



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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April 7, 2017

Nathan Chinchurreta, Administrator
Karcher Post-Acute & Rehabilitation Center
1127 Caldwell Boulevard
Nampa, ID 83651-1701

Provider #: 135110

Dear Mr. Chinchurreta:

On **March 10, 2017**, a survey was conducted at Karcher Post-Acute & Rehabilitation Center 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 a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

After each deficiency has been answered and dated, the administrator should sign the Form 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 17, 2017**. Failure to submit an acceptable PoC by **April 17, 2017**, may result in the imposition of penalties by **May 18, 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 21, 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 8, 2017**. A change in the seriousness of the deficiencies on **May 1, 2017**, may result in a change in

Nathan Chinchurreta, Administrator
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the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 8, 2017** includes the following:

Denial of payment for new admissions effective **June 8, 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 6, 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 8, 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:

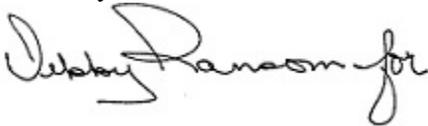
- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **April 17, 2017**. If your request for informal dispute resolution is received after **April 17, 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: 04/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/10/2017
NAME OF PROVIDER OR SUPPLIER KARCHER POST-ACUTE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651		
(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 at the facility from March 6, 2017 through March 10, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Presie C. Billington, RN, Team Coordinator Susan Costa, RN Teresa Kobza, RD, LD Ophelia McDaniels, RN</p> <p>Survey Abbreviations:</p> <p>ADL = Activities of Daily Living ADM = Administrator AKI = Acute Kidney Injury B/C = Because BIMS = Behavioral Indicator of Mental Status BM = Bowel Movement cc = cubic centimeters CFR = Code of Federal Regulations CNA = Certified Nursing Assistant D/C = Discharge or Discontinue DON = Director of Nursing DX = Diagnosis gm = gram HS = At bedtime LCSW = Licensed Clinical Social Worker LN = Licensed Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set Meds = Medications mg = milligrams ml = mililiters MOM = Milk of Magnesia</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

04/17/2017

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

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F 000	Continued From page 1 MRR = Medication Regimen Reconciliation NOC or noc = Night OSHA = Occupation Safety and Health Administration PEG = Percutaneous Endoscopic Gastrostomy PO = orally POA = Power of Attorney PRN = as needed Q = every QAA = Quality Assessment and Assurance Res = Resident RHIT = Registered Health Information Technician RNS = Regional Nurse Support SDC = Staff Development Coordinator Type II DM = Adult onset diabetes mellitus tabs = tablets UM = Unit Manager	F 000			
F 156 SS=F	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written	F 156		4/21/17	

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F 156	Continued From page 2 description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State	F 156			

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F 156	<p>Continued From page 3</p> <p>Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)</p> <p>[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.</p>	F 156			

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F 156	<p>Continued From page 4</p> <p>(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:</p> <p>(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and</p> <p>(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.</p> <p>(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.</p>	F 156			

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F 156	Continued From page 5 (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and	F 156			

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F 156	<p>Continued From page 6</p> <p>periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.</p> <p>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.</p> <p>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 156		

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F 156	<p>Continued From page 7</p> <p>Based on record review, review of the facility's Admission Agreement, and staff interview, it was determined the facility failed to ensure the Admission Packet fully informed residents, prior to, or at the time of admission, of their rights in the facility. This deficient practice created the potential for residents admitted to the facility to not be fully informed of their rights regarding transfers or discharges, abuse, viewing survey results, etc. Findings include:</p> <p>The facility's Admission Agreement, revised January 2008, did not include all residents' rights, as follows:</p> <p>a. 42 CFR 483.10(b)(2) [F153] states, "The facility must provide the resident with access to personal and medical records....within 24 hours and upon request and must allow the resident to obtain a copy of the records...upon request and 2 working days advanced notice to the facility."</p> <p>The facility's Admission Agreement documented the facility would "usually" provide residents copies of their medical records "within 30 days."</p> <p>b. CFR 483.10(g)(10)(11)(i)(ii) [F167] states, "The facility must...have reports with respect to any surveys, certifications, and complaints investigations made...during the 3 preceding years...and post notice of the availability of such reports in areas...prominent and accessible..."</p> <p>The facility's Admission Agreement documented residents and their guardians have the right to examine the facility's most recent survey results.</p> <p>c. CFR 483.10(f)(9) [F169] states, "The plan</p>	F 156	<p>F-156</p> <p>1. There were no specific residents cited.</p> <p>2. Current residents admitted to the facility are receiving an Admission Packet that contains information explaining their Resident Rights regarding transfers or discharges, abuse, viewing survey results, etc.</p> <p>3. Prestige Care Inc has revised the Residents Admission Packet to meet both State and Federal requirements. The Administrator will do random audit of a resident Admission Packet, once a week x4 weeks and monthly x3 months, to ensure the contents meet both State and Federal requirements.</p> <p>4. The Administrator or designee will track and trend audit findings and report results to the Quality Assurance Performance Improvement (QAPI) Committee, monthly x 3 months, to identify opportunities for performance improvement.</p> <p>5. Compliance date: 4/21/2017</p> <p>6. The Administrator or designee will ensure compliance.</p>		

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F 156	<p>Continued From page 8</p> <p>specifies the nature of the services performed and whether the services are voluntary or paid; (iii) Compensation for paid services is at or above prevailing rates; and (iv) The resident agrees to the work arrangement described in the plan of care."</p> <p>The facility's Admission Agreement documented, "...Compensation for paid services at or above prevailing rates, or [instead of "and"] resident agrees to work arrangement described in care plan."</p> <p>d. CFR 483.10(g)(8) [F170] states, "The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research..."</p> <p>The facility's Admission Agreement documented the resident, "...will maintain the right to send and receive personal mail...and will have access to stationary, postage and writing implements..."</p> <p>e. CFR 483.10(e)(4) [F175] states residents have, "...the right to share a room with his or her roommate of choice when practicable..."</p> <p>The facility's Admission Agreement documented residents have the right to share a room with a married spouse if both reside in the facility.</p> <p>f. CFR 483.10(e)(7) [F177] states, residents have, "the right to refuse transfers to another room in the facility, if the purpose...is to relocate...solely for the convenience of staff..."</p> <p>The facility's Admission Agreement documented</p>	F 156			

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F 156	<p>Continued From page 9</p> <p>residents are fully informed of a transfer or discharge.</p> <p>g. CFR 483.15(c) [F201] states, "The facility may not transfer or discharge the resident while the appeal [to the transfer or discharge] is pending..."</p> <p>CFR 483.15(c)(3) [F203] states, "The facility must... send a copy of the notice to a representative of the Office of the Long-Term Care Ombudsman."</p> <p>The facility's Admission Agreement documented residents are fully informed of a transfer or discharge. The agreement documented residents are transferred or discharged only for medical reasons and are given advanced written notice of 30 days.</p> <p>h. CFR 483.13(b) [F223] states, "The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint..."</p> <p>CFR 483.13(c) [F224 and F226] states, "...The facility must not use...corporal punishment, or involuntary seclusion...and must develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property."</p> <p>The facility's Admission Agreement documented, residents are to be "...free from physical, mental and emotional abuse, neglect, violations of civil</p>	F 156			

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F 156	Continued From page 10 rights, exploitation, and from chemical and (except in emergencies) physical restraints..." The agreement did not include the right of residents to be free of corporal punishment, misappropriation of property, and involuntary seclusion. i. CFR 483.10(f)(1) [F242] states, "The resident has the right to choose...schedules (including sleeping and waking times)..." The facility's Admission Agreement documented residents had the right to, "participate in activities of social, religious, and community groups at the resident's discretion..." On 3/7/17 at 2:20 pm, the Administrator stated the facility's admission packet did not include all of the rights afforded to residents. He stated it was the policy of the facility to follow the regulations.	F 156			
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 11 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 staff interview and record review, it was determined the facility failed to ensure a resident's representatives were notified when she was identified as having a possible infection and</p>	F 157	<p>F-157</p> <p>1. Resident # 13 no longer resides in the facility.</p>		

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F 157	<p>Continued From page 12</p> <p>an antibiotic was ordered, and of changes in her medications. This was true for 1 of 15 (#13) sampled residents reviewed for resident representative notification. This deficient practice had the potential to result in missed opportunities for involvement of Resident #13's representatives. Findings include:</p> <p>Resident #13 was admitted to the facility on 3/27/15, and readmitted on 7/9/15, with diagnoses that included stroke with left sided body weakness.</p> <p>Resident #13's March 2015 recapitulated Physician's orders included an order for Norco 5/325 mgs, 1-2 tablets per peg tube every 4 hours as needed for pain.</p> <p>Resident #13's nursing notes documented:</p> <p>* On 6/26/15 at 4:00 pm, "Norco increased from 5/325 mg 2 tablets Q 4 hours PRN to 10/325 mgs [milligrams] tabs two tablets Q [every] 4 hours PRN [as needed] due to resident's c/o [complaint of] no relief [with] current dosage."</p> <p>* On 6/30/17 at 6:30 pm, "Levaquin [antibiotic] 500 mgs 1 PO [orally] Q day [for] 7 days."</p> <p>* On 9/23/15 at 11:15 am, "Per pharmacy recommendations for GDR of psychotropic meds, Cymbalta is [decreased] to 30 mgs daily [for] one week then D/C [discontinue], Prozac [increased] to 40 mg daily. Monitor for [changes]."</p> <p>A note to the attending physician from the pharmacist, dated 12/11/15, documented, "...Staff report numerous incidents of inappropriate</p>	F 157	<p>2.Current residents progress notes have been reviewed for the past 2 months for medication / treatment orders, changes in condition, and behaviors, for responsible party notification of the changes. Corrections made when needed.</p> <p>3.Licensed Nurses (LN□s), Resident Care Managers (RCM□s), MDS nurse, and Director of Nursing (DNS) have be re-educated on notification of resident and/or responsible party with any changes to the residents plan of care, by the Prestige Regional Support Nurse(RSN).</p> <p>During the morning Managing Acute Condition Change (MACC) meeting, the DNS, RCM□s and MDS nurse will review resident interdisciplinary progress notes to ensure any change in condition or changes in the plan of care have been assessed and responsible parties notified.</p> <p>The RCM□s will complete an audit, once a week x4 weeks then once a month x 3 months, of residents reviewed during MACC meeting to ensure any change in condition or changes in the plan of care have been assessed and responsible parties notified. Audits will be forwarded to the DNS and Administrator for review and follow up, if needed.</p> <p>4.The DNS will track and trend audit</p>		

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F 157	Continued From page 13 sexual activities, especially grabbing both male and female staff. Please consider a change in antidepressant to Paxil which is associated with the most significant reduction of sexual urges as a side effect. This may be a dual purpose med to address depression and sexual outbursts..." * On 12/22/15 at 1:50 pm, "Attempted to contact family members to inform them of orders received today, per pharmacy recommendation. D/C Prozac and start Paxil 20 mgs daily. No answer to phone calls to family. Will refer to Social Services to notify and receive consent for Paxil." There was no documentation in Resident #13's clinical record that her representatives were notified of the changes and discontinuance of her medications. Resident #13's representative was also not notified when she was started on an antibiotic. On 3/8/17 at 4:50 pm, the Regional Nurse Support said she did not find documentation that Resident #13's representative were notified of the changes and discontinuance of her medications and when she was started on an antibiotic.	F 157	findings and reports results to the QAPI committee monthly x 3 months to identify opportunities for performance improvement. 5.Compliance date: 4/21/2017 6.The Administrator or designee will ensure compliance.		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must--	F 167		4/21/17	

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F 167	Continued From page 14 (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, it was determined the facility failed to ensure a notice was posted that surveys and complaint investigations for the 3 previous years were available for review. This deficient practices affected all residents or their representative or visitors who may want to review the survey results. Findings include: On 3/7/17 at 10:30 am, a survey results binder was observed in the facility entry way. The binder contained the most recent recertification survey the facility had undergone on 11/20/15. During the same observation of the entry area of the facility on 3/7/17 at 10:30 am, there was no	F 167	F-167 The prior 2 years worth of survey results were added to the survey binders, front entrance near station C and back entrance near station D, prior to survey exit to ensure the 3 years are available for review so current and future residents are no longer impacted. A Resident Council Meeting will be held to update all residents to the location of the survey binders. The Administrator or designee will complete audits of the binders and ask a		

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F 167	Continued From page 15 notice posted that the survey results, including the facility's plans of correction, for surveys and complaint investigations for the past 3 years were available for review. On 3/8/17 at 10:30 am, 13 of 13 residents in a group interview did not know where the survey results were located in the facility. On 3/8/17 at 2:20 pm, the Administrator was informed of the lack of posting about the availability of the past three years worth of surveys.	F 167	resident about knowledge of its location, once a week x4 weeks then once a month x 3 months, all deficient practice identified will be corrected and referred to QA committee for immediate Root Cause Analysis and system review. Administrator or Designee will Ensure compliance. Corrective Action will be completed by April 21, 2017		
F 201 SS=D	483.15(c)(1)(i)(ii) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT (c) Transfer and discharge (1) Facility requirements (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered;	F 201		4/21/17	

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F 201	<p>Continued From page 16</p> <p>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or</p> <p>(F) The facility ceases to operate.</p> <p>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a resident was given an appropriate reason for discharge and that the discharge was necessary. This was true for 1 of 2 (#13) residents whose closed records reviewed. This deficient practice created the potential for Resident #13 to experience psychosocial harm. Findings include: Resident #13 was admitted to the facility on</p>	F 201	<p>F-201 Resident # 13 no longer resides in the facility.</p> <p>Current residents have been reviewed to ensure there is an appropriate discharge plan in place. Revisions and updates completed, as needed.</p> <p>Resident Care Managers (RCM□s) and</p>		

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F 201	<p>Continued From page 17</p> <p>3/27/15, and was readmitted on 7/9/15, with multiple diagnoses, including stroke with left sided paralysis and weakness.</p> <p>A Social Services Note, dated 4/2/15, documented "She has behavior of calling out. Plan to assist with frequent oral swabs...She can be impulsive and has made some sexually inappropriate comments..."</p> <p>Resident #13's Nurses' Notes, between 3/27/15 and 4/2/15, did not include documentation of her making sexually inappropriate comments.</p> <p>Resident #13's care plan during the same time period did not contain a problem regarding sexually inappropriate behavior.</p> <p>Social Services Notes documented:</p> <p>* 7/16/15, "...She enjoys staff attention and she will often get staff attention for a minor need to help her but she really is looking for emotional support...She uses humor to cope with difficult situation. She can be sexually inappropriate..."</p> <p>* 10/16/15, "...She has charted behavioral concerns but can be repetitive about her coffee...Resident can be verbally inappropriate and calls out repetitively. She can make inappropriate sexual remarks..."</p> <p>* 12/7/15, "...LCSW [Licensed Clinical Social Worker] spoke with resident about a number of complaints about resident's sexually inappropriate behavior. LCSW spoke with resident's family about resident's behavioral issues. Family supports plan to monitor and</p>	F 201	<p>Social Services Director (SSD) have been educated on Prestige Policy and Procedure (P&P) for Notice of Transfer or Discharge of a resident by the Prestige Regional Support Nurse (RSN) or designee.</p> <p>Prior to a resident transfer or discharge, the Interdisciplinary Team (IDT) will assess to determine if changes in the residents plan of care can accommodate the resident's needs. Interventions will be evaluated to determine effectiveness and the residents response will be documented in the resident's clinical record. If the resident is being transferred/discharged due to endangering self or others, the physician will document in the clinical record the reason the resident is endangering self or others. A Physician's order is required prior to transfer/discharge. The residents responsible party will be notified by the facility, as soon as practicable.</p> <p>During the morning IDT Stand Up meeting, residents who are to be transferred / discharged, will be reviewed to ensure appropriate reason and necessity.</p> <p>The SSD will track residents who are transferred / discharged for appropriate reason and necessity and provide copy to the Director of Nursing (DNS) and Administrator for follow up if needed.</p> <p>The SSD will track and trend residents</p>		

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F 201	<p>Continued From page 18</p> <p>make a contract with resident to stop her inappropriate behavior. LCSW and charge RN discussed contract and resident agrees to self-monitor her behavior and be aware of possible consequences."</p> <p>A Care Conference Summary report documented:</p> <p>* Risks/Consequences: Behavior risk harm to self and others,</p> <p>* Discharge Potential/Return to Community Referral: D/C [discharge] options D/T [due to] facility inability to meet her needs.</p> <p>A summary of the care plan conference discussion documented, "Facility discussed resident difficulty with inhibition issues. Family informed of behavior concerns and options. Family willing to assist resident in transfer to other facility and [try] psych[iatric] hospital.</p> <p>A Physician Discharge Summary with Resident #13's projected date of discharge of 12/21/15, documented, "...began to have some significant behavioral issues and acting out in sexual manner ...been attempting to fondle and grab at the male and female staff in the facility...she has been making inappropriate comments...Staff have become quite concerned about her and seeking a discharge facility...state not able to really provide cares for her..."</p> <p>An Psychological Services Progress Notes documented:</p> <p>* 12/24/15, "...The patient said that she did not</p>	F 201	<p>who are transferred / discharged for appropriate reason and necessity, and report findings to the Quality Assurance Performance Improvement (QAPI) committee monthly x 3 months to identify opportunities for performance improvement.</p> <p>Date of completion for corrective action: 04/21/2017</p> <p>Administrator or designee will ensure compliance.</p>		

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F 201	Continued From page 19 want to move, that she really liked it here and was attached to her roommate..." * 1/5/16, "Sexual Acting Out: Current, Intervention: ...validate the patient's sense of lowered self-worth...because of an awareness that the place she currently resides no longer wishes to keep her ...previous places that she has stayed do not wish to have her stay with them again...The patient was in an anxious and depressed mood, verbalizing attempts to make sense of what has and is happening to her in terms of placement and care..." Resident #13's clinical record, between March 2015 and January 2016, did not include documentation of how she acted inappropriately or what inappropriate comments she had made. There were no Incident and Accident reports or investigation reports found in Resident #13's clinical record regarding her attempts to grab or touch CNAs. On 3/8/17 at 4:50 pm, the Regional Nurse Support said she did not find documentation regarding Resident #13's inappropriate sexual behavior other than what was written in social service progress notes. The Regional Nurse Support also stated the LSW who wrote the notes was no longer working at the facility. When asked whether the reason for Resident #13's projected discharge on 12/21/15 was appropriate, the Regional Nurse Support said "I would like to see more supporting documents."	F 201			
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must-	F 225		4/21/17	

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F 225	Continued From page 20 (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily	F 225			

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F 225	<p>Continued From page 21</p> <p>injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff and responsible party interview, policy review, and record review, it was determined the facility failed to ensure a resident's allegation of sexual assault by staff and allegations that the resident also engaged in sexually inappropriate behavior toward staff, were investigated. This is true for 1 of 2 (#13) closed record reviewed. This deficient practice created the potential for Resident #13 to experience ongoing psychological harm. Findings include: Resident #13 was admitted to the facility on 3/27/15, and was readmitted on 7/9/15, with multiple diagnoses, including left sided paralysis</p>	F 225	<p>F-225</p> <p>1). Resident # 13 no longer resides in the facility.</p> <p>2). Current residents interdisciplinary team progress notes have been reviewed for the past 2 months to identify any incidents / allegations that required an investigation. There were no new findings.</p> <p>3). Current Staff have been re-educated on Abuse, Neglect, Misappropriation, Exploitation and Reporting Guidelines and Resident Rights by the Prestige RSN.</p>		

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F 225	<p>Continued From page 22 and weakness following a stroke.</p> <p>Social Services Notes, dated 4/2/15, documented, "...She has behavior of calling out. Plan to assist with frequent oral swabs...She can be impulsive and has made some sexually inappropriate comments..."</p> <p>Resident #13's nursing notes, between 3/27/15 and 4/2/15, did not include documentation that she made sexually inappropriate comments.</p> <p>Resident #13's care plan during the same time period did not include a problem and interventions for sexually inappropriate behavior.</p> <p>Social Services Notes documented:</p> <p>* 7/16/15, "She enjoys staff attention and she will often get staff attention for a minor needs to help her but she really is looking for emotional support. Staff supportive. She uses humor to cope with difficult situation. She can be sexually inappropriate..."</p> <p>* 10/16/15, "She has charted behavioral concerns but can be repetitive about her coffee...Resident can be verbally inappropriate and calls out repetitively. She can make inappropriate sexual remarks..."</p> <p>* 12/7/15, "LCSW [licensed clinical social worker] spoke with resident about a number of complaints about resident's sexually inappropriate behavior. LCSW spoke with resident's family about resident's behavioral issues. Family supports plan to monitor and make a contract with resident to stop her</p>	F 225	<p>Licensed Nurses (LN□s), Resident Care Managers (RCM□s), MDS nurse and DNS have been educated on Prestige P & P for Incident Reporting, investigation and notification of appropriate agencies, by the Prestige RSN.</p> <p>SSD, MDS nurse, RCM□s have been educated on Prestige Psychoactive Drug and Behavior Management P & P□s by the Prestige RSN.</p> <p>Certified Nursing Assistants (NAC□s) and LN□s have been educated on Prestige Behavior Monitoring P & P by the Prestige RSN.</p> <p>During the morning Managing Acute Condition Change (MACC) meeting, the DNS, RCM□s and MDS nurse will review resident interdisciplinary progress notes to ensure any allegation of abuse, neglect, misappropriation or exploitation has had an investigation initiated and appropriate agencies and responsible parties notified.</p> <p>The RCM□s will complete an audit, once a week x4 weeks then once a month x 3 months, of residents reviewed during MACC meeting to ensure and incident investigation was initiated, appropriate agencies were notified and responsible party was notified, if indicated. Audits will be forwarded to the DNS and Administrator for review and follow up, if needed.</p>		

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F 225	<p>Continued From page 23</p> <p>inappropriate behavior. LCSW and charge RN discussed contract and resident agrees to self monitor her behavior and be aware of possible consequences."</p> <p>* 12/8/15, "CNA reported that resident continued to have some disinhibited behaviors over inappropriately touching her. LCSW discussed behavior with resident. Resident smiled but denied behavior. LCSW call to family discuss resident...Discussed plan to hold care conference to discuss if change of placement or psych[iatric] hospital needed..."</p> <p>Resident #13's care plan with a problem start date of 10/19/15, documented, "I have sexually inappropriate language, comments and actions." Approaches included:</p> <p>* "Resident understands when she is being inappropriate. Ask her to stop or will stop providing cares until she stops her inappropriate behaviors."</p> <p>* "...tell her she is being inappropriate and direct her away from other residents."</p> <p>* "Watch body positioning and step away when she is inappropriate. Re-approach and use two caregivers for all personal/peri cares."</p> <p>Resident #13's Nurses' Notes documented:</p> <p>* 12/3/15 at 10:00 pm, "CNA notified that Res. [resident] made statement that some girl was fingering her vagina and butt at same time and that Res states she was a lesbian at one time. Res reminded by CNA that comments [were]</p>	F 225	<p>4. The DNS or designee will track and trend audit findings and reports results to the QAPI committee monthly x 3 months to identify opportunities for performance improvement.</p> <p>5) Compliance date: 4/21/17</p> <p>6) The Administrator or designee will ensure compliance.</p>		

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F 225	<p>Continued From page 24 inappropriate."</p> <p>* 12/29/15 at 6:00 am, "res had sexual behaviors. Calling out, using call light in excess..."</p> <p>There was no further documentation found in the nursing notes regarding Resident #13's inappropriate sexual behaviors.</p> <p>A Psychological Services Progress Note documented:</p> <p>* 8/14/15, "The patient was being referred for psychotherapy B/C [because] of behavior (disruptive) such as repeatedly calling out after having just been attended to and denying being in need of anything."</p> <p>* 9/27/15, "Sexual Acting Out: None...The patient also said that she has always been one of limited patience...when she is using a bedpan or needs a bed pan...she readily yells as it seems that help arrives much faster than awaiting a light that she has no way of verifying whether or not it has even been activated."</p> <p>* 11/13/15, "Sexual Acting Out: None, Intervention: Utilized supportive therapy to help the patient problem-solve how to improve her experience at the SNF such that she would not feel the need to yell for help, but rather rely on her call light for assistance." The progress note further documented Resident #13 asked the psychologist why he was visiting her. The psychologist told Resident #13 the purpose of his visit was to help resolve the reasons underlying her behavior, to which he was interrupted by the resident stating "calling for help?". The</p>	F 225			

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F 225	<p>Continued From page 25</p> <p>psychologist affirmed that it was the symptom for which he had come to help resolve.</p> <p>* 11/25/15, "Sexual Acting Out: None, Intervention: ...therapy to validate the patient's stated sense of hopelessness regarding escaping her chronic pain...Patient's response to intervention:..she continued to relate difficulties getting help in a timely manner utilizing the call light, hence the need to yell when in need of assistance..."</p> <p>* 12/10/15, "Sexual Acting Out: None, Intervention: Utilized supportive therapy to the patient's sense of shame about a behavioral choice employed..." The progress note further documented Resident #13 said she had made a bad choice and said the CNA was reaching over her and the CNA's chest was approximately where her mobile hands and she grabbed the CNA's breast.</p> <p>* 12/18/15, "Sexual Acting Out: None, Intervention: Utilized supportive therapy to validate the patient's sense of shame and worry about the consequences of her actions with the staff [boundary violations]. Patient's Response to Intervention: The patient was in an anxious and remorseful mood. Worried about the impact of her behavior on her [resident representative]..."</p> <p>* 12/24/15, Sexual Acting Out: Current, Intervention: Utilized supportive therapy to validated the patient's sense of anxiety regarding what might happen to her since she has started acting out with sexualized comments...Patient's Response to Intervention: ...The patient oriented toward minimizing the behavior she revealed last</p>	F 225			

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F 225	<p>Continued From page 26 week..."</p> <p>* 1/5/16, "Sexual Acting Out: Current, Intervention: ...validate the patient's sense of lowered self-worth...because of an awareness that the place she currently resides no longer wishes to keep her..."</p> <p>* 1/13/16, "...she doesn't recall things as a defense to her behaviors of calling out and being sexually inappropriate...she reports feeling down and has feelings that she has let her family down. She reports feeling that she would be better off dead..."</p> <p>* 1/14/16, Sexual Acting Out: Current, Intervention: ...reinforcing the patient's sense of acceptance within a local SNF while also reinforcing that her sexualized behaviors are unacceptable..."</p> <p>Resident #13's Initial Mood and Behavior Monitor Log between June 2017 and November 2017 documented:</p> <ul style="list-style-type: none"> * 6/6/15 - "inappropriate behaviors" * 6/8/15 - "inappropriate behaviors in room" * 6/13/15 - "inappropriate statements" * 8/15/15 - "inappropriate conversation" * 9/16/15 - "inappropriate language" * 9/17/15 - "inappropriate language" * 11/1/15 - "saying inappropriate things in the dining room" <p>Resident #13's Monthly/Quarterly Behavioral Summary documented:</p> <p>* 7/8/15, "the resident specific target behaviors</p>	F 225			

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F 225	<p>Continued From page 27</p> <p>were tearful, sadness, hopelessness statements, noncompliance, irritability repetitive calling out, impulsive use of call light."</p> <p>* 10/1/15, "the resident specific target behaviors were calling out and repetitive fearful panic."</p> <p>* 12/12/15, "the resident specific target behaviors were expressed sadness and repetitive issues."</p> <p>Resident #13's clinical record, between March 2015 and January 2016, did not include documentation that described her inappropriate behaviors, statements, and language. Additionally, Incident and Accident reports or investigation reports related to Resident #13's allegation of sexual abuse or of her alleged sexual abuse of staff, were not found in her clinical record.</p> <p>On 3/8/17 at 4:50 pm, the Regional Nurse Support [RNS] said she found nothing in Resident #13's clinical record regarding her sexually inappropriate behavior. She said nursing notes did not include documentation of how Resident #13's sexually inappropriate behavior was manifested and monitoring of the behavior. The Regional Nurse Support also said there was no documentation by CNAs or other nursing staff in Resident #13's record, Incident Reports, or investigation reports, related to Resident #13 grabbing the breast of a CNA during her cares. Additionally, the RNS said she did not find documentation that an investigation into Resident #13's allegations of sexual abuse was completed. The RNS said the facility is under new ownership and provided a copy of the Abuse Policy and Procedure. The policy included the following:</p>	F 225			

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

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FORM APPROVED
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F 225	Continued From page 28 * "Resident assessment related to sexual behaviors will include the resident's cognitive status, what the resident verbalizes regarding sexual desires...Family members will be utilized in the assessment process as appropriate..." * "Resident with sexually abusive behaviors will be assessed by social services or nursing to determine appropriate referrals and care plan interventions to protect other residents." * "Staff with knowledge of inappropriate sexual comments or contact between staff and resident or resident and resident will report immediately to the facility social services director, DNS, or administrator." * The facility social services director, DNS or administrator will investigate incidents of sexual abuse and act to protect other residents by suspending accused staff or closely monitoring accused residents." On 3/10/17 at 9:18 am, during a telephone interview, Resident #13's representative said she was first notified of the resident's inappropriate sexual behavior during a care conference in December 2015. Resident #13's representative also said two care conferences were completed prior to the December 2015 care conference and the facility had not mentioned Resident #13's sexually inappropriate behavior.	F 225			
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident	F 279		4/21/17	

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F 279	<p>Continued From page 29</p> <p>assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.</p> <p>483.21 (b) Comprehensive Care Plans</p> <p>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p>	F 279			

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F 279	<p>Continued From page 30</p> <p>(iv) In consultation with the resident and the resident's representative (s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure residents' care plans addressed behaviors that could interfere with their ability to continue to reside in the facility. This was true for 1 of 2 (#13) residents whose closed record was reviewed. This resulted in Resident #13 exhibiting behaviors described as sexually inappropriate for 7 months, prior to the develop and initiation of a care plan to consistently address the behavior. The deficient practice created the potential for Resident #13 to receive inappropriate and inconsistent interventions related to sexually inappropriate behavior, which could lead to an increase in the behavior. Findings include:</p> <p>Resident #13 was admitted to the facility on 3/27/15, and was readmitted on 7/9/15, with multiple diagnoses, including left sided paralysis</p>	F 279	<p>F-279</p> <p>1). Resident #13 no longer resides in the facility.</p> <p>2). Current residents Comprehensive Care Plans (CCP) have been reviewed to identify those with behaviors and that appropriate interventions are in place and consistent with the Behavior Monitoring Flow Sheets.</p> <p>3). Current SSD, RCMs, and MDS nurse have been educated on completion of Comprehensive Assessments, Development of CCP and Revision of CCP, when indicated, by the Prestige RSN.</p> <p>During the Monthly Psychotropic and Behavior meeting, the DNS, SSD and</p>		

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F 279	<p>Continued From page 31 and weakness following a stroke.</p> <p>Resident #13's Social Services Notes documented:</p> <ul style="list-style-type: none"> * 4/2/15, "She can be impulsive and has made some sexually inappropriate comments..." * 7/16/15, "She can be sexually inappropriate..." * 10/16/15, "She can make inappropriate sexual remarks..." <p>Resident #13's Initial Mood and Behavior Monitor Log between June 2015 and September 2015 documented:</p> <ul style="list-style-type: none"> * 6/6/15 - "inappropriate behaviors" * 6/8/15 - "inappropriate behaviors in room" * 6/13/15 - "inappropriate statements" * 8/15/15 - "inappropriate conversation" * 9/16/15 - "inappropriate language" * 9/17/15 - "inappropriate language" <p>Resident #13's care plan with a problem start date of 10/19/15, documented, "I have sexually inappropriate language, comments and actions." Approaches included:</p> <ul style="list-style-type: none"> * "Resident understands when she is being inappropriate. Ask her to stop or will stop providing cares until she stops her inappropriate behaviors." * "...tell her she is being inappropriate and direct her away from other residents." * "Watch body positioning and step away when 	F 279	<p>RCM□s will review each residents behavior flow sheets to identify patterns/ trends, effectiveness of interventions and notify the physician and responsible party when changes occur.</p> <p>The SSD will complete an audit, once a week x4 weeks then once a month x 3 months, of the resident□s reviewed to ensure the CCP reflects appropriate Behavior problem and interventions. A copy of the audit will be forwarded to the DNS and Administrator for review and follow up, if needed.</p> <p>4). The SSD will track and trend findings of the audits and report results to the QAPI committee, to identify opportunities for performance improvement, monthly x 3 months and randomly thereafter.</p> <p>5). Compliance date: 4/21/17</p> <p>6). The Administrator or designee will ensure compliance.</p>		

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F 279	Continued From page 32 she is inappropriate. Re-approach and use two caregivers for all personal/peri cares." Resident #13's record documented she engaged in sexually inappropriate behavior for 7 months, from 4/2/15 through 10/16/15. Resident #13's care plan prior to 10/19/16, did not include sexually inappropriate behavior as a concern or include interventions for staff to follow if the behavior occurred.	F 279			
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 record review and staff interviews, it was determined the facility failed to ensure licensed nurses adhered to professional standards of practice related to clarifying physician's orders Tylenol administration for elevated temperatures. This deficient practice had the potential for than minimal harm if residents' temperatures were allowed to reach 105 degrees before temperture lowering	F 281	F-281 1). Resident # 17 no longer resides in the facility. 2). Current residents have had their Physician Orders reviewed for appropriate parameters for PRN orders. Orders that required physician	4/21/17	

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F 281	<p>Continued From page 33</p> <p>medication was administered. This was true for 1of 2 (Resident #17) closed records reviewed. Findings include:</p> <p>Resident #17 was admitted to the facility on 2/13/16, for rehabilitative care following hospitalization for the repair of a fractured hip. Additional diagnoses included history of dehydration, acute kidney injury, dementia, and generalized muscle weakness.</p> <p>Resident #17's MAR included an order, dated 2/13/16, for acetaminophen [Tylenol] 325 mg, 1-2 tabs every 4 hours, as needed, for fever greater than 105 degrees Fahrenheit. Resident #17's record did not include documentation that she had a fever greater than 105 degrees Fahrenheit.</p> <p>A Nurse's Note, dated 2/16/16 at 9:40 am, documented Tylenol 650 mg was administered for a "slight temp 99.0". The LN did not include documentation of the Tylenol administration on Resident #17's MAR. The Tylenol was not administered as ordered.</p> <p>On 3/10/17 at 2:00 pm, the Unit Manager reviewed Resident #17's record and stated the LN who administered Tylenol for the temperature of 99 degrees, did not administer it as ordered, and should have clarified the order with the physician. He stated the LN should have clarified the Tylenol order for a temperature over 105 degrees Fahrenheit, and that it was an unusually high temperature before treating it with Tylenol.</p>	F 281	<p>clarification have been completed.</p> <p>3). LN□s educated on Prestige Medication and Treatment Orders P & P, Standards of practice for medication administration, clarification of orders and procedure to Read Back and Verify all Telephone orders received by a physician, by the Prestige RSN.</p> <p>RCM□s, LN□s and MDS nurse educated on new electronic medication administration record (eMAR) order entry and documentation of medications administered by Prestige Central Support Staff.</p> <p>The RCM□s, MDS nurse and the DNS will review new Physician Orders daily during the morning MACC meeting to ensure appropriate and complete orders are received and implemented.</p> <p>The RCM□s will complete an audit, once a week x4 weeks then once a month x 3 months, of residents with new orders to ensure complete orders have been received. A copy of the audit will be forwarded to the DNS for review and follow up, if needed.</p> <p>4). The DNS or designee will track and trend audit findings and report results to the QAPI committee monthly x 3 months to identify opportunities for performance improvement.</p> <p>5). Compliance date: 4/21/17</p>		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/10/2017
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F 281	Continued From page 34	F 281			
F 309 SS=D	<p>483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.</p> <p>483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:</p> <p>(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards</p>	F 309	6). The DNS or designee will ensure compliance.	4/21/17	

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F 309	<p>Continued From page 35 of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review, and staff and resident interviews, it was determined the facility failed to ensure residents received care and services required to meet their highest practicable level of physical, mental, and psychosocial well-being. This was true for 1 of 2 (#17) residents whose closed records were reviewed. The failure to monitor Resident #17's bowel routine and implement interventions to ensure residents receive appropriate bowel care. Findings include:</p> <p>Resident #17 was admitted to the facility on 2/13/16, for rehabilitative care following hospitalization for the repair of a fractured hip. Additional diagnoses included resolved dehydration, acute kidney injury, and dementia. An admission nursing assessment was performed on 2/13/16 at 3:30 pm. The LN documented Resident #17 had a history of acute kidney failure and dehydration, resolved in the hospital prior to her admission to the facility on 2/13/16. Additionally, the LN documented on the admission nursing assessment Resident #17 had active bowel sounds, and was incontinent of stool at the time of the assessment. Nursing notes documented assessment of Resident #17's abdomen and bowel sounds twice over the next 17 days (on 2/17/16 & 2/18/16), before she was transferred to a hospital on 3/1/16, with bloody stools and abdominal pain.</p> <p>Resident #17's MAR [medication administration</p>	F 309	<p>F-309</p> <ol style="list-style-type: none"> 1. Resident # 17 no longer resides in the facility. 2. Current residents have had their bowel records reviewed to identify any bowel elimination patterns that were greater than every 3 days and that a bowel management program is ordered and followed with medication administration. Physician Orders, Medication Administration Records (MARs) and CCPs updated, as needed. 3).Current NACs have been re-educated on asking residents who independently toilet themselves, whether they had a BM each shift and timely documentation in the Point of Care (POC) record, by Prestige RSN. <p>Current LN's have been re-educated on reviewing the Matrix report for resident's who haven't had a BM x 3 days and implementation of PRN bowel medications per Prestige P & P, documentation of PRN medication administration and the effectiveness of the medication, by the Prestige RSN.</p> <p>RCM's will review the Matrix report for residents without a BM x 3 days, during</p>		

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F 309	<p>Continued From page 36 record] for February 2016, included a page titled "DAILY BOWEL CARE FLOWSHEET," which included documentation of Resident #17's bowel movements and interventions for regular bowel movements. The MAR documented:</p> <ul style="list-style-type: none"> * Document bowel movements. * Day two - no bowel movement, give 30 milligrams of Milk of Magnesia, orally, on the evening shift * Day three - no bowel movement give suppository or Dulcolax tablets on the night shift * Day four - no bowel movement *Notify Supervisor ASAP* day shift. <p>The MAR did not include what kind of suppository was to be administered, or the amount of Dulcolax to be administered on day three, if Resident #17 did not have a bowel movement.</p> <p>Resident #17's MAR/Bowel Care Flow sheet included documentation of her bowel movements as follows:</p> <ul style="list-style-type: none"> * 2/13/16, evening shift- "large." * 2/14/16, noc shift- "medium," day shift- "large formed." * 2/15/16, "no stool." * 2/16/16, "no stool." <p>Resident #17's MAR did not document Milk of</p>	F 309	<p>each MACC meeting, and then ensure the PRN Bowel program was initiated. Daily follow up will continue until results are effective or the MD notified for other orders.</p> <p>4). The DNS or designee will do random audits, once a week x4 weeks then once a month x 3 months of resident's Bowel Records and MAR's to ensure consistent bowel elimination is achieved. The DNS will track and trend audit results and report findings to the QAPI committee to identify opportunities for performance improvement, monthly x 3 months and randomly thereafter.</p> <p>5). Compliance date: 4/21/17</p> <p>6). The Administrator, DNS or designee will ensure compliance.</p>		

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F 309	<p>Continued From page 37</p> <p>Magnesia was administered on the second day without a bowel movement.</p> <p>* 2/17/16, "no stool." The MAR included initials of an LN on the evening shift who documented administration of a suppository or Dulcolax tablets. The documentation did not state which was administered. A Nurse's Note, dated 2/17/16 at 3:30 am, documented Resident #17 had active bowel sounds in all 4 quadrants.</p> <p>2/18/16, "no stool." The MAR included initials of an LN for evening shift who documented administration of a suppository or Dulcolax tablets. A Nurse's Note, dated 2/18/16 at 3:45 am, documented Resident #17 had active bowel sounds in all 4 quadrants.</p> <p>2/19/16, "no stool."</p> <p>2/20/16, day shift - "medium formed."</p> <p>2/21/16, day shift - "small soft," evening shift- "large liquid."</p> <p>2/22/16, day shift - "small soft"</p> <p>2/23/16, "no stool"</p> <p>2/24/16, evening shift - "small liquid"</p> <p>2/25/16, evening shift - "small liquid"</p> <p>2/26/16, day shift - "small" - The MAR included initials of an LN on the evening shift who documented administration of a suppository or Dulcolax tablets.</p>	F 309			

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F 309	<p>Continued From page 38</p> <p>2/27/16, evening shift - "small" - The MAR included initials of an LN on the evening evening shift who documented administration of a suppository or Dulcolax tablets.</p> <p>2/28/16, day shift - "medium," evening shift - "medium."</p> <p>2/29/16, night shift - "medium soft," evening shift - "medium."</p> <p>3/1/16, A nursing note entry at 7:45 pm, documented, "Patient passed a small amt [amount] liquid dark red blood and a small amt loose brown stool. She continues to ooze dark red liquid. Lower mid abd [abdomen] is tender to palpation. Bowel sounds diminished."</p> <p>3/1/16, A nursing note entry at 8:15 pm, documented Resident #17's physician was notified, and orders were received to transport her to the hospital for evaluation. Resident #17 was admitted to the hospital on 3/1/16. Her hospital record for that admission included a radiology report, dated 3/1/16 at 11:40 pm, which documented "Large volume stool within the colon suggesting impaction." Resident #17's hospital discharge summary, dated 3/3/16, and received by the State Survey Agency on 3/10/17, documented a diagnosis of a fecal impaction.</p> <p>Resident #17's record included orders for Norco 5/325 mg, a narcotic pain medication. According to Drugs.com, a nationally recognized resource used by nursing and medical professionals, Norco contains a combination of acetaminophen and hydrocodone. Hydrocodone is an opioid pain medication, used to relieve moderate to severe</p>	F 309			

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F 309	Continued From page 39 pain. Side effects of Norco include nausea, vomiting and constipation. Resident #17's MAR documented Norco 5/325 mg, 1-2 tablets every 3 hours as needed for pain. Her MAR documented administration of Norco as follows: 2/13/16, 2 tablets at 4:15 pm and 7:15 pm. 2/14/16, 2 tablets at 5:20 am, 11:00 am, 2:35 pm, and 7:55 pm. 2/15/16, 1 tablet at 2:15 am, 1 tablet at 11:45 am. 2/16/16, 2 tablets at 5:25 am, and 1 tablet at 12:15 am. Resident #17's record did not include a care plan related to her potential risk for constipation. On 3/10/17, at 2:00 pm, the Unit Manager reviewed Resident #17's record and stated Milk of Magnesia should have been administered on the second day without a bowel movement, and before the suppository or Dulcolax tablets were given. He stated Resident #17's MAR included multiple administrations of Norco which could contribute to her constipation. He stated a care plan should have been initiated to include risk of constipation related to immobility, inadequate fluid intake and use of narcotic pain medications.	F 309			
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	F 323		4/21/17	

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F 323	Continued From page 40 (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, review of facility water temperature logs, observations, and staff interviews, it was determined the facility failed to ensure residents were not exposed to hot water temperatures in excess of 120 degrees Fahrenheit. This deficient practice placed 11 of 12 sampled residents (#1-#7 and #9-#12) residing in the facility, and the other 31 residents who showered in the facility's shower rooms from 2/14/17 to 3/8/17, at risk of sustaining burns. The failure of the facility to have an effective system in place to test water temperatures throughout the facility, placed all 48 residents residing in the facility at risk of burns. Findings include: The facility's Water Temperature logs for	F 323	F-323 1.Residents # 1 □ 7, 9 -12 were not injured due to hot water temperature. 2.Current residents are being bathed/showered with water temperatures within 105 □ 120 degree range, per regulatory standard. 3.The facilities two hot water heaters have been adjusted and piping re-installed and separated so there is no cross-pipe water flow that can cause spikes in the resident accessible water. The facility is utilizing the The Equipment Life System (TELS) through Direct		

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F 323	<p>Continued From page 41</p> <p>December 2016 through February 2017 documented water temperatures were checked in the same rooms each month. The room and locations routinely checked were; 540, 541, 548, 549, 556, 557, 582, 583, 590, 591, Laundry, and the Kitchen. The water temperature logs did not differentiate what water source was tested in the resident rooms. The resident rooms had a room sink, bathroom sink, and a shower.</p> <p>The facility's Water Temperature logs for December 2016 through February 2017 documented 5 instances where the water in resident rooms 541, 549, 556, and 557 was 120 degrees Fahrenheit. The water temperature logs did not differentiate what water source was tested in the resident rooms.</p> <p>On 3/8/17 at 2:00 pm, the environmental tour started with the Maintenance Supervisor. Station C's Shower Room shower water temperature first reading was 128.8 degrees Fahrenheit. The Maintenance Supervisor rechecked the shower water temperature and got a reading of 126.2 degrees Fahrenheit. The Maintenance Supervisor stated it was a little hot and the maximum temperature should be 120 degrees Fahrenheit. He stated staff members giving the showers would regulate the temperature to prevent residents from getting burned. Station D's shower room shower water temperature was 97.2 degrees Fahrenheit. He stated this one was a bit low.</p> <p>A document provided by the facility was reviewed on 3/10/17, which contained documentation that the facility tested the water temperatures on 3/8/17, after the environmental tour, at an</p>	F 323	<p>Supply, to document maintenance inspection efforts. This system provides procedures for water temperature checking that includes the shower rooms.</p> <p>The Maintenance Director (MD) will complete the hot water TELS inspection, once a week x4 weeks then once a month x 3 months, and report findings to the Administrator.</p> <p>4.The MD will identify and correct any deficient practice immediately for patient safety and the issue will be referred to the QAPI committee for immediate Root Cause Analysis, system review and trend tracking.</p> <p>5.Administrator or Designee will be responsible.</p> <p>6.Corrective Action will be completed by April 21, 2017</p>		

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F 323	<p>Continued From page 42</p> <p>unknown time. The facility tested the water temperatures in rooms 540, 541, 545, 554, 556, 559, 560, 563, 582, 584, 585, 586, 587, 589, 590, 591, shower rooms C & D, and public restrooms in the C and D hallways of the facility. This document included documentation that the water was tested in the rooms listed above to include the bathroom sinks, the room sinks, and the showers. The facility found temperatures of 122 degrees Fahrenheit in the bathroom sink of rooms 556, and 121 degrees in the room sink of 589.</p> <p>On 3/8/17 at 4:00 pm, the Maintenance Supervisor stated it was not the facility's practice to test the water temperatures in the shower rooms before today's environmental tour. He stated the facility had just bought a new hot water heater recently and he was still working out the kinks. He stated he had not checked temperatures for March prior to the 3/8/17's environmental tour. He stated a plumber was in route to the facility to perform a system balance of the hot water heater and he had placed an out of order sign on the shower room after the discovery of the hot water temperature in the Station C Shower room.</p> <p>On 3/9/17 at 9:45 am, the facility provided an invoice from the plumber detailing the work performed at the facility on 3/8/17.</p> <p>On 3/10/17 at 9:00 am, the Interim Director of Nursing stated the facility was unable to determine which shower rooms were used in the last three weeks. She stated she wrote on the ADL Flow-sheets which hall the residents lived in and if a resident had a bed bath in their rooms.</p>	F 323			

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F 323	Continued From page 43 She stated some independent residents showered using the showers in their rooms. The facility's Activities of Daily Living [ADL] Flow-sheets were provided for 48 residents currently residing in the facility. The flow-sheets documented 42 residents received a shower in one of the facility's shower rooms during the dates of 2/14/17 through 3/8/17. Based on the documentation provided, it could not be determined which shower room was used. On 3/10/17 at 8:30 am, the facility provided an undated Policy and Procedure from Direct Supply Tels which the Administrator stated the facility had been using and the facility was in the process of developing a new one. The policy stated the water was to run for at least 3 minutes before taking the reading and fully immerse the sensor of the thermometer. The policy stated resident rooms water temperatures should be between 105-115 degrees Fahrenheit or as specified by state requirements.	F 323			
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	F 327		4/21/17	

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F 327	<p>Continued From page 44 ensure that a resident-</p> <p>(2) Is offered sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents were provided sufficient fluids to prevent dehydration. This was true for 1 of 2 residents (#17) whose closed records were reviewed. The deficient practice had the potential for harm when Resident #17 did not receive the fluids as documented by the nutritional assessment. Findings include:</p> <p>Resident #17 was admitted to the facility on 2/13/16, for rehabilitative care following hospitalization for the repair of a fractured hip. Additional diagnoses included resolved dehydration, acute kidney injury and dementia.</p> <p>An admission nursing assessment was performed on 2/13/16 at 3:30 pm. The LN documented Resident #17 had a history of acute kidney failure and dehydration, resolved in the hospital prior to her admission to the facility on 2/13/16. Additionally, the LN documented Resident #17 was independent with eating, ate well, and took fluids independently throughout the day.</p> <p>On a Nutritional Evaluation form, dated 2/17/16, the facility dietician documented Resident #17's daily fluid intake requirement was 2,170 ml [milliliters]. The Nutritional Evaluation documented the fluids Resident #17 consumed during meals did not meet her hydration needs.</p>	F 327	<p>F-327</p> <p>1). Resident # 17 no longer resides in the facility.</p> <p>2). Current residents have been reviewed with a history of dehydration or that are currently at risk of dehydration for daily fluid intake meeting minimum daily recommendations per the Registered Dietician (RD).</p> <p>3). LN's and NAC's have been re-educated on documentation of resident daily fluid intake in Point of Care (POC) and on eMAR's, by the Prestige RSN.</p> <p>RCM's, MDS nurse and Dietary Manager (DM) have been educated on completion of Comprehensive Assessments and Prestige Nutrition at Risk P & P to include residents at risk of dehydration.</p> <p>Residents who have a history of dehydration or are at risk of dehydration will be reviewed by the RD at admission, quarterly, annually and with significant change. The RCM's / MDS nurse will review the RD's recommendations and update the residents CCP and In Room Care Plan (IRCP) when needed.</p>		

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F 327	<p>Continued From page 45</p> <p>The summary section of the evaluation included the following statement by the dietician: "Recent dehydration dx [diagnosis] with AKI [Acute Kidney Injury]." Additionally, the dietician documented "...not meeting assessed needs for fluid." She wrote a recommendation for additional fluids of 180 ml three times daily, as well as, a nutritional supplement 60 ml three times daily. Resident #17's MAR reflected the orders for nutritional supplementation and additional fluids as of 2/17/16.</p> <p>Resident #17's record included Meal Monitor Flowsheets, that documented her fluid intake with each meal and during the night shift. Resident #17 did not receive the amount of minimal fluid intake as calculated by the dietician. Her fluid intake documentation from the MAR, and Meal Monitor Flowsheets, was used to assess her daily fluid intake. The MAR and flowsheets from 2/13/16 to 3/1/16, documented Resident #17's average fluid intake was 1,200 ml, which did not meet her minimum fluid intake requirements of 2,170 ml, as identified by the dietician.</p> <p>Resident #17's Plan of Care did not include her past history of dehydration and interventions to prevent dehydration during her stay at the facility.</p> <p>Resident #17's medical record documented she was transferred from the facility to a hospital on 3/1/16. Patient #17's hospital history and physical, dated 3/2/16, included diagnoses of dehydration and AKI.</p> <p>On 3/10/17, at 2:00 pm, the Unit Manager [UM] reviewed Resident #17's record. The UM reviewed the Meal Monitor Flowsheet and stated</p>	F 327	<p>The RCMs, DNS, DM and RD will meet weekly, during the Nutrition at Risk (NAR) meeting to review residents that are at risk of dehydration to ensure adequate fluid intake or implement additional interventions to meet daily fluid recommendations.</p> <p>The DNS or designee will do random weekly audits of resident's CCPs, once a week x4 weeks then once a month x 3 months, that are at risk of dehydration to ensure appropriate interventions are in place.</p> <p>4). The DNS or designee will track and trend the audit results and report findings to the QAPI committee to identify opportunities for performance improvement, monthly x 3 months and randomly thereafter.</p> <p>5). Compliance date: 4/21/17</p> <p>6). The Administrator or designee will ensure compliance.</p>		

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F 327	Continued From page 46 Resident #17's daily fluid intake did not meet the dietitian's recommended intake. The UM reviewed the Plan of Care, and stated it did not include Resident #17's past history dehydration and interventions to prevent dehydration.	F 327			
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based	F 441		4/21/17	

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F 441	<p>Continued From page 47</p> <p>precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and policy review, it was determined the facility failed to ensure infection control</p>	F 441	<p>F-441 1. Resident # 4 & # 6 have their urinary drainage bags suspended from the W/C</p>		

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F 441	<p>Continued From page 48</p> <p>practices for resident care, procedures to separate soiled and clean laundry, and linens were stored to prevent cross contamination. This was true for 2 of 3 sampled residents (#4 and #6) observed in common areas with urinary collection devices. The laundry department failed to ensure soiled and clean laundry were separated, and residents' towels and washcloths were separated sufficiently to indicate which towel set belonged to which resident for 10 random residents in double occupancy rooms (#8, #12 and #28-#35). This failure created the potential for residents to develop infection from cross-contamination. Findings include:</p> <p>1. Resident #6 was admitted to the facility on 5/27/16, with diagnoses which included collapsed vertebrae, back pain, and bladder obstruction. Resident #6 had an indwelling foley catheter, attached to a drainage device.</p> <p>On 3/7/17 at 12:20 pm, Resident #6 was observed in the "D" dining room. He was in a wheelchair and his urinary collection device was attached to his wheelchair. The bag section of the device was resting on the dining room floor.</p> <p>On 3/8/17 at 8:30 am, during the morning meal, Resident #6 was observed in the "D" dining room. His urinary collection device was attached to his wheelchair with the bag section of the device touching the dining room floor.</p> <p>On 3/8/17 at 10:30 am, during a Resident Council meeting, Resident #6 was observed in the "D" dining room. His urinary collection device was attached to his wheelchair with the bag section of the device touching the dining room</p>	F 441	<p>and bed, so that the tubing and bag do not touch the floor.</p> <p>The small washing machine in the facility Laundry Room was removed prior to the end of the survey process. Laundry is being processed within clear boundaries of soiled and clean areas.</p> <p>Resident□s # 1, 8, 12, 28, 29, 30, 31, 32, 33, 34, who are in double occupancy rooms, have had their towel racks labeled to indicate specific resident use.</p> <p>2. Current residents with urinary drainage bags are suspended from the W/C and bed, so that the tubing and bag do not touch the floor.</p> <p>Laundry is being processed within clear boundaries of soiled and clean areas.</p> <p>Current double occupancy rooms have had the towel racks in the bathroom (BR) labeled to indicate specific resident use.</p> <p>3. Current RCM□s, LN□s, NAC□s, and Laundry staff have been re-educated on Infection Control practices for linen handling, maintaining clear boundaries between clean and dirty areas for processing linens in the Laundry room, Prestige P & P for Indwelling Catheters and keeping the tubing / bags from touching a dirty surface, and implementation of signage in double occupancy BR□s to indicate which resident uses each towel rack by the</p>		

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F 441	<p>Continued From page 49 floor.</p> <p>On 3/8/17 at 11:30 am, LN #3 observed Resident #6 with his urinary collection bag touching the floor. She stated the bag should be elevated slightly and not touch the floor.</p> <p>Resident #6 was at risk of infection if his urinary collection bag was contaminated with infectious substances which could potentially be found on the floor.</p> <p>2. Resident #4 was admitted to the facility on 2/2/17, with multiple diagnoses including prostate cancer.</p> <p>Resident #4's current Care Plan, initiated on 2/12/17, documented, "I have a foley catheter...Empty my drainage bag q [every] shift, Keep my catheter bag and tubing below my bladder level. Make certain that the bag is not hanging on the floor..."</p> <p>The CDC 2009 Catheter-associated Urinary Tract Infection Toolkit found on the www.cdc.gov website, includes the following UTI prevention guidance, "Keep the collecting bag below level of bladder at all times. Do not rest bag on floor."</p> <p>Resident #4's February 2017 recapitulated Physician's orders included an order for an indwelling catheter.</p> <p>On 3/8/17, Resident #4 was observed in his room, lying on his bed with his catheter bag on the floor at 9:10 am, 11:50 am, and 12:00 noon.</p> <p>On 3/9/17 at 2:10 pm, Resident #4 was observed</p>	F 441	<p>Prestige RSN.</p> <p>The RCMs will do floor rounds /audit, once a week x4 weeks then once a month x 3 months, to monitor proper urinary drainage bag positioning, and resident's in double occupancy rooms are utilizing the assigned towel rack in the BR . Copies of audits will be forwarded to the DNS.</p> <p>The Infection Control Nurse or DNS will complete Infection Control Round audit, once a week x4 weeks then once a month x 3 months, for linen processing to prevent cross contamination.</p> <p>4. The DNS or designee will track and trend the audit results and report findings to the QAPI committee to identify opportunities for performance improvement, monthly x 3 months.</p> <p>5. Compliance date: 4/21/17</p> <p>6. The Administrator or designee will ensure compliance.</p>		

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F 441	<p>Continued From page 50</p> <p>in his room, lying on his bed with his catheter bag touching the floor. LN #3 was informed of the observation and went to Resident #4's room. LN #3 said the urinary catheter bag was not to be on the floor.</p> <p>3. The facility's Policy and Procedure for Laundry and Linens, documented the staff was to "keep soiled and clean linens, their respective hampers and laundry carts, separate at all times." Staff was to consider "all soiled linens to be potentially infectious." Staff was to wear heavy-duty gloves, a gown or apron, and a mask when handling and sorting soiled linens.</p> <p>On 3/8/17 at 3:15 pm, the Laundry Supervisor described the linen cleaning process. She stated the linens came in through a small sorting room where linens were sorted. This room was located in front of the main laundry room. She stated her staff wore aprons, gloves, and masks while in the small sorting room when they sorted laundry. She stated it was not facility practice to leave the sorting room with these items on. In addition, the Laundry Supervisor stated the washers were part of the soiled area and the dryers were part of the clean area.</p> <p>On 3/8/17 at 3:18 pm, the layout of the main laundry room was observed to contain; two large washing machines and two large dryers on the right-hand side. There was no separation between the washers and dryers. The left hand side of the room contained two folding tables, a storage closet for clean linens, and a third small washing machine in the corner. The right side edge of the small washing machine was touching one of the folding tables and was next to the</p>	F 441			

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F 441	<p>Continued From page 51 entrance of the clean linen storage closet.</p> <p>On 3/8/17 at 4:44 pm, the Laundry Supervisor stated the small washing machine was used about twice a day for small loads. She stated the small loads contained items such as napkins and table clothes. She stated she kept the items in a bag while bringing the soiled linens into the clean area to prevent cross-contamination. She stated she threw the bag away after she dumped the items out and into the small washing machine.</p> <p>The facility failed to ensure a clear boundary of clean and dirty areas were kept separate. The facility contaminated the clean area when dirty soiled items were brought into the clean area.</p> <p>On 3/10/17 at 5:25 pm, the Administrator stated the facility had removed the small washing machine from the laundry room to correct the cross contamination concern.</p> <p>4. In double-occupancy resident rooms, towels sets were observed on one towel bar in the bathroom. Each room had additional towel bars which were empty or used as a rack to dry personal items. On 3/9/17 at 3:30 pm, the following observations were made:</p> <ul style="list-style-type: none"> - Resident room for Residents #8 and #28, 3 towel bars were in the bathroom. One set of towels was on 1 bar, the others were empty. Resident #8 stated "I think my towels are on the right side." - Resident room for Residents #12 and #29, 2 towel bars were in the bathroom. Two sets of towels were on 1 bar, the other bar was empty. 	F 441			

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F 441	Continued From page 52 - Resident room for Residents #30 and #31, 2 towel bars were in the bathroom. Two sets of towels were on 1 bar, the other towel bar held damp stockings and gloves. - Resident room for Resident #32 and #33, 2 towel bars were in the bathroom. Two sets of towels were on 1 bar, the other bar was empty. - Resident room for Residents #1 and #34, 2 towel bars were in the bathroom. Two sets of towels were on 1 bar, the other bar was empty. On 3/9/17 at 4:00 pm, LN #5 stated, "I don't know which towel belongs to which resident," referring to Residents #30 and #31. Towels for residents in double-occupancy rooms were not identified to belong to each specific resident, which could lead to cross-contamination and possible infection of one or both residents.	F 441			
F 463 SS=D	483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH (g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area - (2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, it was determined the facility failed to	F 463	F-463 1. Call light system for room 582 has	4/21/17	

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F 463	Continued From page 53 ensure a reliable communication system from a resident's room to the nursing station was available. This was true for 1 of 7 (#582) rooms checked for call lights. This failure created the potential for harm if residents or staff assisting residents could not alert others for assistance when needed. Findings include: On 3/7/17 at 10:30 am, the Maintenance Supervisor stated that under previous ownership it was not the facility's practice to test call lights for functionality. He stated testing call lights was a new requirement for him since the facility underwent a change of ownership on 12/1/16. He stated he had not yet initiated a process for testing call lights. On 3/8/17 at 10:30 am, 4 out of 13 residents during resident council stated their call lights had been malfunctioning recently and when someone came to look at it; the residents were told there was nothing wrong with their call lights. On 3/8/17 at 2:30 pm, the call light in room #582 was observed not to sound outside of the room when the Maintenance Supervisor activated the call cord in the resident's room. He stated the call light should sound to notify staff of resident's needs.	F 463	been repaired. 2. Facility call light systems have been audited and are functioning appropriately. 3. The Maintenance Director (MD) will complete random call system audits, once a week x4 weeks then once a month x 3 months and report, findings to the Administrator. Deficient practice identified will be immediately corrected. 4. The MD will report any issue to the QAPI committee for immediate Root Cause Analysis, system review and trend tracking, to identify opportunities for improvement. 5. Administrator or Designee will be responsible to ensure compliance 6. Corrective Action will be completed by April 21, 2017		
F 465 SS=E	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		4/21/17	

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F 465	<p>Continued From page 54</p> <p>(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure residents were provided a safe and clean environment. This was true for residents who lived in rooms 540-563 and residents who frequented the two dining rooms observed, Dining Rooms D & C, and had the potential to cause harm should the condition of the facility cause residents embarrassment, sadness, depression or experience other adverse reactions to a less-than clean and homelike environment. Findings include:</p> <p>On 3/8/17 at 9:00 am, the grounds on the west side of the building had trash near an entry way next to the D Dining room. The trash included 4 empty boxes; empty bags of fertilizer; and a small trash can without a lid on it. The dumpster out back had cardboard boxes next to it on the ground. The East side of the Long Term Care facility had wet cardboard boxes, empty bags, blue latex gloves, and empty fertilizer bags. The C Dining room windows looked out to the trash recepticals. Rooms 540-563 windows faced the East and West sides of the buildings and could see trash on the grounds.</p> <p>On 3/8/17 at 2:45 pm, the Maintenance Supervisor stated trash should be in a covered trash receptacle. He stated the small trash can</p>	F 465	<p>F-465</p> <p>The trash concerns were disposed of prior to survey exit to ensure comfort for residents in rooms 540 - 563, and all current and future residents.</p> <p>The MD will complete entire trash inspections, once a week x4 weeks then once a month x 3 months. Any deficient practice identified will be immediately corrected, and reported to the Administrator.</p> <p>Any identified issue will be referred to the QAPI committee for immediate Root Cause Analysis, system review and trend tracking.</p> <p>Administrator or Designee will be responsible to ensure compliance.</p> <p>Corrective Action will be completed by April 21, 2017</p>		

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F 465	Continued From page 55 by the back door was for the covered patio and should not be used for other trash. He stated he would make sure the trash was picked up.	F 465			
F 468 SS=E	483.90(i)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS (i)(3) Equip corridors with firmly secured handrails on each side; and This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure handrails in the facility were securely fastened to walls. This had the potential to affect 1 of 12 (#10) sampled residents residing in the facility and all other ambulatory resident moving about the C hallways. The failure had the potential for more than minimal harm if resident's sustained falls and/or injuries related to unsecured handrails. Findings include: On 3/7/17 at 10:30 am, a loose handrail was observed in C hallway outside of Rooms #552 and #553. Resident #10 moved about the hallway at the time of the observation. On 3/8/17 at 9:18 am, the handrail was observed loose in C hallway and when pressure was applied to the handrail, it gave away and came off the wall. At 9:23 am, the Maintenance Director was shown the loose handrail and fixed the unsecured handrail. He stated the plan was to remodel the facility and handrails were one of the items being replaced.	F 468	F-468 1. The identified handrail was adjusted and fixed prior to survey exit to ensure resident #10 no other current and future residents are impacted. 2. Facility handrails in hallways were audited and adjusted as necessary. 3. The Maintenance Director or designee will complete random facility handrail inspections, once a week x4 weeks then once a month x3 months, and report findings to the Administrator. 4. Any deficient practice identified will be immediately corrected for patient safety and the issue referred to QAPI committee for immediate Root Cause Analysis, system review and trend tracking. 5. Administrator or Designee will be responsible to ensure compliance 6. Corrective Action will be completed by April 21, 2017	4/21/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/10/2017
NAME OF PROVIDER OR SUPPLIER KARCHER POST-ACUTE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651		
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F 514 SS=D	<p>483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>(i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete;</p> <p>(ii) Accurately documented;</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it</p>	F 514		4/21/17	
			F-514		

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F 514	Continued From page 57 was determined the facility failed to maintain clinical records for each resident that were complete and accurate. This was true for 1 of 2 (#13) residents whose closed records were reviewed. This deficient practice created the potential for medical decisions to be based on inaccurate information, which increased the risk for complications due to inappropriate care or interventions. Findings include: Resident #13 was admitted to the facility on 3/27/15, and was readmitted on 7/9/15, with multiple diagnoses, including left sided paralysis and weakness following a stroke. Resident #13's record included her daily Initial Mood and Behavior Log between June 2015 and November 2015. The first page of the October Initial Mood and Behavior Log had a name of another resident on the top left corner which was hand written, and on the bottom right corner had Resident #13's name. The second page of the October Initial and Behavior Log had a name of the same resident as the first page, which was also hand written, and on the top right corner was Resident #13's name. On 3/8/17 at 4:50 pm, the Regional Nurse Support looked surprised when the Initial Mood and Behavior Log was shown to her. The Regional Nurse Support did not comment.	F 514	1. Resident #13 no longer resides in the facility. 2. Current residents with Behavior Monitors have been reviewed and accurately reflect each residents name and room number. 3. The SSD has been educated on the Prestige P & P for Behavior Monitoring and implementation of the Prestige Behavior Monitors were initiated 4/1/17. The SSD will review and ensure accurate resident information is on resident Behavior Monitor Flowsheets at the beginning of each month. 4. The Medical Records Director (MR) will audit the Behavior Monitors at the beginning of each month, to ensure accurate resident name on each flowsheet. Copy of audit will be forwarded to the SSD for follow up if needed. 5. The MR Director will track and trend audit results and report findings to the QAPI committee to identify opportunities for performance improvement, monthly x 3 months and randomly thereafter. 5. Compliance date: 4/21/17 6. The Administrator will ensure compliance.		
F 518 SS=F	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS	F 518		4/21/17	

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F 518	<p>Continued From page 58</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of facility procedures, it was determined the facility failed to ensure staff were able to describe the steps to take to safely assist residents from the facility in the event of a fire or power outage. This was true for 3 of 5 staff interviewed on emergency preparedness (Certified Nursing Assistants [CNA] #1 & #2 and the Staff Development Coordinator [SDC]). This deficient practice placed 48 of 48 residents residing in the facility at risk of harm, if they required the assistance of CNAs #1 and #2, and the SDC, during a fire or power outage emergency. Findings include:</p> <p>The facility's General Fire Procedures, revised on 2/27/13, directed staff to follow the procedures of RACE, which is defined as:</p> <ul style="list-style-type: none"> * "Rescue" residents * "Alarm" * "Contain" the area of the building in which there is fire by closing fire doors and extinguish the fire if possible * "Evacuate" residents <p>The facility's General Fire Procedures did not direct staff on how to use a fire extinguisher. According to the Occupational Safety and Health Administration, [OSHA] the procedure to operate a fire extinguisher is PASS. This is defined as:</p>	F 518	<p>F-518</p> <ol style="list-style-type: none"> 1.No resident was immediately identified as being impacted. 2.Current residents are being provided care and services by staff who have been trained on Fire Safety and Emergency Response. 3.Current staff have been re-educated regarding the facility policy for fire safety and emergency preparedness by the Administrator and or designee. <p>The Staff Development Coordinator (SDC) will complete random staff sample quizzes, once a week x4 weeks then once a month x 3 months. All deficient practice identified will be immediately corrected. Results will be reviewed at QAPI meeting monthly.</p> <ol style="list-style-type: none"> 4.The SDC will track and trend the quiz responses and report findings to the QAPI committee, monthly x 3 months to identify opportunities for performance improvement. 5. Administrator or Designee will be responsible to ensure compliance. 		

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F 518	<p>Continued From page 59</p> <ul style="list-style-type: none"> * "Pull" the pin * "Aim" the nozzle at the base of the fire * "Squeeze" the handle * "Sweep" nozzle side to side <p>On 3/8/17 at 10:00 am, CNA #1 stated if a disaster happened, like a fire in the facility, she would go get the emergency preparedness book which told her what to do. CNA #1 stated she could not remember the procedure for what to do in a fire. When asked what RACE stood for, she was able to define the "R" to mean rescue and "A" to mean alarm. She could not remember the rest. CNA #1 did not know what "PASS" stood for or how to use the fire extinguisher. In addition, CNA #1 stated if a resident was missing she would tell an RN and go back to what she was doing. CNA #1 said if the power went out she thought there might be a generator and she would grab a portable oxygen tank if residents needed oxygen.</p> <p>On 3/8/17 at 10:08 am, CNA #2 stated she did not know what PASS stood for and she would not attempt to put out a fire. CNA #2 saw the SDC and asked the SDC what PASS stood for. The SDC could not remember and stated she would find out.</p> <p>On 3/8/17 at 1:59 pm, the SDC stated she had in-serviced staff working on 3/8/17, on fire safety to include PASS which gave staff instructions on how to use the fire extinguishers.</p> <p>On 3/8/17 at 2:00 pm, the Maintenance Supervisor stated staff members should know how to manage a fire and what to do when the</p>	F 518	6. Corrective Action will be completed by April 21, 2017		

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F 518	<p>Continued From page 60</p> <p>power went off. He stated the generator provided power to the Long Term Care facility. He stated the staff was trained on fire safety and emergency preparedness regularly; and he would be doing an in-service soon.</p> <p>On 3/9/17 at 9:45 am, the facility provided a copy of the in-service, completed by the SDC on 3/8/17, on fire safety and how to use the extinguisher. The name CNA #1 and CNA #2 were not on the list of employees who received the in-service on 3/8/17.</p> <p>On 3/9/17 at 9:45 am, the facility provided a Disaster Emergency - Required In-Service Sign-In Sheet, dated 12/12/16 at 2:00 pm, which documented staff participation. The Sign-In Sheet included the names of all the staff members who were required to participate and attend. The Sheet was missing documented signatures for the following numbers of personnel employed by the facility:</p> <ul style="list-style-type: none"> * 15 of 28 CNAs * 8 of 12 Licensed Practical Nurses * 5 of 7 Registered Nurses * 3 of 14 Housekeeping/ Maintenance/ laundry personnel * 22 of 24 Dietary personnel * 4 of 8 Business office personnel * 1 of 1 Activities personnel * 3 of 4 Transportation personnel * 1 of 1 Chaplin * 2 out of 2 Administration personnel <p>CNA #1's signature was not among the staff members who received the Disaster training on 12/12/16.</p>	F 518			

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

PRINTED: 04/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/10/2017
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F 518	Continued From page 61 The facility failed to ensure staff was adequately trained on Emergency Preparedness and fire safety.	F 518			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/10/2017
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NAME OF PROVIDER OR SUPPLIER KARCHER POST-ACUTE & REHABILITATION C	STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the licensing and complaint investigation surveys conducted at the facility from March 6, 2017 through March 10, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Presie C. Billington, RN, Team Coordinator Susan Costa, RN Teresa Kobza, RD, LD Ophelia McDaniels, RN</p> <p>Abbreviations: RHIT = Registered Health Information Technician</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the Housekeeping and Laundry Supervisor, and the Pharmacist participated in the facility's Infection Control Meetings. This failure had the potential to affect all residents, staff and visitors to the facility. Findings include:</p> <p>On 3/10/17 at 1:40 pm, the Interim DON who was also the Infection Control Nurse said the facility held their Infection Control Meetings on a monthly basis. Review of the sign-in sheets for the last 9 months, from January 2016 to September 2016, covered the last 3 quarterly</p>	C 664	<p>C664</p> <p>No residents were identified as being impacted.</p> <p>The facility consultant pharmacist attended QA meeting(s) by phone but inconsistently had a signature or by phone labeled on the signature. Future QA meeting <input type="checkbox"/>s will ensure the pharmacist attendance is noted properly by a signature.</p> <p>Department Heads and Managers were</p>	4/21/17

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 04/17/17
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Bureau of Facility Standards

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C 664	Continued From page 1 meetings, revealed the Housekeeping and Laundry Supervisor had not attended any of the monthly meetings, and the Pharmacist attended only one of the monthly meetings. The ICN said the Pharmacist was present during the meetings via telephone, and they failed to ask him to sign the attendance sheets whenever he was in the facility.	C 664	educated on the Prestige QAPI P & P. The Administrator or Designee will be responsible to ensure compliance. Corrective Action will be completed by April 21, 2017	
C 880	02.203,01 Responsible Staff 01. Responsible Staff. The administrator shall designate a staff member the responsibility for the accurate maintenance of medical records. If this person is not a Registered Records Administrator (RRA) or an Accredited Records Technician (ART), consultation from such a qualified individual shall be provided periodically to the designated staff person. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the staff member responsible for the accurate maintenance of medical records periodically received consultation from a qualified individual. This affected 14 of 14 (#1-#14) sampled residents and had the potential to affect all residents who resided in the facility. Findings include: On 3/6/17 at 8:20 am, during the entrance conference, the Administrator was asked for a list of Key Facility Personnel which included the name of the facility's Registered Health	C 880	C880 Terry Lemmon, RHIT, has been contracted to provide staff oversight of our medical records personnel, to ensure that residents Residents #1-#14 are no longer currently impacted, and all future residents will not be impacted by lack of oversight. RHIT contract and oversight will be kept current and will be reviewed annually. Administrator or Designee will be	4/21/17

Bureau of Facility Standards

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C 880	<p>Continued From page 2</p> <p>Information Technician (RHIT).</p> <p>On 3/6/17 at 10:15 am, the Administrator said their Medical Records Technician was not certified but sought consultation with the Regional Medical Records Technician, when necessary, and gave the telephone number of the facility's Regional Medical Records Technician.</p> <p>On 3/10/17 at 10:30 am, the facility's Medical Records Technician said he was not a certified Medical Records Technician but he was planning to become certified. He said he consulted with the regional RHIT periodically, and when necessary. He also said the surveyor could call the RHIT anytime. The Medical Records Technician was asked to request a copy of the regional RHIT's certificate.</p> <p>On 3/10/17 at 2:20 pm, the Medical Records Technician provided a copy of an email that was sent by the regional RHIT. The email related to the Idaho State Rule related to Patient and Resident Records. The Medical Records Technician said he just found out the Regional RHIT was not certified.</p>	C 880	<p>responsible to ensure compliance.</p> <p>Corrective Action will be completed by April 21, 2017</p>	
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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May 26, 2017

Nathan Chinchurreta, Administrator
Karcher Post-Acute & Rehabilitation Center
1127 Caldwell Boulevard
Nampa, ID 83651-1701

Provider #: 135110

Dear Mr. Chinchurreta:

On **March 10, 2017**, an unannounced on-site complaint survey was conducted at Karcher Post-Acute & Rehabilitation Center. The complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted from March 6, 2017 to March 10, 2017.

The following observations were conducted:

- Accessibility of call lights,
- Staff response time to residents' requests and call lights,
- Nursing cares provided to residents,
- Staff-to-resident interactions.

The following documents were reviewed:

- The entire clinical record of the identified residents and nine other residents,
- The facility grievance file,
- Resident Council meeting minutes between November 2015 and February 2016,
- Incident and Accident reports between July 2015 and January 2016.

The following interviews were conducted:

- Thirteen residents were interviewed at a group interview regarding quality of care issues,
- Four individual residents were interviewed regarding quality of care and quality of life issues,
- Two residents' representatives were interviewed regarding quality of care and quality of life issues,
- The Administrator, Regional Nurse Support, Interim Director of Nursing, and two Certified Nursing Assistants were interviewed regarding quality of care issues.

The complaint allegations, findings and conclusion are as follows:

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007244

ALLEGATION #1

The Social Worker was rude, did not return telephone calls, and was less than forthright when asked about care concerns and the identified resident's "behaviors."

FINDINGS:

The identified resident was no longer at the facility at the time the complaint was investigated and the Social Worker was no longer working in the facility at the time of investigation. Thirteen residents interviewed during the group interview said they were treated by staff in a respectful manner and had not heard or seen any staff being rude to residents. Two residents' representative said their loved ones were treated with respect by the staff.

Based on observations, record review, and resident and representative interviews, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The identified resident used her call light often so staff moved the call light out of her reach.

FINDINGS:

Call lights accessibility were observed while residents were inside their respective rooms and all call lights were within the residents' reach. There were no concerns voiced during the residents group interview regarding the accessibility of call lights.

Based on observation and interviews, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The staff were often observed positioning the identified resident on her back against physician orders.

FINDINGS:

Throughout survey staff were observed repositioning residents after their nursing cares were provided and when necessary.

Based on observation, review of the resident's clinical record, and interviews with residents, resident representatives and staff, this allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Facility personnel said there were not enough staff to respond to residents' call lights.

FINDINGS:

Call light response times were observed throughout survey and no staff response time was in excess of ten minutes. All but one resident attending a group interview stated they had no concerns with the amount of time it took staff to respond to call lights.

Based on observation and interviews, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

Facility staff did not assess an identified resident's blood sugar levels.

FINDINGS:

The identified resident's Treatment Administration Record documented the identified resident's blood sugar was assessed four times daily from April 2015 through June 2015. A care conference in July 2015 attended by the resident, Licensed Social Worker and three other staff members with the resident's representative on the phone addressed physician orders for discontinuing the identified resident's routine blood sugar assessment as it was stable.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The identified resident was falsely accused of inappropriately touching another resident's breast and putting her hand down a male staff members pants. At a subsequent care conference, the identified resident and family member challenged the allegation and were informed the male staff member no longer worked at the facility.

FINDINGS:

Review of Resident #13's clinical record between March 2015 and January 2016 did not show any documentation how she acted inappropriately or what inappropriate comments she had made. There were no Incident and Accident report or investigation report found on her clinical record regarding the resident attempting to grab or touch any of the CNAs.

On 3/8/17 at 4:50 pm, the Regional Nurse Support said she did not find any documentation regarding the resident's inappropriate sexual behavior other than what the LSW written on her progress notes, and that the LSW was no longer working in the facility. When asked whether the reason for Resident #13's projected discharge on 12/21/15 was appropriate, the Regional Nurse Support said "I would like to see more supporting documents."

Nathan Chinchurreta, Administrator
May 26, 2017
Page 5 of 7

Based on record review and interview, this allegation was substantiated and the facility was at F201. Please refer to Federal Report 2567 for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #7:

During a conference, the Director of Nursing exuded "threatening body language" and the facility "had been threatening a thirty day involuntary discharge almost since she (the identified resident) was admitted."

FINDINGS:

The Director of Nursing was no longer working in the facility at the time of the investigation and there were no concerns voiced during a resident group interview that staff were rude or threatening to residents.

Based on interviews, observations, clinical record review, and review of the facility's grievance file, incident reports, and Resident Council minutes, this allegation could not be substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

Upon discharge from the facility, the identified resident was assessed with severe perineal excoriation from being left in soiled adult briefs because staff refused to toilet her due to the resident's difficult transfer needs.

FINDINGS:

The identified resident's clinical record documented staff provided appropriate incontinent care and barrier cream was applied as needed; there was no documentation of perineal excoriation located in the resident's clinical record. Two residents' representative and four individual residents were interviewed regarding quality of care issues and there were no concerns identified.

Based on record review and interviews, the allegation could not be substantiated.

Nathan Chinchurreta, Administrator
May 26, 2017
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CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #9:

The identified resident was started on antidepressant therapy and received other medications of concern without family notification or consent.

FINDINGS:

The identified resident's clinical record documented the interested party was not notified of medication changes and the discontinuance of medications, or when the identified resident began receiving antibiotic therapy.

This allegation was substantiated and the facility was cited at F157. Please refer to Federal Report 2567 for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #10:

The facility lost several articles of the identified resident's newly purchased clothing.

FINDINGS:

Thirteen residents attending a resident group interview stated the facility attempts to locate any lost articles of clothing. If the lost items are not located the facility has replaced that clothing with articles of like value.

Based on interview and record review, the allegation could not be substantiated.

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.

Nathan Chinchurreta, Administrator
May 26, 2017
Page 7 of 7

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The "D" is stylized with a vertical line through it, and "Scott" is written in a cursive-like font.

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

DS/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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May 26, 2017

Nathan Chinchurreta, Administrator
Karcher Post-Acute & Rehabilitation Center
1127 Caldwell Boulevard
Nampa, ID 83651-1701

Provider #: 135110

Dear Mr. Chinchurreta:

On **March 10, 2017**, an unannounced on-site complaint survey was conducted at Karcher Post-Acute & Rehabilitation Center. The complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted from March 6, 2017 to March 10, 2017.

Resident care by nurses, therapists, and Certified Nursing Assistants (CNAs) was observed, thirteen resident medical records were reviewed, facility policy and procedures were reviewed and resident and staff interviews were conducted.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007257

ALLEGATION #1:

The facility failed to ensure residents received adequate fluid intake and failed to follow physician-ordered bowel care for an identified resident who developed a fecal impaction that required his/her transfer to a hospital for treatment.

Nathan Chinchurreta, Administrator
May 26, 2017
Page 2 of 2

FINDINGS:

The identified resident was admitted to the facility for rehabilitative services following hospitalization for the repair of a fractured hip. The resident was also diagnosed with dementia and a history of dehydration. Seventeen days after admission to the facility, the identified resident was transferred to a hospital with diagnoses of abdominal pain, bloody stools, and fecal impaction.

The allegation was substantiated and the facility was cited at F309 and F327. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a clear "Scott" following.

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

DS/lj