **April 12, 2017**, may result in the imposition of penalties by **May 5, 2017**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **April 23, 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 **June 7, 2017**. A change in the seriousness of the deficiencies on **April 23, 2017**, may result in a change

Briar Hesler, Administrator
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in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 7, 2017** includes the following:

Denial of payment for new admissions effective **June 7, 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 **September 5, 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 **June 7, 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:

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

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

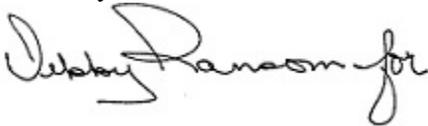
- BFS Letters (06/30/11)

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

This request must be received by **April 12, 2017**. If your request for informal dispute resolution is received after **April 12, 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,



Nina Sanderson, LSW, Supervisor
Long Term Care

ns/dr
Enclosures

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

PRINTED: 05/04/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2017
NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint investigation survey conducted March 6, 2017 to March 9, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Marci Clare, RN Sheila Sizemore, RN Haley Young, LSW</p> <p>ABBREVIATIONS:</p> <p>ADL = Activities of Daily Living A-Fib = Atrial Fibrillation BIMS = Brief Interview for Mental Status CM = Centimeters CNA = Certified Nursing Assistant CPR = Cardiopulmonary Resuscitation DON = Director of Nursing DNR = Do Not Resuscitate EMLA = Eutectic Mixture of Local Anesthetics GDR = Gradual Dose Reduction Hx = History of IV = Intravenous LN = Licensed Nurse LPN = Licensed Practical Nurse MAR = Medication Administration Record MASD = Moisture Associated Skin Damage MDS = Minimum Data Set mg = milligrams PDR = Psychotropic Drug Review PRN = As Necessary TAR = Treatment Administration Record UM = Unit Manager</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

04/12/2017

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 UTA = Unable to Assess VS = Versus X = by	F 000			
F 155 SS=E	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the	F 155		4/21/17	

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F 155	<p>Continued From page 2</p> <p>time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and review of facility policies, it was determined the facility failed to ensure a resident's cardiopulmonary resuscitation [CPR] code status was correct on a Resident Census Sheet, a document developed and updated by nurses and used to improve workflow. This was true for 1 of 13 sampled residents (Resident #2) whose code status was reviewed. This failure created the potential for Resident #2 to receive life-sustaining treatment against her wishes. It also created the potential for incorrect documentation on the census sheet of the code status of the other 21 residents residing on the Shoshone Falls Unit, and for life-sustaining</p>	F 155	<p>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 the Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.</p> <p>F155</p>		

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F 155	<p>Continued From page 3</p> <p>treatment to be provided, or withheld, contrary to their wishes. Findings include:</p> <p>During the initial tour on 3/6/17 beginning at 11:15 am, a surveyor received a Shoshone Nurses Census [a Resident Census Sheet] to assist with the tour. The census sheet indicated it had been updated on 2/25/17 and contained the residents' names, room numbers, physicians' names, a blank space for notes, and the residents' code status.</p> <p>The Shoshone Nurses Census sheet documented Resident #2's resuscitation code status as a "full code" which indicated CPR would be administered.</p> <p>Resident #2 was admitted to the facility with diagnoses including stroke, depression and hypertension.</p> <p>Resident #2's Idaho Physician Orders for Scope of Treatment [POST], dated 3/28/16, documented Resident #2's Cardiopulmonary Resuscitation status was "Do Not Resuscitate [DNR]."</p> <p>A Physician Order, dated 3/1/17, documented, "Clarification order...1. Code status: DNR..."</p> <p>Resident #2's care plan, dated 2/25/15, documented her code status was DNR as of 3/28/16 and, "CPR would not be initiated in honor with their wishes through the next review date."</p> <p>During an interview on 3/6/17 at 5:35 pm, the DON stated the nurses updated the Resident Census sheets.</p>	F 155	<p>SPECIFIC RESIDENT</p> <p>Resident #2 had code status removed from the working tool, "Resident Census Sheet". Resident #2 had accurate documentation of code status in all other areas confirmed in CMS-2567.</p> <p>OTHER RESIDENTS:</p> <p>Residents residing in facility will not have code status included in the working tool, "Resident Census Sheet".</p> <p>SYSTEMIC CHANGES:</p> <p>1. Direct care staff provided education related to removing of residents' code status on the working tool, "Resident Census Sheet". Training provided regarding the location of the code status for facility residents for accurate reference. 2. Facility wide audit completed to ensure code status was removed from working tool, "Resident Census Sheet". 3. Saved "Resident Census Sheet" was updated in computer files to ensure all previous working tool, "Resident Census Sheet", removed from facility. 4. House wide audit of all code status was done to ensure that the code status on the "POST" matches the order and care plan.</p> <p>MONITORING:</p> <p>DON and/or Nurse Manager to conduct audits of: 1) facility assigned units to ensure the working tool, "Resident Census Sheet", does not include residents' code status, which will include all four units in facility each audit and</p>		

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F 155	Continued From page 4 During an interview on 3/7/17 at 10:15 am, Unit Manager #1 stated the nurses create the sheets for themselves as a tool to help with the workflow. Unit Manager #1 stated the nurses should not use the census sheets to determine a resident's code status; the resident's chart should be used instead. Unit Manager #1 stated the use of the census sheets was not encouraged, as they could be wrong. On 3/9/17 at 8:25 am, Medication Administration Record binder by the Niagara Dining Room, was observed to have Resident Census Sheets placed at the front of the residents' Medication Administration Records. The facility policy, titled Advance Directives, dated 11/28/16, stated, "The Director of Nursing or designee establishes a system to inform all direct care staff of the resident's DNR status..."	F 155	2)ensure that residents' code status per "POST" matches order and care plan, which will include all new admits and re-admits after the house wide audit done on 4/11/17. Audits will be conducted twice weekly for four weeks, weekly for eight weeks and then every two weeks for four weeks. Results of audits will be reviewed at PI meeting for trending and ongoing education needs to ensure continued compliance.		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 157		4/21/17	

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F 157	<p>Continued From page 5 status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interviews, it was determined the facility failed to ensure a resident's responsible party was notified of a resident's fall after admission to the facility</p>	F 157	<p>F157</p> <p>SPECIFIC RESIDENT: Resident #14 has been discharged from</p>		

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F 157	<p>Continued From page 6</p> <p>following surgical repair of a thigh bone fracture, and initiation of an antibiotic due to redness at the surgical site. This was true for 1 of 16 (#14) sampled residents. This deficient practice precluded Resident #14's responsible parties from providing timely emotional comfort and support to her during her recovery and limited their ability to promptly advocate for her, if they deemed it necessary. Findings include:</p> <p>Resident #14 was admitted on 9/28/16, with multiple diagnoses including a fall with a femur [thigh] fracture that resulted in surgery prior to admission.</p> <p>The Admission MDS assessment, dated 10/5/16, documented Resident #14 had a fall with a fracture prior to admission, and a urinary catheter on admission.</p> <p>The Discharge Summary from the hospital, dated 9/28/16, documented Resident #14 was admitted to the facility with a history of falls and confusion.</p> <p>The facility's Policy for Changes in Resident's Condition or Status, received from the facility on 3/7/17 at 4:20 pm, documented nursing services was responsible for notifying the resident, his/her next of kin, or representative, as each case may apply when:</p> <p>*The resident is involved in an accident that results in injury. *There is significant change in the resident's physical, mental, or emotional status. *There is a change in the resident's room or roommate assignment. *A decision has been made by the executive</p>	F 157	<p>facility.</p> <p>OTHER RESIDENTS: Residents residing in the facility who experience a fall with injury and/or have an antibiotic ordered will have notification of family/representative notification present in their medical record; unless alert/oriented resident verbalizes to exercise their right to privacy and declines family/representative notification.</p> <p>SYSTEMIC CHANGES: 1. Education provided to LN staff in relation to family/representative notification and the accompanied documentation required related to change in condition which includes fall with injury and MD orders for new antibiotic treatment. 2. Education including notifying available contacts listed if unable to reach primary contact. 3. House wide audit completed for family/representative notifications for falls with injury since March 10, 2017. 4. House wide audit completed for family/representative notification for new antibiotics ordered since March 10, 2017.</p> <p>MONITORING: DON and/or Nurse Manager to conduct audits for proper family/representative notification related to falls with injury after facility admission and after the start of antibiotic treatment. Audits will be conducted twice a week for four weeks, weekly for eight weeks, and then every two weeks for four weeks.</p>		

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F 157	<p>Continued From page 7</p> <p>director or social services director to discharge the resident from the facility. *It is necessary to transfer the resident to a hospital.</p> <p>A physician order, dated 10/5/16, documented an antibiotic was started for an infection to Resident #14's surgical wound. The antibiotic was completed on 10/29/16.</p> <p>A Nurse's Note, dated 10/5/16 at 4:20 am, documented an antibiotic had been started due to redness around the surgical incision site. It did not document that Resident #14's Responsible Party #1 or Responsible Party #2 were notified.</p> <p>A Fall care plan initiated 10/21/16, documented staff were to report falls to Resident #14's physician and responsible party.</p> <p>The Face Sheet for Resident #14, updated on 10/29/16, documented to notify Responsible Party #2 if the first one could not be reached.</p> <p>The Incident Follow-Up and Recommendation Form, dated 11/9/16 at 4:00 am, documented Resident #14 had an unwitnessed fall, and the facility was unable to notify Resident #14's Responsible Party #1. The nurse did not document attempts to notify Responsible Party #2.</p> <p>A Nurse's Note, dated 11/9/16 at 4:30 am, documented the nurse attempted to call, but was unable to notify Responsible Party #1 of the fall. The note did not include attempted notification of Responsible Party #2.</p>	F 157	Results of audits will be reviewed at PI meeting for trending and ongoing education needs to ensure continued compliance.		

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F 157	Continued From page 8 On 3/8/17 at 3:15 pm, the Director of Nursing stated the nurses documented responsible party notifications in the nursing notes, care conference notes, or accident investigation documents, unless the resident was alert and oriented, and then it would depend on what the resident wanted or who they wanted notified.	F 157			
F 202 SS=D	483.15(c)(2)(ii) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES (c)(2) Documentation. (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- [483.15(c)(2)(i) will be implemented beginning November 28, 2017 (Phase 2)] (A) The resident's physician when transfer or discharge is necessary under paragraph 483.15(c)(1)(A) or (B) of this and (B) A physician when transfer or discharge is necessary under paragraph 483.15(c)(1)(i)(C) or (D). This REQUIREMENT is not met as evidenced by: Based on record review, review of an appointment book, and staff interview, it was determined the facility failed to ensure a future date of a medical care appointment appointment was provided to the receiving Long Term Care facility. This was true for 1 of 3 (#14) residents whose closed records were reviewed. This created the potential for more than minimal harm if Resident #14 missed an appointment as part of her ongoing care. Findings include: Resident #14 was admitted on 9/28/16, with	F 202	F202 SPECIFIC RESIDENT: Resident #14 has been discharged from the facility. OTHER RESIDENTS: Residents who discharge from the facility, including discharging to another SNF, will have their discharge summary completed, including the follow up appointment section for facility known scheduled	4/21/17	

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F 202	<p>Continued From page 9</p> <p>multiple diagnoses including a fall with a femur [thigh] fracture that resulted in surgery prior to admission.</p> <p>Resident #14 was discharged from the facility to another long term care facility on 11/15/16 at 3:52 pm with a discharge summary that included diagnoses, brief facility course, vital signs, medications, plan of care, and pending appointments but did not include the appointment for 11/21/16 at 9:20 am.</p> <p>On 3/9/17 at 11:00 am, the Resident Services Coordinator stated she got the appointments from the Transportation Coordinator appointment book and placed them on the discharge summary.</p> <p>On 3/9/17 at 11:05 am, the Transportation Coordinator stated she never canceled appointments whether the resident was still at the facility or not. The appointment book showed an appointment was made for Resident #14 for 11/21/16 at 9:20 am, but had been erased, and not carried over to the discharge summary.</p>	F 202	<p>appointments that will occur after discharge.</p> <p>SYSTEMIC CHANGES:</p> <p>1. Education provided to LN staff related to the discharge process; including the completion of the discharge summary. LN will review the discharge summary with the resident and family/representative if present at time of admission; including the appointment section. 2. Nurse Management staff educated to ensure the completion of the appointment section of the discharge summary. 3. Social Services educated on verification that the appointment section of the discharge summary is completed. 4. House wide audit completed for the last 7 days of discharged residents to ensure appointment section of the discharge summary is present.</p> <p>MONITORING:</p> <p>DON and/or designee to conduct audits of the discharge summaries to ensure appointment section is completed and scheduled appointments that the facility is aware of are present. Audits will be conducted weekly for eight weeks, and then every other week for eight weeks.</p> <p>Results of audits will be reviewed at PI meeting for trending and ongoing education needs to ensure continued compliance.</p>		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		4/21/17	

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F 281	<p>Continued From page 10 (b)(3) Comprehensive Care Plans</p> <p>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, it was determined the facility failed to ensure a resident's wound dressings were changed at the frequency ordered by the physician, and a resident's apical pulse rate was assessed before he was administered a antihypertensive medication and anesthetic cream was applied to his IV port site prior to chemotherapy. This was true for 2 of 16 sampled residents (#4 and #15). This deficient practice created the potential for the condition of Resident #4's skin tear to deteriorate without staffs' knowledge when dressing changes to the wound were not completed at the frequency ordered by the physician. Resident #15 was at risk of experiencing dangerously low heart rates when he was administered an antihypertensive medication without assessment of his apical pulse rate prior to administration of the medication. Failure to apply an anesthetic cream to Resident #15's IV port site prior to him receiving chemotherapy, placed him at risk of more than minimal harm due to pain and discomfort during the infusions. Findings include:</p> <p>1. Resident #4 was readmitted to the facility on 1/6/17, with multiple diagnoses that included pain, Guillain Barre Syndrome [a rare disorder in which your body's immune system attacks your</p>	F 281	<p>F281</p> <p>RESIDENT SPECIFIC: Resident #4's skin tear resolved without complication. Resident #15 has discharged from facility.</p> <p>OTHER RESIDENTS: Residents who reside in facility who receive a skin tear will have treatment completed per MD order. Residents who reside in the facility who have an MD order for Lopressor will have an apical pulse obtained prior to administration. Residents who reside in the facility who have anesthetic cream ordered prior to chemotherapy will have cream applied per MD order.</p> <p>SYSTEMIC CHANGES: 1. Direct education provided to LN's whom did not follow MD orders in relation to skin tear treatment. 2. Direct education provided to LN whom did not follow MD orders in relation to providing anesthetic cream prior to chemotherapy appointments. 3. Education provided to transportation staff on communication changes in resident's appointments with direct care staff and</p>		

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F 281	<p>Continued From page 11</p> <p>nerves, causing muscle weakness that can evolve into paralysis], and obesity.</p> <p>A Skin Care Plan, dated 1/6/17, documented Resident #4 was at risk for impaired skin integrity related to increased weakness, falling, mobility and range of motion...complicated by osteoarthritis, chronic pain, history of Guillain Barre syndrome causing chronic weakness and non-ambulatory status. Multiple interventions listed included wound care as ordered and to monitor Resident #14 to determine the effectiveness of, and response to, treatment.</p> <p>A Nurse's note, dated 2/16/17 at 10:05 pm, documented Resident #4 sustained a skin tear to her right shin when she caught her leg on a bolt on the bed.</p> <p>A physician order, dated 2/16/17, documented a Mepilex [self-adhesive dressing suitable for a wide range of wounds] dressing was to be applied to the wound on Resident #4's right shin and the dressing was to be changed every third day.</p> <p>The Treatment Administration Record [TAR], dated 2/16/17, document staff were to monitor Resident #4's skin tear for signs and symptoms of infection, change the dressing every 3 days, and notify wound nurse if the wound got worse.</p> <p>The TAR, for March, 2017, documented the dressing was scheduled to be changed on 3/3/17 and 3/6/17. The TAR did not include documentation the dressing was changed on those dates.</p> <p>On 3/8/17 at 11:10 am, the dressing to Resident</p>	F 281	<p>Nurse Management at the time the appointment is rescheduled. 4. Education provided to LN staff on following MD orders. Training completed on proper procedure if an MD order is unable to be completed as ordered. 5. Obtaining an apical pulse, and holding for apical heart rate less than 60 and notifying MD, prior to administering Lopressor has been added for residents receiving medication. 6. Education provided to Medical Records staff on requirements to be placed on MAR for Lopressor administration. 7. House wide audit completed on April 12, 2017 on wound dressing changes to ensure frequency is completed per MD order. 8. House wide audit completed on April 11, 2017 to ensure apical pulse monitoring is in place for Lopressor administration. 9. House wide audit completed on April 11, 2017 to ensure anesthetic creams are being applied to IV site prior to chemotherapy per MD orders.</p> <p>MONITORING: DON and/or Nurse Manager to conduct audits on: 1) Facility acquired skin tears have dressing changes completed per MD order. 2) Verify that anesthetic cream is applied to IV site prior to chemotherapy appointment per MD order. 3) Verify residents receiving Lopressor have apical pulse rate verified prior to medication administration and to hold Lopressor and notify MD for apical heart rate less than 60. Audits will be completed twice weekly for four weeks, weekly for eight weeks</p>		

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F 281	<p>Continued From page 12</p> <p>#4's right shin was observed with a date on the dressing of 2/27/17.</p> <p>On 3/8/17 at 11:10 am, Resident #4 stated that the dressing had not been changed since the date on it, and that no one had looked at the wound underneath.</p> <p>On 3/8/17 at 11:15 am, Unit Manager #1 stated the dressing was dated 2/27/17, and that it should have been changed every three days, as ordered.</p> <p>On 3/8/17 at 12:10 pm, the Director of Nursing stated the dressing should have been changed per the physician's order.</p> <p>2. Resident #15 was admitted to the facility on 8/30/16 with multiple diagnoses, including Hypertension [high blood pressure], A-Fib [Atrial Fibrillation, irregular heart rhythm], and Esophageal [throat] Cancer.</p> <p>a. The Recapitulation Physician Orders, dated September 2016, documented Resident #15 received Lopressor [medication to lower blood pressure, and/or stabilize heart rhythm] 50 mg [milligrams] twice daily for A-Fib, started 8/30/16.</p> <p>The 8/30/16 through 12/20/16 MARs [Medication Administration Records] documented Resident #15 received Lopressor 50 mg twice daily as ordered.</p> <p>The Nursing 2017 Drug Handbook by Wolters Kluwer documented, "Always check patient's apical pulse rate [a measure of heart function that is completed by placing a stethoscope at the</p>	F 281	<p>and then every other week for four weeks.</p> <p>Results of audits will be reviewed at PI meeting for trending and ongoing education needs to ensure continued compliance.</p>		

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F 281	Continued From page 13 top of the heart and counting for one minute] before giving drug. If it's slower than 60 beats [per] minute, withhold drug and call prescriber immediately." The Nurses' Notes documented Resident #15's heart rate was assessed daily from 8/30/16 to 12/19/16. The Nurses' Notes did not document Resident #15's apical pulse was assessed prior to the administration of the Lopressor twice a day. b. A physician's order, dated 9/13/16, documented Resident #15 was to have an LN [Licensed Nurse] apply a generous amount of EMLA 2.5-2.5 % cream [numbing cream] to his IV [intravenous] port [device that is placed under the skin to provide IV access] site 60-90 minutes prior to chemotherapy appointments. The September 2016 TAR did not include documentation the EMLA cream was applied to Resident #15's IV port site on 9/20/16. A Nurse's Note, dated 10/12/16, which was a late entry for 10/10/16, documented Resident #15 did not have the EMLA cream applied to his IV port site prior to his appointment on 10/10/16, because the appointment date was changed from 10/11/16 to 10/10/16. On 3/9/17 at 10:15 am, the DON verified the lack of documentation to show the EMLA cream was applied to Resident #15's IV port site prior to his chemotherapy on 9/20/16.	F 281			
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		4/21/17	

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F 314	<p>Continued From page 14</p> <p>(b) Skin Integrity -</p> <p>(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure an open wound located over a boney prominence was identified as a pressure ulcer. This was true for 1 of 3 sample resident (Resident #2) reviewed for pressure ulcers. This deficient practice created the potential Resident #2 to receive inappropriate care for a pressure ulcer. Findings include:</p> <p>Resident #2's clinical record documented she had diagnoses that included cerebral vascular accident [stroke], hemiplegia [weakness on one side of the body], and depression.</p> <p>Resident #2's quarterly MDS assessment, dated 10/10/16, documented Resident #2 was at risk for developing pressure ulcers, but did not have a pressure ulcer.</p>	F 314	<p>F314</p> <p>RESIDENT SPECIFIC: resident #2 has had a wound consultation at community wound clinic for assessment/treatment on 4/7/17.</p> <p>OTHER RESIDENTS: Residents who reside in the facility, who have open area, will have accurate assessment of area to ensure appropriate treatment is obtained by MD.</p> <p>SYSTEMIC CHANGES: 1. Education provided to facility Treatment Nurse on accurate assessment of open area/accurate identification. 2. In-house physician provided education on accuracy of wound</p>		

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F 314	<p>Continued From page 15</p> <p>Review of Resident #2's annual MDS assessment, dated 1/10/17, documented Resident #2 was at risk for developing pressure ulcers but did not have a pressure ulcer.</p> <p>A "Braden Scale for Predicting Pressure Sore Risk," dated 1/10/17, specified Resident #2 had a score of 12, which indicated she had a high risk for pressure ulcer development.</p> <p>Resident #2's care plan, dated 10/15/15, and revised on 1/31/17, with a target date of 5/1/17, included a problem statement: "At risk for impaired skin integrity...Hx [history] of MASD [Moisture Associated Skin Damage] to coccyx [lower back] area which despite treatments has continued to worsen...."</p> <p>The interventions for the above problem included:</p> <ul style="list-style-type: none"> * Complete Braden Scale Risk Assessment quarterly and PRN [as necessary] * Complete weekly skin assessments * Inspect skin during bathing, especially over bony prominences * Provide incontinence care PRN - apply barrier cream PRN * Report changes in skin status to physician * 3/2/17 Treatment changed to coccyx * 1/1/17 "Wound care Licensed nurse as ordered...Observe effectiveness of/response treatments as ordered. * Special protective devices used included: 3/1/17 low air loss mattress, Roho [pressure reduction] cushion to electric wheelchair * Minimize exposure to moisture and keep skin 	F 314	<p>classification/assessment and/or obtaining a second opinion to identify in unsure of clinical presentation. 3. Facility Treatment Nurse will consult with a WCC on a weekly bases via telephone for a three month period for proper identification process of an open area. A WCC Nurse will come to Bridgeview Estates for a monthly visit for a three month period to visually assess wounds for proper identification and appropriate treatment. A WCC Nurse will then be available as needed for consultation and arrive for a quarterly assessment of wound care program until proficiency from facility Treatment Nurse obtained. 4. Facility Treatment Nurse to continue gaining knowledge and experience. 5. House wide audit completed by DON for current facility wound to verify accurate assessment, which was completed on April 12, 2017.</p> <p>MONITORING: DON and/or designee to conduct audit on accurate assessment of open areas on a weekly basis for sixteen weeks.</p> <p>Results of audits will be reviewed at PI meeting for trending and ongoing education needs to ensure continued compliance.</p>		

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F 314	<p>Continued From page 16 clean of fecal contamination * 2/7/16 Reposition hourly</p> <p>A Weekly Care Team Note, dated 9/27/16, documented, "Resident has 0.5 cm [centimeter] by 1.0 cm white base open area to the right side of coccyx...This area does not appear pressure in nature. The skin is almost peeling off..."</p> <p>A Weekly Care Team Note, dated 10/4/16, documented, "Her left [area was on the right] coccyx 1.1 cm x 1.2 cm scab looking area almost if someone had scratched the area..."</p> <p>Resident #2's Non-Pressure Skin Condition Records documented the following:</p> <p>* "MAD (sic) 9/27/16 L (left) coccyx area...1.1 cm x [by] 1.0 cm...appearance of wound epithelial [thin fragile tissue], response to treatment may deteriorate."</p> <p>* 10/4/16: "1.1 cm x 1.2 UTA [unable to assess] depth, appearance of wound granular [pink or beefy red tissue] deteriorated."</p> <p>* 10/11/16: "1.0 cm x 1.2 cm UTA depth appearance of wound granular no change."</p> <p>* 10/19/16: "1.5 cm x 1.3 cm UTA depth appearance of wound granular no change."</p> <p>The wound decreased in size from 10/25/16 through 11/22/16. From 11/22/16 to 1/31/17 the wound fluctuated in size. The Non-Pressure Skin Condition Records further documented:</p> <p>* 1/31/17: "1 cm by 1.5 cm less than .1 cm depth</p>	F 314			

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F 314	<p>Continued From page 17 with a small amount of drainage..."</p> <p>* 2/13/17: "3.5 cm by 3 cm UTA depth small amount of drainage 70% granular [and] 30% slough [yellow, gray or tan-colored devitalized or dead tissue] response to treatment deteriorated.</p> <p>* 2/23/17: "4 cm x 0.8 cm UTA depth small amount of drainage 100% slough no change.</p> <p>* 2/28/17: "3 cm x 0.7 cm UTA small amount of drainage 100% slough improved..."</p> <p>A Physician's Progress Note, dated 2/16/17, "Pressure ulcer on her bottom..."</p> <p>On 3/7/17 at 10:55 am, the DON stated she was unsure of the accuracy of the physician's determination that the wound was a pressure ulcer.</p> <p>On 3/7/17 at 11:20 am, the in-house physician stated she was not updated on wound treatment and would defer to the facility's Wound Nurse as to the type of wound.</p> <p>On 3/6/17 at 5:55 pm, the Licensed Practical Nurse [LPN] Wound Nurse for the facility stated Resident #2 perspired a lot and was moist. She stated the wound was moisture associated skin damage [MASD]. She stated she "decides the treatment" for the wound on Resident #2's coccyx.</p> <p>On 3/8/17 at 9:25 am, the in-house physician stated she had looked at the wound and stated the wound had a whitish film over it and she was unsure if the film was slough. She stated she did</p>	F 314			

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F 314	<p>Continued From page 18 not know what it was.</p> <p>Resident #2's wound to the coccyx area was observed on 3/8/17 at 9:32 am, with the Wound Consultant and the LPN Wound Nurse. The total area measured 3 cm by 1 cm, the surrounding skin blanched and there was no excoriation to indicate MASD. The wound had a slim bridge of tissue in the middle with the superior area measuring 2 cm by 1 cm and the wound bed was covered with slough. The Wound Consultant stated the area was full thickness loss [tissue destruction that involves subcutaneous [fat] tissue and possibly bone and muscle] and had slough. The posterior wound measured .6 cm by .4 cm and the wound bed was red. The depth of the wound measured .1 cm. The surrounding area was free of excoriation or rash as associated with MASD.</p> <p>The facility's Non-Pressure Ulcer Treatment Plan Tool Guide, provided by the Wound Consultant on 3/8/17 at 8:25 am, documented, "...MASD, Clinical Manifestations/Characteristics Skin in the presence of constant moisture from fecal/urinary incontinence, wound exudate [drainage] effluent [flowing out] from stoma/fistula, or perspiration develops to persistent erythema [redness] - leading to diffuse erosions and partial thickness wound." Resident #2's coccyx wound did not meet the facility's definition of MASD, as it had full thickness tissue loss and its surrounding area was free of excoriation and rash.</p> <p>On 3/8/17 at 10:55 am, the Wound Consultant stated that she "came in the middle of this." She stated she understood there had been 3 different descriptions of Resident #2's wound, from scabs</p>	F 314			

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F 314	Continued From page 19 to denuded [the loss of the outer layer of the skin caused by exposure to urine, feces, body fluids, wound exudate or friction] areas. She stated Resident #2's wound could have been caused by shearing from the pad of the Hoyer lift. During a telephone interview on 3/8/17 at 5:05 pm, the Medical Director stated he did not see Resident #2's wound but would talk to the facility about it. During an interview on 3/9/17 at 8:25 am, the Wound Consultant stated she knew there were concerns with the facility's assessment and documentation of wounds. She stated facility staff needed to document a better description of residents' wounds. A facility policy, titled Pressure Ulcer Prevention, revised on 2/25/15, documented, "...Pressure ulcer, an ulceration of the skin secondary to pressure or shearing. May be superficial or full thickness."	F 314			
F 327 SS=D	483.25(g)(2) SUFFICIENT FLUID TO MAINTAIN HYDRATION (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- (2) Is offered sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by:	F 327		4/21/17	

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F 327	<p>Continued From page 20</p> <p>Based on observation, resident and staff interview, and record and policy review, it was determined the facility failed to ensure a resident whose arms were impaired, and who could not independently move about in his room, had a glass of water with a straw in it close to him so he could drink water at will without lifting the glass. This was true for 1 of 16 sample residents (Resident #7) whose hydration needs were reviewed. The deficient practice created the potential for Resident #7 to become dehydrated and develop urinary tract infections or other medical complications due insufficient fluid intake. Findings include:</p> <p>Resident #7's Physician's Orders, dated March 2017, documented he was admitted to the facility on 12/24/16, with diagnoses that included cerebral palsy and acute kidney failure.</p> <p>Resident #7's most recent MDS assessment, dated 12/31/16, documented Resident #7 was cognitively intact. The MDS also stated Resident #7 required extensive assistance from one person with eating and drinking. The assessment documented Resident #7 was totally dependent on the staff for locomotion in his wheelchair, had impaired range of motion to both of his upper extremities, and weighed 200 pounds.</p> <p>Resident #7's care plan, dated 12/24/16, documented staff were to, "encourage fluids with 'Frazier Free Water Program [FFWP]' and "offer additional fluids throughout the day."</p> <p>On 3/6/17 at 4:45 pm to approximately 5:00 pm, the following was observed and an interview with Resident #7 was completed. A sign was</p>	F 327	<p>F327</p> <p>RESIDENT SPECIFIC: Resident #7's water placed within reach while in his room.</p> <p>OTHER RESIDENTS: Residents residing in the facility will have water within reach unless; the resident prefers to have water placement in other location, medically contraindicated, and/or resident refuses.</p> <p>SYSTEMIC CHANGES: 1. Education provided to direct care staff on placement of fluid within resident reach and promoting hydration. 2. House wide audit completed for water within reach.</p> <p>MONITORING: Nurse Managers to conduct audit on fluid accessibility for residents three times a week for four weeks, twice weekly for eight weeks and then weekly for four weeks.</p> <p>Results of audits will be reviewed at PI meeting for trending and ongoing education needs to ensure continued compliance.</p>		

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F 327	<p>Continued From page 21</p> <p>observed on Resident #7's door that read "FFWP" and had a picture of a glass of water. Resident #7 sat in his wheelchair in his room. His water cup was on his bedside table, which was on the other side of the room pushed against the wall. The water cup was not within Resident #7's reach. Resident #7 stated sometimes the staff put his water cup on the bedside table next to him, but not always. He said when that happened he had to use the call light for a staff member to come put the cup to his mouth. Resident #7 stated sometimes he had to wait for 15 to 20 minutes or more for the staff to come. He then stated that he was thirsty; however, during the 15-minute observation and interview, none of the staff entered his room to offer him fluids or encourage his fluid intake.</p> <p>During an interview on 3/6/17 at 2:11 pm, CNA #3 stated Resident #7 can have water any time other than meal times. She stated he needs the water cup next to him because he cannot lift his arms to pick it up. CNA #3 said as long as the bedside table is pushed up next to Resident #7's wheelchair he can lean over and drink from the straw in the cup.</p> <p>During an observation on 3/7/17 at 8:35 am, CNA #5 brought Resident #7 into his room after breakfast and assisted him with oral care. After CNA #5 completed Resident #7's oral care, she did not ask him if he was thirsty or put his water cup within his reach.</p> <p>During observations on 3/7/17 at 8:35 am, 10:18 am, and 12:55 pm, Resident #7 sat in his wheelchair in his room. His water cup was not in his reach.</p>	F 327			

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F 327	<p>Continued From page 22</p> <p>During an observation on 3/8/17 at 3:20 pm, Resident #7 sat in his wheelchair in his room. His water cup was not in his reach.</p> <p>During an interview on 3/8/17 at 3:20 pm, LN #1 stated Resident #7 had to lean over his bedside table to drink his water out of his cup using a straw. She stated the staff should always place the bedside table next to him so he can reach it. LN #1 then moved Resident #7's bedside table with his water cup on it from against the wall and brought it to his side so he could reach it.</p> <p>During an interview on 3/8/17 at 3:35 pm, the Registered Dietician [RD] stated Resident #7 was on the "Frazier Free Water Program," which meant he could have water any time except for with meals. When asked for the facility's policy and procedure for the "Frazier Free Water Program," the RD stated they did not have a policy; however, a sign was placed on Resident #7's door that said "FFWP" with a picture of a glass of water so staff knew he could have water.</p> <p>During an interview on 3/8/17 at 3:35 pm, Unit Manager #2 stated Resident #7 could have water while in his room and did not need to be supervised. She stated the staff were responsible for placing the water cup next to Resident #7 because he was unable to lift the cup himself.</p> <p>During an interview on 3/8/17 at 3:35 pm, the Director of Nursing stated he expected the staff to always place Resident #7's water cup in reach of him so he can drink.</p> <p>The facility's Hydration & Nutrition policy, dated</p>	F 327			

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F 327	Continued From page 23 11/2016, documented, "fluid is available to patients at all times." This policy was not followed for Resident#7.	F 327			
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 329		4/21/17	

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F 329	Continued From page 24 (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents administered psychotropic medications had clear indications for use of the medications and the medications were administered at the lowest effective dose. This was true for that 3 of 6 sampled residents (#1, #2, and #4) reviewed for psychotropic medications. This deficient practice created the potential for more than minimal harm if residents received psychotropic medications that may result in negative outcomes, without evidence the benefits of the medications outweighed the risks associated with the use of the medications. Findings include: 1. Resident #1 was admitted to the facility with diagnoses including congestive heart failure, chronic obstructive pulmonary disease, and depression. Resident #1's annual MDS assessment, dated 1/3/17, documented she had moderate cognitive impairment. The MDS assessment stated Resident #1 had difficulty focusing attention and was easily distracted. The MDS assessment documented Resident #1 demonstrated no behaviors, did exhibit weight loss, and received antipsychotic and antidepressant medications. A Physician's Order, dated 10/5/16, documented Resident #1 received Zyprexa [an antipsychotic	F 329	F329 RESIDENT SPECIFIC: #1 had Zyprexa discontinued. Resident #2 had Abilify decreased to 2.5mg daily. Resident #4 had Celexa decreased to 30mg daily on 4/12/17 and will have Amitriptyline decreased to 125mg on 5/1/17. Decreasing Amitriptyline sooner has been deemed contraindicated by Dr. Wiggins due to recent changes to Seroquel, Celexa and Buspar. OTHER RESIDENTS: Resident in the facility who receive a psychoactive medication will have accurate monitoring to indicate appropriate use. GDR requests will be discussed with MD providing the current monitoring available to support request. If GDR request is declined will send follow up clarification to MD to obtain clinical pertinent rationale. SYSTEMIC CHANGES: 1. Education provided to direct care staff on accurate monitoring of psychoactive medications to indicate appropriate use. 2. Education provided to DON, Nurse Management Team and Social Services to obtain MD clarification of clinically		

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F 329	<p>Continued From page 25 medication] 2.5 milligrams [mg] at bedtime.</p> <p>Resident #1's Behavior Monitoring Sheets for November 2016 through March 2017, documented she exhibited one behavior, that of being "bossy to others" on 1/5/17.</p> <p>Resident #1's December 2016 Behavior Monitoring Sheet included a notation that read, "...Mood improved, Res [Resident] up more attending activities, wt [weight] is stable..."</p> <p>Resident #1's Physician's Order, dated 1/27/17, documented the physician directed the staff to, "Increase Zyprexa to 5 mg po [by mouth] at bedtime. Wt. loss/failure to thrive..."</p> <p>During an interview on 3/7/17 at 11:10 am, the Director of Nursing [DON] stated he spoke with Resident #1's physician on 3/6/17 and the physician discontinued the medication.</p> <p>During an interview on 3/7/17 at 2:30 pm, Social Service Designee #1 stated she did not agree with the physician's decision to increase Resident #1's Zyprexa because of weight loss. Social Service Designee #1 stated she had called the physician and he "was adamant about" the medication increase.</p> <p>2. Resident #2 had diagnoses of depression, hypertension, and cerebral vascular accident [stroke].</p> <p>Resident #2's annual MDS assessment, dated 1/10/17, documented she exhibited no behaviors during the assessment's evaluation period.</p>	F 329	<p>pertinent rationale for GDR refusals. This clarification will be placed in resident's medical records. 3. House wide audit completed on residents on psychoactive medication for pertinent rationale if GDR request declined.</p> <p>MONITORING: Nurse Management and/or Social Services to conduct audits of: 1) behavior monitoring to support clear indication of use, 2) ensure requests for GDR attempts have clinically pertinent rationale if declined. Audits will be conducted twice weekly for eight weeks, then weekly for four weeks and then every other week for four weeks.</p> <p>Results of audits will be reviewed at PI meeting for trending and ongoing education needs to ensure continued compliance.</p>		

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F 329	<p>Continued From page 26</p> <p>The February 2017 Physician's Orders documented Resident #2 received Abilify [antipsychotic medication] 5 mg daily and Zoloft [antidepressant medication] 50 mg daily.</p> <p>Resident #2's Behavior Monitoring Sheets from November 2016 through March 2017, documented she exhibited no "Episodes of tearfulness" throughout that time period.</p> <p>A Pharmacy Consultant Report, dated 1/11/17, documented Resident #2 had received Abilify since 11/1/15. The pharmacist documented, "Recommendations: Please consider a gradual dose reduction [GDR] or provide a statement of risk versus benefit for the continuation at the current dose..." The Pharmacy Consultant Report had the physician's response written on the bottom of the page which read, "NOT a good idea. She's finally not crying all the time." The physician's response lacked documentation of the risks versus the benefits of the medication.</p> <p>On a Monthly Behavior Summary/Psychoactive GDR Review for the "Period Ending 12/16" the pharmacist documented, "Mood stable will request risk vs [versus] benefits regarding dual antidepressant therapy."</p> <p>During an interview on 3/6/17 at 5:35 pm, the DON stated the physician had not given an explanation of the risk versus the benefit of Resident #2 continuing to receive Abilify 5 mg daily.</p> <p>During an interview on 3/7/17 at 10:15 am, Unit Manager #1 stated the physician had not documented the risks versus benefits of Resident</p>	F 329			

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F 329	<p>Continued From page 27</p> <p>#2 continuing to receive the antipsychotic Abilify at the same dose of 5 mg daily. Unit Manager #1 said Resident #2 had not been crying and was doing "Very well."</p> <p>3. Resident #4 was admitted to the facility on 5/1/15, and readmitted on 1/6/17, after a one day discharge to the hospital. Her diagnoses upon readmission included bipolar disorder, depression, anxiety, insomnia, and Guillain Barre Syndrome [a rare disorder in which your body's immune system attacks your nerves, causing muscle weakness that can evolve into paralysis].</p> <p>The Quarterly MDS assessment, dated 11/1/16, documented Resident #4 had no cognitive impairment, and minimal symptoms of depression.</p> <p>A Physician order, dated 5/1/15, documented to give Resident #4 Citalopram [antidepressant] 40 milligram [mg] tablet, by mouth, every day.</p> <p>A Physician order, dated 7/6/15, documented to give Resident #4 Amitriptyline [antidepressant] 150 mg tablet, by mouth, every day.</p> <p>Resident #4's the Medication Regimen Reviews, completed by the consultant pharmacist, documented the following recommendations:</p> <p>*5/25/16, "Two antidepressants, including Amitriptyline 150 mg every night, and Citalopram 40 mg every day. Need a statement of risk versus [vs] benefit for dual antidepressant therapy."</p> <p>*11/16/16, "...Citalopram 40 mg every day for diagnoses of depression since 5/1/15...Need a</p>	F 329			

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F 329	<p>Continued From page 28</p> <p>GDR [Gradual Dose Reduction] request or a strong statement of risk vs benefit for continuation of treatment." *1/11/17, "Resident is at risk for potential falls due to several psychotropic medications."</p> <p>The Pharmacy Consultation Report, dated 6/29/16, documented Resident #4 was receiving two anti-depressants, the recommendation stated to re-evaluate the need for both medications, and if both are to continue, provide a statement of risk vs benefit for dual antidepressant therapy.</p> <p>The Pharmacy Consultation Report, dated 1/11/17, documented that Resident #4 is at risk for falls that may be related to multiple antipsychotic medications.</p> <p>A Physician's order, dated 1/6/17, documented Resident #4 was to be administered Citalopram 40 milligram tablet, by mouth, every day.</p> <p>Behavior/Intervention Monthly Flow Records, for the months of May 2016 through November 2016, and January 2017, documented the following shifts with depression symptoms. The facility monitored three shifts per day.</p> <p>*May 2016 - zero shifts with depressive behaviors *June 2016 - one shift with depressive behaviors *July 2016 - zero shifts with depressive behaviors *August 2016 - zero shifts with depressive behaviors *September 2016 - zero shifts with depressive behaviors *October 2016 - zero shifts with depressive behaviors</p>	F 329			

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F 329	<p>Continued From page 29</p> <p>*November 2016 - zero shifts with depressive behaviors</p> <p>*December 2016 - facility could not provide</p> <p>*January 2017 - zero shifts with depressive behaviors</p> <p>Resident #4's Psychotropic Medication care plan, initiated 5/1/15, and last revised on 1/6/17; documented Resident #4 had the potential for adverse reactions or side effects from use of psychotropic medications. The interventions documented to review by Psychotropic Drug Review [PDR] committee for possible GDR per facility protocol.</p> <p>The facility's Policy and Procedure for GDR's, revised on 11/17/16, documented each patient's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:</p> <ul style="list-style-type: none"> *In excessive dose (including duplicate therapy) *For excessive duration *Without adequate monitoring *Without adequate indication for its use *In the presences of adverse consequences which indicate the dose should be reduced or discontinued. <p>It also stated based on comprehensive assessment the facility must ensure that antipsychotics, antidepressants, antianxiety and hypnotics meet the below:</p> <ul style="list-style-type: none"> *Patients who use these drugs receive gradual dose reduction and behavioral interventions, unless clinically contraindicated in an effort to discontinue these drugs. <p>The Policy defined GDR as the "stepwise</p>	F 329			

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F 329	<p>Continued From page 30 tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued."</p> <p>Social Service notes, dated below, documented the following depressive behaviors and GDR's for antidepressant usage::</p> <ul style="list-style-type: none"> * 3/28/16 - no behaviors * 4/13/16 - no behaviors * 5/19/16 - no behaviors * 6/6/16 - no behaviors * 6/28/16 - one episode of tearfulness, reviewed in PDR, no medication changes * 7/22/16 - no behaviors * 8/16/16 - no behaviors * 8/25/16 - no behaviors, reviewed in PDR, no medication changes * 8/29/16 - no behaviors * 9/6/16 - no behaviors * 10/20/16 - no behaviors, reviewed in PDR, no medication changes * 11/6/17 - no behaviors * 11/17/17 - no behaviors, reviewed in PDR, no medication changes * 12/7/16 - no behaviors, reviewed in PDR, no medication changes. * 1/11/17 - no behaviors, reviewed in PDR, no medication changes. * 1/24/17 - no behaviors * 2/17/17 - no behaviors, reviewed in PDR, no medication changes <p>On 3/9/17 at 9:20 am, the Social Service Designee #1 stated the facility has a PDR meeting monthly, where they discuss the residents and all psychotropic medications, pharmacy referrals, and review Behavior</p>	F 329			

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F 329	Continued From page 31 Monitoring sheets. If the decision is to not do a GDR they would ask the physician to document the risks versus the benefits in the record. Social Service Designee #1 was unable to provide documentation of the risks versus the benefits for Resident #4. On 3/9/17 at 9:35 am, the in-house physician stated she did not know Resident #4 well enough to do a GDR and had not completed a risks versus benefits analysis of her medications, as she had recently assumed care of Resident #4. On 3/9/17 at 9:50 am, the DON stated the in-house physician recently assumed responsibility for Resident #4's care. The DON was unable to provide documentation of the risks versus the benefits for Resident #4's continued use of Citalopram 40 mg daily. On 3/9/17 at 4:00 pm, the DON provided a note from Resident #4's physician, dated 1/8/17, that stated "To whom it may concern, Resident #4 has a diagnoses of Bipolar disorder. A dose reduction is contraindicated for this resident secondary to a chronic persistent severe mental illness with documented history of severe decompensation following previous dose reduction attempts." An addendum to the physician's note, added on 3/9/17 at 4:00 pm, documented, "the doctor clarified the above statement to include Seroquel [an antipsychotic] and Celexa [Citalopram] for Bipolar Depression" and the dose reduction of Seroquel occurred on 9/5/16.	F 329			
F 368 SS=E	483.60(f)(1)-(3) FREQUENCY OF MEALS/SNACKS AT BEDTIME (f) Frequency of Meals	F 368		4/21/17	

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F 368	<p>Continued From page 32</p> <p>(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.</p> <p>(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.</p> <p>(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 observation, resident and staff interview, and review of facility policy, it was determined the facility failed to ensure the staff offered snacks daily at bedtime for 6 of 20 residents (Residents #7, #9, #13, #17, #18, and #19) reviewed for 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 Hydration and Nutrition policy, dated 11/2016, documented, "The hydration cart provides a means of offering beverages/snacks at 10 am, 2 pm, and HS [night]." This policy was</p>	F 368	<p>F368</p> <p>RESIDENT SPECIFIC: Resident #7, #9, #13 and #19 will have HS snacks offered. Resident #18 has been discharged from facility.</p> <p>OTHER RESIDENTS: Residents in the facility will have HS snacks offered; unless medically contraindicated.</p> <p>SYSTEMIC CHANGES: 1. Direct care staff provided education on facility hydration/snack policy. 2. Nursing Management provided education on</p>		

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F 368	Continued From page 33 not followed. Example include: * During a group interview on 3/6/17 at 2:00 pm, 3 out of 8 residents stated they were not offered bedtime snacks. Resident #17, Resident #18, and Resident #19 stated unless you have a snack ordered by the physician you do not get one. * During an interview on 3/6/17 at 4:45 pm, Resident #7 stated the staff did not regularly offer him a bedtime snack. He stated he was unsure why they did not and that they used to offer a snack. * During an interview on 3/7/17 at 9:35 am, Resident #9 stated the staff do not come by and offer snacks in the evenings. * During an interview on 3/8/17 at 2:25 pm, Resident #13 stated the staff did not offer bedtime snacks. * During an interview on 3/8/17 at 4:25 pm, Resident #18 stated she had not been offered a bedtime snack since her admission earlier in the week. * During an interview on 3/8/17 at 8:00 pm, Resident #17 stated she was not offered a bedtime snack and she had a diagnosis of diabetes. Resident #17 stated if she needed a bedtime snack she would have to ask the staff for one. * During an interview on 3/9/17 at 1:10 pm, Resident #19 stated she was not offered a bedtime snack by the staff.	F 368	facility hydration/snack policy. 3. Snack/hydration cart placed in service on April 12, 2017 to increase accessibility of snacks offered to the resident. 4. Unit Nurse will ensure offering of HS snack to facility residents, unless medically contraindicated. 5. House wide audit completed to ensure HS snacks offered to facility residents. MONITORING: DON, SDC and/or Unit Nurse will conduct audits of HS snack offering to twenty percent of facility residents. Monitoring to be conducted three times a week for four weeks, twice a week for four weeks, weekly for four weeks and then every other week for four weeks. Results of audits will be reviewed at PI meeting for trending and ongoing education needs to ensure continued compliance.		

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F 368	Continued From page 34 During an observation on 3/8/17 at 8:00 pm, evening snacks had not offered to the residents. There was no cart with food items on it. There were food items available in the refrigerator and cabinet. During an interview on 3/8/17 at 8:10 pm, LN #2 stated snacks were assigned to certain residents and ordered by the physician. She stated there were snacks available for other residents but it was not part of the CNA's routine to offer snacks to every resident at bedtime. During an interview on 3/9/17 at 9:20 am, Unit Manager [UM #2] stated the staff did not need to offer a bedtime snack to every resident. UM #2 stated the staff did not go room to room in the evenings to offer snacks to the residents. She stated it depended on each resident's situation if they get a snack. During an interview on 3/9/17 at 9:25 am, the Director of Nursing stated all residents should be offered a bedtime snack every evening.	F 368			
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 514		4/21/17	

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F 514	Continued From page 35 (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, the facility failed to maintain accurate meal intake documentation for 3 of 20 sampled residents (#7, #9, and #16) whose records were reviewed. This failure had the potential to compromise residents' nutritional and overall health status if medical decisions were based on inaccurate meal intake information. Findings include: 1. Resident #9's Physician's Orders, dated March 2017, documented she was admitted to the facility on 8/14/13, with diagnoses that included	F 514	F514 SPECIFIC RESIDENTS: Residents #7 and #9 have accurate meal documentation. Resident #16 has been discharged from the facility. OTHER RESIDENTS: Residents in the facility will have accurate documentation reflecting amount of intake per meal. SYSTEMIC CHANGES:		

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F 514	<p>Continued From page 36</p> <p>Type II diabetes, gout, Meniere's disease [a disease of the inner ear], anxiety disorder, and dysphagia [difficulty swallowing].</p> <p>Resident #9's MDS assessment, dated 2/2/17, documented she was cognitively intact.</p> <p>An ADL Meal Intake sheet, dated March 2017, documented Resident #9 ate 100% of breakfast on 3/7/17.</p> <p>During an interview on 3/7/17 at 9:35 am, Resident #9 stated she did not eat breakfast that morning because she was not feeling well.</p> <p>During an interview on 3/8/17 at 8:30 am, Resident #9 stated she did not get a breakfast tray on 3/7/17 and did not eat breakfast that day. She stated it was by choice because she was not feeling well.</p> <p>During an interview on 3/8/17 at 8:40 am, Certified Nursing Assistant [CNA] #4 stated Resident #9 refused breakfast on 3/7/17 because she was not feeling well. CNA #4 stated the charting was wrong and she made a mistake.</p> <p>2. Resident #7's Physician's Orders, dated March 2017, documented he was admitted to the facility on 12/24/16, with diagnoses that included cerebral palsy and acute kidney failure.</p> <p>Resident #7's MDS assessment, dated 12/31/16, documented he was cognitively intact.</p> <p>An Activities of Daily Living [ADL] Meal Intake sheet, for March 2017, documented Resident #7 refused his evening snack on 3/8/17.</p>	F 514	<p>1. Direct care staff provided education related to meal percentage documentation accuracy. 2. House wide audit of residents in the facility for accurate meal documentation of three scheduled meals (Breakfast, Lunch and Dinner).</p> <p>MONITORING: Nurse Manager and/or designee to audit meal documentation of seven residents for accuracy. Monitoring to occur three times a week for four weeks, twice weekly for four weeks, weekly for four weeks and then every other week for four weeks.</p> <p>Results of audits will be reviewed at PI meeting for trending and ongoing education needs to ensure continued compliance.</p>		

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F 514	<p>Continued From page 37</p> <p>During an interview on 3/6/17 at 4:45 pm, Resident #7 stated the staff did not regularly offer him a bedtime snack. He stated they used to offer him a bedtime snack but no longer did so.</p> <p>During an interview on 3/9/17 at 8:55 am, Resident #7 stated he was not offered a bedtime snack on 3/8/17.</p> <p>3. Resident #16's Physician's Orders, dated August 2016, documented he was admitted to the facility on 7/29/16, with diagnoses that included Type II diabetes, Guillain-Barre syndrome [a rare disorder in which your body's immune system attacks your nerves, causing muscle weakness that can evolve into paralysis] and achalasia cardia [a swallowing disorder].</p> <p>Resident #16's discharge MDS assessment, dated 8/17/16, documented he was cognitively intact.</p> <p>An ADL Meal Intake sheet, dated August 2016, documented Resident #16 ate 75% of his dinner and 100% of his bedtime snack on 8/15/16.</p> <p>A Nurse's Progress Note, dated 8/15/16, documented Resident #16 refused dinner on 8/15/16 due to his throat condition.</p> <p>During an interview on 3/8/17 at 9:20 am, Unit Manager [UM] #1 stated it was important for residents to have accurate meal intake documented because the staff relied on that information for weight and nutrition decisions.</p> <p>During an interview on 3/8/17 at 10:40 am, UM</p>	F 514			

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F 514	<p>Continued From page 38</p> <p>#1 stated she recalled Resident #16 not being able to eat his meal due to his throat condition. UM #1 stated Resident #16 was given some broth but was unable to eat most of it. She stated the meal intake documentation was inaccurate because it indicated the resident ate a percentage of his dinner tray which he did not.</p> <p>During an interview on 3/9/17 at 9:25 am, the Director of Nursing stated the certified nursing assistants were expected to document accurately. He stated the CNAs should not document on a resident's meal intake without seeing how much they ate.</p>	F 514			