



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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3232 Elder Street
P.O. Box 83720
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April 13, 2017

Tom de Oro, Administrator
Ivy Court
2200 Ironwood Place
Coeur d'Alene, ID 83814-2610

Provider #: 135053

Dear Mr. de Oro:

On **March 24, 2017**, a survey was conducted at Ivy Court by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 24, 2017**. Failure to submit an acceptable PoC by **April 24, 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 **May 5, 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 22, 2017**. A change in the seriousness of the deficiencies on **May 5, 2017**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 22, 2017** includes the following:

Denial of payment for new admissions effective **June 22, 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.

Michael Littman, Administrator
April 13, 2017
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We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 20, 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 22, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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 24, 2017**. If your request for informal dispute resolution is received after **April 24, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Michael Littman, Administrator
April 13, 2017
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Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large, stylized "D" and "S".

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

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

PRINTED: 05/03/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/24/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
(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 survey conducted at the facility from March 20, 2017 to March 24, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Brad Perry, LSW, Team Coordinator Susan Costa, RN Brenda Cross, RN, BSN</p> <p>Survey Abbreviations: ADON = Assistant Director of Nursing am = morning BP = Blood Pressure C-diff = Clostridium Difficile cm = centimeter CNA = Certified Nursing Assistant COPD =Chronic Obstructive Pulmonary Disease DON = Director of Nursing D/T = Due To ESRD = End Stage Renal Disease GDR = Gradual Dose Reduction IDT = Interdisciplinary Team LLE = Left Lower Extremity LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligram NS = normal saline pm = afternoon PRN = As Needed QID = four times daily R = Right RCM = Resident Care Manager TAR = Treatment Administration Record TID = three times daily</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

04/21/2017

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 W/ = With W/C = Wheelchair > = Greater than	F 000			
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure residents who self-administered medications had been assessed as safe to do so. This was true for 2 of 15 residents (#10 and #13) whose records were reviewed and/or observed during medication pass. This failure created the potential for residents to self-administer medications incorrectly. Findings include: 1. Resident #13 was admitted to the facility on 8/8/16 with diagnoses that included End Stage Renal Disease [ESRD], hypertension [HTN], Congestive Heart Failure [CHF], diabetes mellitus, peripheral vascular disease [PVD], and pacemaker. A "Self-Medication Data Collection and Assessment" form, dated 8/22/16, documented Resident #13 chose not to self-medicate at that time. Resident #13's physician orders documented: * Refresh Optive, both eyes four times daily. May keep at bedside. (10/11/16)	F 176	“This plan of correction constitutes this facility’s written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Department’s inspection report” How the nursing home will correct the deficiency as it relates to the resident: Resident #13 and #10 have been evaluated by the IDT team as safe to self administer medications. Resident #13 and #10 are routinely observed with self medication program and medications at bedside are stored safely. How the nursing home will act to protect residents in similar situations: Residents residing at the facility willing and able to participate in the self medication program have the potential to be affected by this deficiency and have been evaluated to be clinically appropriate to do so. Residents	5/5/17	

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F 176	<p>Continued From page 2</p> <p>* Saline nasal spray, instill 4 sprays in each nostril four times daily. (2/21/17)</p> <p>Resident #13's care plan did not document the resident self-administered medications, nor did it address the storage of medications.</p> <p>On 3/21/17 at 8:21 am, LN #4 was observed administering medications to Resident #13. The two medications were also observed on the resident's shelf at this time.</p> <p>LN #4 stated Resident #13 self-administered the medications on her own schedule and without staff oversight. LN #4 stated the medications were documented as having been administered when the resident told nurses she had taken the medications and staff did not routinely observe the resident self-administer any medication.</p> <p>On 3/23/17 at 4:00 pm, the ADON stated self-administration assessments were performed on a quarterly basis and that three quarterly assessments had been completed since Resident #13's admission in August 2016. The ADON stated Resident #13 had not been assessed to self-administer medications and that she was unaware medications were kept at the resident's bedside.</p> <p>2. Resident #10 was admitted to the facility on 2/23/17 with diagnoses that included Chronic Obstructive Pulmonary Disease [COPD] and chronic respiratory failure with hypoxia.</p> <p>Resident #10's physician's orders documented: * Proventil MDI [multiple dose inhaler] 2 puffs every 4 hours as needed (2/23/17)</p>	F 176	<p>participating in self medication program are routinely observed during administration and medications at bedside are stored safely.</p> <p>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur: Licensed Nurses have been inserviced on the self medication assessment/careplan. Licensed nurses have been inserviced on the safe storage of bedside medications. Residents participating in self medications have been educated on routine observation process and safe storage of bedside medications.</p> <p>How the nursing home plans to monitor its performance to make sure that solutions are sustained: Residents participating in self medication program will be monitored daily by the Director of Nursing X 30 Monday through Friday and then weekly X 8 for accuracy and safe storage of bedside medications. MD orders will be reviewed by the Director of Nursing daily at morning meeting Monday through Friday to identify medications that may be left at bedside and ensure the self medication program is implemented. Findings will be corrected upon occurrence and presented to QAPI monthly X 3 for further corrective opportunities.</p> <p>Dates when corrective action will be completed and title of person responsible to ensure correction:</p>		

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F 176	Continued From page 3 * Proventil MDI to be kept at resident's bedside (2/20/17) Resident #10's clinical record did not include documentation that the facility had assessed her to self-administer medication. On 3/20/17 at 10:30 am, Resident #10 was observed sitting on her bed with an inhaler and pulse oximeter on her lap. When asked about the inhaler, Resident #10 stated she needed it close by because she could not wait for staff to respond to her call light for the inhaler to be brought to her. On 3/23/17 at 4:00 PM, RCM #2 stated Resident #10 became "nervous" if she needed her inhaler and it was not immediately available. RCM #2 stated the resident's physician ordered staff to store the medication at Resident #10's bedside. RCM #2 stated she could not locate any evidence that Resident #10 had been assessed to self-administer medications.	F 176	05/05/2017 Director of Nursing		
F 226 SS=E	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and	F 226		5/5/17	

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F 226	<p>Continued From page 4</p> <p>(3) Include training as required at paragraph §483.95,</p> <p>483.95</p> <p>(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-</p> <p>(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.</p> <p>(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property</p> <p>(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on review of personnel files and facility policies, and staff interview, it was determined the facility failed to ensure new employee background checks were completed for 2 of 3 CNAs (Employee A & B) whose employee files were reviewed. This created the potential for harm if newly-hired CNAs with a history of abuse and/or neglect were put into direct contact with residents residing in the facility. Findings include:</p> <p>The facility's current abuse policy and procedures, dated July 2015, documented, "Screen all potential employees for a history of abuse, neglect, or mistreatment of residents during the hiring process. Screening will consist of...inquiries into [the] State nurse aide registry."</p>	F 226	<p>How the nursing home will correct the deficiency as it relates to the resident: There are no residents identified</p> <p>How the nursing home will act to protect residents in similar situations: Residents residing at the facility could be potentially affected by this deficiency. Facility has reviewed abuse and neglect allegations for the previous 30 days. There are no residents identified affected by this deficient practice. CNA's employed at the facility have the correct State Nurse Aide Registry Verification completed</p>		

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F 226	Continued From page 5 The facility's hiring list documented Employee A and B, both CNAs, were hired on 11/16/16 and 12/6/16 respectively. Employees A and B nurse aide employee personnel files were reviewed for the State Nurse Aide Registry Verification Report and none were found. On 3/23/17 at 3:10 pm, the Payroll Clerk said she thought the certification cards the CNAs brought to her were adequate proof of their state registry status. The Payroll Clerk performed a registry check that day (3/23/17), which did not identify abuse or neglect findings for either Employee A or B.	F 226	Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur: The payroll clerk has been inserviced on required abuse and neglect pre-hire screening for nurse's aides through the State Nurse Aide Registry Verification. How the nursing home plans to monitor its performance to make sure that solutions are sustained: Facility will monitor abuse and neglect screening of hired nurses aides to ensure completion prior to general orientation. The Business Office manager will monitor nurses' aides registry for abuse and neglect screening monthly X 3 to ensure completion. Findings will be reviewed monthly X 3 through QAPI for further corrective action. Dates when corrective action will be completed and title of person Responsible to ensure correction: 05/05/2017 Administrator		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		5/3/17	

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F 278	<p>Continued From page 6</p> <p>(i) Certification (1) A registered nurse must sign and certify that the assessment is completed.</p> <p>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>(j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</p> <p>(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents' MDS assessments accurately reflected the status of residents' wounds. This was true for 1 of 15 (#7) residents reviewed for MDS assessment accuracy. This resulted in the potential for Resident #7's care plan to inaccurately reflect her current functional status and wound care needs. Findings include: Resident #7 was admitted to the facility on</p>	F 278	<p>How the nursing home will correct the deficiency as it relates to the resident: Resident #7 has had her MDS modified to accurately reflect current functional status and wound care needs.</p> <p>How the nursing home will act to protect residents in similar situations: Residents residing at the facility with identified wounds have been evaluated and their MDS reflect these wounds</p>		

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F 278	<p>Continued From page 7</p> <p>12/20/16, with multiple diagnoses, which included insulin dependent diabetes, contusion to the left lower leg, chronic anemia, major depression, and obesity.</p> <p>An admission nursing assessment, performed 12/20/17 at 7:15 pm, included a skin assessment of Resident #7. The assessment identified 3 areas of impaired skin integrity on Resident #7's left lower leg. The area closest to her knee was identified as a pressure wound and measured 7 cm X 3 cm. Just below the first area, the LN documented a skin tear but did not include a measurement. The third area just above Resident #7's ankle was documented as 5 cm X 2 cm. The type of impaired skin integrity was not documented.</p> <p>Resident #7's 12/27/16 initial MDS assessment documented Resident #7 had no wounds.</p> <p>A physician's progress note, dated 12/29/16, documented a hematoma [a localized swelling that is filled with blood caused by a break in the wall of a blood vessel] on Resident #7's lower left leg was drained. The physician's progress note documented staff were to cleanse Resident #7's lower left leg wound with normal saline, pack the wound with Kerlix, loosely wrap the wound with an absorbent padded dressing, and apply an Ace or Coban wrap daily.</p> <p>An admission medical evaluation, dated performed on 1/3/17, documented Resident #7 was hospitalized prior to her admission to the facility. It stated she fell at home and sustained a hematoma to her lower left leg. The evaluation also documented an ultrasound of her leg was</p>	F 278	<p>accurately.</p> <p>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur: MDS staff has been inserviced on coding of wounds to accurately reflect resident status.</p> <p>How the nursing home plans to monitor its performance to make sure that solutions are sustained: MDS accuracy will be reviewed through the comprehensive care plan review meeting by the IDT in accordance with resident MDS schedule daily Monday through Friday X 12 weeks. Findings will be corrected and then presented to QAPI monthly X 3 for further corrective opportunities.</p> <p>Dates when corrective action will be completed and title of person responsible to ensure correction: 05/03/2017 Director of Nursing</p>		

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F 278	<p>Continued From page 8</p> <p>performed on 12/15/16, which described a hematoma and edema. The admission medical evaluation included that reportedly on 12/28/16, Resident #7's lower left leg wound appeared swollen and red and she was experiencing increased pain. The admission medical evaluation documented Resident #7 was sent out of the facility to be seen by a physician on 12/29/16, and the hematoma (that was identified by the hospital after her fall,) was drained and surgical debridement of the wound was performed. [Wound debridement includes removal of unhealthy tissue from a wound to promote healing.]</p> <p>A Skin Grid initiated on 12/28/16, documented assessments of Resident #7's lower left leg wound were performed on 1/8/17, 1/11/17, 1/18/17, 1/25/17, 2/16/17, 2/24/17, 3/3/17, 3/8/17, and 3/15/17. The Skin Grid described the wound to Resident #7's lower left leg as a "surgical debridement." The assessments completed on 3/8/17 and 3/15/17 documented, "Wound bed red, scant serosanguineous [both blood and the liquid part of blood] (drainage), (no) odor, (no) pain, (no) slough noted ..."</p> <p>Resident #7's quarterly MDS assessment, dated 3/11/17, documented she had one wound, a skin tear. The assessment did not identify the wound on her lower left leg, or document daily wound care was provided.</p> <p>On 3/24/17 at 9:30 am, the MDS nurse stated Resident #7 did not have wounds on the initial or quarterly MDS assessments. She stated Resident #7 had a contusion to her left leg and there was not a code for "contusion" on the MDS</p>	F 278			

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F 278	Continued From page 9 assessment. The MDS nurse stated she was unaware the contusion was drained and debrided. After the MDS RN reviewed Resident #7's weekly skin assessments, she stated the documentation confirmed a wound on her left lower leg and said the quarterly MDS assessment should have included the wound.	F 278			
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 observation, record review, staff interviews, and review of facility procedures, it was determined a) the facility failed to ensure physician orders were followed for the care of wounds. This was true for 2 of 15 residents (#4 and #7) sampled for wound care and had the potential for more than minimal harm should those residents develop infections related to inadequate wound care. b) the facility failed to follow physicians' orders for medications, for 3 of 3 sampled residents (#4, #10 and #13.) This deficient practice placed Resident #10 at risk of adverse events related to receiving more medication than ordered by her physician, and had the potential for Resident #13 to experience shortness of breath, abdominal cramps, muscle cramps, nausea or vomiting, due to hypotension during dialysis treatment, and not meeting the nutritional needs of residents #4 and #13.	F 281	How the nursing home will correct the deficiency as it relates to the resident: Resident #4 and #7 have had MD orders reviewed and residents are receiving wound care as per MD order. Resident #13 is receiving medications and Nepro as per order. Resident #10 is receiving analgesic medications as per current MD order. Pain flow sheet is current to evaluate pain management and effectiveness of analgesic. How the nursing home will act to protect residents in similar situations: Residents with ordered wound care have been evaluated and are receiving wound care as per physician order.	5/5/17	

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F 281	<p>Continued From page 10</p> <p>Findings include:</p> <p>1. Resident #4 was admitted to the facility on 2/18/17, following surgical repair of a femur fracture, with diagnoses that included COPD [Chronic Obstructive Pulmonary Disease], pneumonia and insulin dependent diabetes.</p> <p>a.) Admission orders included instructions for dressing changes to a surgical wound and right leg brace and documented that staff "may remove brace for bathing and skin check. Leave dressings on 7 days then may remove. May shower, but not submerge."</p> <p>On 3/22/17 at 3:25 pm, the RCM [Resident Care Manager] was observed removing Resident #4's brace and an Ace wrap on the right leg from mid-thigh to the lower calf. The surgical incision was covered with a Telfa pad that the RCM said appeared as if it had been in place since Resident #4's hospitalization. The dressing, Ace wrap, and brace were then changed and replaced.</p> <p>After the procedure was finished, RCM #2 reviewed Resident #4's physician orders and stated the dressing should have been discontinued on 2/25/17.</p> <p>On 3/22/17 at 4:00 pm, LN #5 stated she removed Resident #4's brace daily and checked the skin. She stated she did not evaluate Resident #4's incision area for a week and, when asked, stated she was unable to offer a reason for not assessing the incision area.</p> <p>On 3/22/17 at 4:45 pm, RCM #2 stated Resident</p>	F 281	<p>Residents with ordered nutritional supplements have been evaluated and are receiving nutritional supplements as per MD order.</p> <p>Residents with ordered PRN analgesics have accurate documentation as per policy and procedure.</p> <p>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur: MD orders will be reviewed by Director of Nursing at morning meeting daily ongoing. Licensed Nurses providing wound care have been inserviced on facility policy and procedure for wound care including "clean" VS "sterile" procedures.</p> <p>Licensed Nurses have been inserviced on ordered nutritional supplements per policy and procedure</p> <p>Licensed Nurses have been inserviced on how dialysis affects medications and importance of maintaining medication as per orders.</p> <p>Licensed Nurses have been inserviced on required documentation for PRN analgesia.</p> <p>How the nursing home plans to monitor its performance to make sure that solutions are sustained: MD orders will be audited daily by</p>		

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F 281	<p>Continued From page 11</p> <p>#4's admission orders documented, "May remove brace...leave dressings on 7 days then may remove." RCM #2 stated the TAR did not include dressing change or removal orders, and that the Ace wrap and dressing should have been discontinued on 2/25/17.</p> <p>b.) A physician's order dated 2/24/17, directed staff to provide Resident #4 with 90 cc [cubic centimeters] of Med Plus 2.0 nutritional supplement three times daily. The February 2017 MAR documented Resident #4 received the supplement as ordered.</p> <p>Resident #4's March 2017 recapitulated physician's orders included the Med Plus 2.0 nutritional supplement three times daily. March 2017 MAR did not include the supplement or documentation that she received it.</p> <p>On 3/23/17 at 3:30 pm, RCM #2 stated the nutritional supplement was not included on the March 2017 MAR and was not given in March 2017.</p> <p>2. Resident #7 was admitted to the facility on 12/20/16, with multiple diagnoses which included insulin dependent diabetes, contusion to the left lower leg, chronic anemia, major depression, and obesity.</p> <p>A 12/29/16 physician's order documented staff were to cleanse Resident #7's lower left leg wound with normal saline, pack the wound with Kerlix, loosely wrap the wound with an absorbent padded dressing, and apply an Ace or Coban wrap daily. The order did not specify whether the dressing change was to be "clean" or "sterile"</p>	F 281	<p>Medical Records to ensure accurate transcription to Medication Administration Record and Treatment Administration Record. Residents requiring wound care will be monitored weekly X 12 to ensure wound care is being provided as per MD order and that assessment of wound and required documentation is current and accurate in the medical record.</p> <p>Licensed nurses will be observed performing wound care by Unit Manager/DON 2X a week for 12 weeks to ensure correct procedure</p> <p>Residents undergoing dialysis will have there MAR's reviewed weekly for 12 weeks to ensure medications are being administered in collaboration with dialysis schedule and medication needs</p> <p>Residents will have their Medication Administration Record reviewed daily X 30 days Monday through Friday to ensure documentation is accurate and complete per policy and procedure in the medical records.</p> <p>Above findings will be corrected upon identification and reviewed through QAPI monthly X 3 months for further corrective opportunities.</p> <p>Dates when corrective action will be completed and title of person responsible to ensure correction: 05/05/2017 Director of Nursing</p>		

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F 281	<p>Continued From page 12 procedure.</p> <p>On 3/21/17 at 4:00 pm, LN #5 was observed changing Resident #7's left calf wound dressing. LN #5 placed the resident's leg on 2 brown paper towels from a dispenser in the room, removed the soiled dressing, and squirted normal saline into the wound. LN #5 then used the paper towels under Resident #17's calf to dry the normal saline, packed the wound bed with Kerlix using her gloved finger, applied an absorbent dressing, and then secured the dressing with Coban elastic wrap.</p> <p>When the wound care was completed, LN #5 stated she performed Resident #7's daily wound dressing changes and the wound care team was scheduled to evaluate the wound and take measurements weekly. She stated the dressing change was a "clean" rather than "sterile" procedure, and that Resident #7's wound was healing well.</p> <p>On 3/24/17 at 9:30 am, the corporate consultant provided a copy of the wound care procedure and stated the facility followed Lippincott Procedures, (a nationally recognized resource for nursing procedures). The wound care procedure, dated 8/12/16, documented, "Dressing a wound calls for sterile technique and sterile supplies to prevent contamination." Irrigation was to be performed with sterile gauze pads saturated with a cleaning agent (normal saline) and wound packing consisted of a sterile 2 x 2 or 4 x 4 gauze pad using sterile forceps as cotton fibers could adhere to wound surfaces and lead to complications.</p>	F 281			

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F 281	<p>Continued From page 13</p> <p>Resident #7's dressing change was not completed consistent with the facility's policy and procedures.</p> <p>3. Resident #13 was admitted to the facility on 8/18/16, with diagnoses including ESRD [End Stage Renal Disease], insulin dependent diabetes, and high blood pressure.</p> <p>a.) Resident #13 left the facility every Monday, Wednesday, and Friday to receive dialysis. Her March 2017 MAR documented she was to be dropped off at the dialysis center at 10:00 am, and received dialysis from 10:15 am to 1:15 pm.</p> <p>Her record included a physician order dated 3/6/17, for Midodrine 10 mg, 1 orally, 30 minutes before dialysis. The website www.mayoclinic.com states a drop in blood pressure is a common side effect of hemodialysis, particularly for people who are diabetic. Low blood pressure may be accompanied by shortness of breath, abdominal cramps, muscle cramps, nausea or vomiting. According to PubMed, a search engine for the National Institutes of Health, Midodrine is an oral medication used for the treatment of hypotension associated with dialysis. The PubMed information directs that the medication be administered 30 minutes before each dialysis session, as it is rapidly metabolized. Its onset of action was listed at 1 hour, and duration of action was listed as 2 to 3 hours.</p> <p>Resident #13's March 2017 MAR included the order for Midodrine, with the physician ordered instructions for time of administration. However, the scheduled time of administration on the MAR was "AM" [morning]. There was no</p>	F 281			

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F 281	<p>Continued From page 14 documentation on the MAR as to the time Resident #13 actually received the medication.</p> <p>During morning medication pass observations on 3/21/17, LN #4 was observed providing medications to Resident #13 at 8:20 am.</p> <p>On 3/23/17 at 2:30 pm, LN #4 stated she administered medications approximately the same time each day. She said the Midodrine was administered to Resident #13 on the days she received dialysis, and that she gave the Midodrine together with her other medications during the morning medication pass. She stated she was not aware of the significance of the medication timing. LN #4 stated the MAR should include a space for the time of administration to ensure it was given within 30 minutes before the scheduled dialysis.</p> <p>b.) Resident #13's record included a physician's order, dated 2/7/17, which documented "Please make sure resident receives Nepro, 1 can each day. Does not need to count towards fluid restriction." Nepro is a Therapeutic Nutritional Supplement specifically designed to help meet the nutritional needs of patients on dialysis.</p> <p>Resident #13's MAR for February and March 2017, did not include the nutritional supplement Nepro.</p> <p>Resident #13's recapitulated orders for March 2017, did not include the nutritional supplement Nepro.</p> <p>A quarterly "Nutritional Risk Assessment," dated 2/22/17, did not document Resident #13 received</p>	F 281			

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F 281	<p>Continued From page 15 a nutritional supplement.</p> <p>On 3/22/17 at 1:55 pm, the Registered Dietician stated she was not aware Resident #13 received a nutritional supplement.</p> <p>On 3/22/17 at 3:05 pm, RCM #2 stated the Nepro order was not included in Resident #13's care plan or placed on a MAR. She stated Resident #13 had not received the supplement since it was ordered on 2/7/17.</p> <p>4. Resident #10 was admitted to the facility on 2/23/17, after hospitalization for chronic respiratory failure. Additional diagnoses included COPD [chronic obstructive pulmonary disease], major depressive disorder, generalized anxiety disorder, and fibromyalgia.</p> <p>Resident #10's 2/23/17 admission orders included Flexeril 10 mg, one tablet, daily PRN [as needed] for muscle spasms.</p> <p>The March 2017 MAR documented Resident #10 received a prn dose on 3/11/17, the entry did not include what time the medication was administered. The MAR documented an additional dose of Flexeril was administered at 5:00 pm on 3/11/17. Resident #10's MAR included a PRN Analgesic Record/Pain Flow Sheet, however, there was no documentation of the Flexeril given. Her nursing progress notes did not document a reason for the additional dose of Flexeril or that the physician was either consulted or notified the additional dose was given.</p> <p>On 3/23/17 at 4:00 pm, RCM #2 stated the additional dose of Flexeril was administered on</p>	F 281			

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F 281	Continued From page 16 3/11/17 at 5:00 pm without an order.	F 281			
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents received interventions to maintain or improve trunk control. This was true for 1 of 13 (#3) sampled residents reviewed for treatment and services related to activities of daily living [ADLs]. This failed practice had the potential for more than minimal harm if residents did not receive equipment necessary to maintain or enhance the ability to participate in ADLs. Findings include: Resident #3 was admitted to the facility on 10/8/15, with multiple diagnoses including Parkinson's disease. A physician's telephone order, dated 7/22/16, documented Resident #3 was to be equipped with a half-lap tray to the right side of his wheelchair "to add support to [the] right side."	F 318	How the nursing home will correct the deficiency as it relates to the resident: Resident #3 has use of the ½ lap tray for support as per assessment and MD order. How the nursing home will act to protect residents in similar situations: Resident at the facility have the potential to be affected by this deficient practice. A house wide review of MD orders was completed for the identification of resident using lap trays. Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur: Nursing staff has been inserviced on the use of lap trays related to MD orders and use.	5/5/17	

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F 318	Continued From page 17 Resident #3's device assessment, dated 10/6/16, documented the half-lap tray was for poor trunk control. Resident #3's current care plan, dated 1/9/17, directed staff to apply the half-lap tray while he was in his wheelchair for increased trunk control. On 3/21/17 and 3/22/17, Resident #3 was observed in his wheelchair without the lap tray on eight occasions. On 3/21/17 at 9:50 am, Resident #3 was observed in his room while in a wheelchair without the half-lap tray and leaning to his right side. On 3/22/17 at 11:45 am, Resident #3 was observed in the dining room in his wheelchair without a half-lap tray and leaning to his right side. On 3/21/17 at 9:50 am, Resident #3 was unable to communicate his positioning preferences. On 3/22/17 at 3:55 pm, RCM #1 [Resident Care Manager] said Resident #3 should have the half-lap tray on his wheelchair. RCM #1 entered Resident #3's room, observed his wheelchair without the half-lap tray and said she would look for the tray. A few minutes later, RCM #1 found the tray in Resident #3's closet and attached it to his wheelchair.	F 318	Supportive devices (lap trays) will be added to the treatment administration record to include Licensed Nursing monitoring. How the nursing home plans to monitor its performance to make sure solutions are sustained: Residents utilizing supportive devices (lap trays) will be observed by the licensed Nurses each shift to ensure device is being used as indicated. Unit Managers will audit treatment records to evaluate compliance daily Monday through Friday X 30 days and then weekly X 8. Findings will be corrected upon identification and then reviewed through QAPI monthly X 3 for further corrective opportunities. Dates when corrective action will be completed and title of person responsible to ensure correction: 05/05/2017 Director of Nursing		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance	F 328		5/5/17	

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F 328	<p>Continued From page 18 with professional standards of practice, including to prevent complications from the resident's medical condition(s) and</p> <p>(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments</p> <p>(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.</p> <p>(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.</p> <p>(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.</p> <p>(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the</p>	F 328			

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F 328	<p>Continued From page 19 residents' goals and preferences, and 483.65 of this subpart.</p> <p>(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, policy and record review, and staff interview, it was determined the facility failed to ensure a) Oxygen therapy was administered consistent with physician orders. This was true for 2 of 3 residents (#4 and #10) reviewed for use of oxygen and had the potential to cause more than minimal harm if residents failed to maintain adequate levels of oxygenation, and b) Diabetic nail care was performed as ordered and/or consistent with the needs 2 of 3 sampled residents (#4 and #7) who were diabetic. This failed practice had the potential to cause more than minimal harm if the toenails of Residents #4 and #7 became infected or skin damage occurred. Findings include:</p> <p>1. Oxygen Therapy was not provided consistent with physician's orders. Examples include:</p> <p>a. Resident #10 was admitted to the facility on 2/23/17, after hospitalization for chronic respiratory failure, with diagnoses that included COPD [Chronic Obstructive Pulmonary Disease], major depressive disorder, generalized anxiety disorder, and fibromyalgia.</p>	F 328	<p>How the nursing home will correct the deficiency as it relates to the resident: Resident #4 and #10 are receiving oxygen therapy as per MD order with accurate documentation related to oxygen use in the medical record.</p> <p>Residents #4 and #7's diabetic nail care is current and scheduled as indicated with appropriate care planning in the medical record.</p> <p>How the nursing home will act to protect residents in similar situations: Residents utilizing oxygen therapy have the potential to be affected by this deficiency.</p> <p>Residents utilizing oxygen therapy have been reviewed and are receiving oxygen therapy per MD order and have accurate documentation in the medical record.</p> <p>Residents requiring diabetic nail care have the potential to be affected by this deficiency.</p>		

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F 328	<p>Continued From page 20</p> <p>Resident #10's physician admission orders, dated 2/23/17, directed staff to provide Resident #10 with oxygen at 6 liters per minute via nasal cannula to maintain blood-oxygen saturation levels at 88% or above.</p> <p>A 2/24/17 physician order directed staff to provide Resident #10 with oxygen at 1-8 liters per minute via oximizer to maintain blood-oxygen saturation levels greater than or equal to 88%. [An oximizer is an oxygen delivery device similar to a nasal cannula, however it has a reservoir to store oxygen and facilitates the delivery of high-flowing oxygen therapy].</p> <p>A physician order, dated 2/27/17, directed staff to change Resident #10's oxygen to 0-6 liters per minute via nasal cannula to maintain blood-oxygen saturation levels greater than or equal to 85-89%.</p> <p>Resident #10's MAR documented nasal cannula oxygen flow rates of 7-8 liters per minute from 3/1/17 to 3/21/17, which was above the flow rate ordered by the physician for Resident #10.</p> <p>The 3/20/17 physician's order directed that Resident #10 was to "Wear oximizer overnight and titrate to sats equal or greater than 90%."</p> <p>Resident #10 was observed in her room, on 3/20/17 at 10:30 am, receiving oxygen via nasal cannula at 8 liters per minute. Her blood-oxygen saturation monitor read 91%.</p> <p>On 3/23/17 at 11:30 am, Resident #10 was observed in her room receiving oxygen via nasal cannula at 8 liters per minute, a blood-oxygen</p>	F 328	<p>Residents with diagnoses of diabetes have been evaluated and are receiving nail care assistance as indicated. Residents residing at the facility with diagnoses of diabetes have had their careplans reviewed and are current related to nail care assistance needs.</p> <p>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur: Licensed Nurses have been inserviced on oxygen therapy including MD orders, and documentation requirements.</p> <p>Licensed Nurses have been inserviced on diabetic nail care, schedule of nail care for resident and required documentation.</p> <p>How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <p>Residents with MD orders for oxygen therapy will be monitored daily for accurate delivery and documentation daily Monday through Friday X 30 and then 2X a week for 8 weeks. Residents residing at the facility with diagnoses including diabetes and needing nail care assistance will be monitored by Director of Nursing weekly X 12 to ensure nail care assistance was provided. Findings will be corrected and then reviewed at QAPI monthly X 3 for further educational/corrective opportunities.</p>		

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F 328	<p>Continued From page 21</p> <p>saturation rate of 79%, and a heart rate of 105 beats per minute. Resident #10 was noted to have rapid breathing with subclavicular retractions [pulling inward of the chest below the clavicles, which can indicate increased effort to breath].</p> <p>On 3/23/17 at 11:32 am, LN #4, when informed of Resident #10's low oxygen saturation reading, stated, "We check her saturations once a shift, and it was ok earlier."</p> <p>On 3/23/17 at 4:00 pm, RCM #2 stated the oxygen flow rate was not written on the MAR correctly and that the current oxygen flow rate specified 0-6 liters per minute by nasal cannula. She stated the physician order to wean the oximizer overnight on 3/20/17 was not written on the MAR correctly and that the LN may have read the word "wean" as "wear."</p> <p>b. Resident #4 was admitted to the facility on 2/18/17, following surgical repair of a femur fracture, with diagnoses that included COPD [Chronic Obstructive Pulmonary Disease], pneumonia and insulin dependent diabetes.</p> <p>Physician admission orders, dated 2/18/17, directed staff to provide Resident #4 with oxygen at 0-3 liters per minute via nasal cannula to maintain blood-oxygen saturation levels at 88% or above.</p> <p>The next physician's order related to oxygen delivery, dated 3/2/17, directed staff to change Resident #4's oximizer to a nasal cannula, although the 2/18/17 admission order, directed the use of a nasal cannula. The 3/2/17 order also</p>	F 328	Dates when corrective action will be completed and title of person responsible to ensure correction: 05/05/2017 Director of Nursing		

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F 328	<p>Continued From page 22</p> <p>directed staff to monitor Resident #4's oxygen levels and maintain blood saturation levels at 88% or greater, and return the resident to the oximizer if blood-oxygen saturations fell below 88%.</p> <p>Resident #4 was observed in her room on 3/20/17 at 10:45 am, receiving oxygen via oximizer at 3.5 liters per minute.</p> <p>On 3/21/17 at 11:09 am, Resident #4 was observed in her room receiving oxygen via oximizer at 5 liters per minute.</p> <p>From 3/2/17 to 3/20/17, the oxygen method of delivery (oximizer or nasal cannula) was not documented.</p> <p>On 3/4/17, evening shift oxygen saturations and flow rate were not documented.</p> <p>On 3/8/17, day shift oxygen saturations and flow rate was not documented.</p> <p>On 3/18/17, day and evening shift, oxygen saturations were not documented.</p> <p>On 3/19/17 and 3/20/17, evening shift documented oxygen flow rate at 3.5 liters per minute, greater than the amount specified by the physician.</p> <p>From 3/8/17 to 3/20/17 the night shift did not document oxygen flow rate.</p> <p>Resident #4 was observed in her room on 3/20/17 at 10:45 am, receiving oxygen via oximizer at 3.5 liters per minute.</p>	F 328			

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F 328	<p>Continued From page 23</p> <p>On 3/21/17 at 11:09 am, Resident #4 was observed in her room receiving oxygen via oximizer at 5 liters per minute.</p> <p>On 3/23/17 at 3:30 pm, RCM #2 stated Resident #4's order for oxygen and method of delivery was not specific at the time of the observations. She stated nursing staff increased Resident #4's oxygen flow rate without receiving orders or communication from the physician.</p> <p>2. A July 2015 facility policy titled, "Guidelines for Providing Hand, Foot, and Nail Care," documented:</p> <ul style="list-style-type: none"> * Clip nails straight across, then round the edges with an emery board. * Push the cuticles back with a washcloth or the dull end of the orange stick. * Dry the feet well, carefully dry between each toe and inspect for red or cracked areas. * Lotion may be applied to the hands or feet if the skin is dry. <p>Residents who were diabetic were not provided foot care necessary to minimize the risk injury or infection. Examples include:</p> <p>a. Resident #4 was admitted to the facility on 2/18/17, following surgical repair of a femur fracture, with diagnoses that included COPD, pneumonia and insulin dependent diabetes.</p> <p>On 3/21/17 at 11:10 am, RCM #2 removed Resident #4's socks to look at her feet, both of which were scaly with large callus formations on each heel and the balls of her feet. Resident #4's</p>	F 328			

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F 328	<p>Continued From page 24</p> <p>toenails were long, thick, and yellow, and the large toenail on each foot was elevated with discolored matter underneath. The knuckle on the outer aspect of the right big toe was red and the small toe appeared to have a scab.</p> <p>Resident #4's admission orders, dated 2/18/17, included weekly skin care orders, but there were no orders written for diabetic foot and nail care.</p> <p>Resident #4's care plans did not include diabetic foot and nail care.</p> <p>Resident #4's February and March 2017 TARs included weekly diabetic foot and nail care on day shift every Tuesday and did not include documentation of diabetic foot and nail care on 2/21/17, 3/7/17, 3/14/17 and 3/21/17.</p> <p>On 3/21/17 at 2:30 pm, RCM #2 stated Resident #4's toenails were thick, long, and in need of care. She stated skin checks and diabetic nail care were scheduled weekly and as needed, and the order was placed on each TAR for day shift staff to perform. RCM #2 stated, "Somehow her [Resident #4's] toenails and feet were missed, or not charted on 2/21/17, 3/7/17, 3/14/17 and 3/21/17." RCM #2 stated she would request a Podiatry appointment for Resident #4.</p> <p>b. Resident #7 was admitted to the facility on 12/20/16, with multiple diagnoses which included insulin dependent diabetes, contusion to the left lower leg, chronic anemia, major depression and obesity.</p> <p>Physician orders, dated 12/20/16, and signed monthly included "LN to do diabetic nail care</p>	F 328			

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F 328	Continued From page 25 every week," and "may see podiatrist as needed." Resident #7's wound care and dressing change was observed on 3/21/17 at 4:00 pm. After completion of the wound care, LN #5 removed Resident #7's socks to look at her feet. Both feet were scaly, with large callus formation on each heel, and ball of her feet. Resident #7's toenails were long, thick and the large toenail on each foot was lifted with discolored matter underneath. LN #5 stated Resident # 7 was bathed twice weekly by the CNA staff and they would alert her if they noted any skin or foot problems. LN #5 stated she documented nail-care weekly on the TAR. She was unable to explain how Resident #7's feet appeared in that condition with routine nail care. She stated Resident #7 needed a podiatry consult to trim her nails.	F 328			
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences	F 329		5/5/17	

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F 329	<p>Continued From page 26 which indicate the dose should be reduced or discontinued; or</p> <p>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--</p> <p>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interview, and record review, it was determined the facility failed to ensure residents administered antipsychotic medications had clear indications for use of the medications and non-pharmacological interventions were initiated and found to be unsuccessful, prior to the use of psychotropic medications. This was true for 1 of 2 residents (Resident #9) reviewed for chemical restraints. This deficient practice created the potential for more than minimal harm if Resident #9 received an antipsychotic medication that may result in significant negative outcomes, without evidence the benefits of the medication</p>	F 329	<p>How the nursing home will correct the deficiency as it relates to the resident: Resident #9 has had pharmacy/MD review and is receiving antipsychotic with appropriate diagnoses and with non-pharmacological measures in place. Gradual reduction for antipsychotic was done.</p> <p>How the nursing home will act to protect residents in similar situations: Residents with ordered anti-psychotics have a potential to be affected by this deficiency. Residents with ordered anti-psychotics</p>		

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F 329	<p>Continued From page 27</p> <p>outweighed the risks associated with the use of the medication. Findings include:</p> <p>Resident #9 was admitted to the facility 11/14/15 with diagnoses that included Alzheimer's Disease without behaviors or psychosis.</p> <p>Nurses' notes for Resident #9 documented the following: * 7/17/16 - "In a very agitated and confused state. Repeatedly stating she needed to go home to take care of her animals & kids. Also stated she needed to leave so she wouldn't be late for work." * 7/19/16 - "Resident continues to become agitated and exit seeking during most of the shift. Resident was really hard to redirect."</p> <p>Physician orders for Resident #9, dated 7/25/16, documented Zyprexa, 2.5 mg, was to be given daily at noon for "delusional thoughts."</p> <p>An 8/6/16 Nurse's Note documented, "Continues [with] exit seeking behaviors remains confused wanting to go home now! Continues [with] angry outbursts."</p> <p>On 8/16/16, Resident #9's physician changed the daily Zyprexa dosage from 2.5 mg at noon to 5 mg.</p> <p>Nurses' Notes for Resident #9 documented the following: * 8/20/2016 - "Alert [with] confusion...stayed busy throughout shift. Did not notice anxiety or exit seeking pleasant [sic] mood." * 8/24/16 - "Resident drowsy this am...sleeping in</p>	F 329	<p>have a current gradual dose reduction, evaluation, non-pharmacological interventions attempted prior to administration, and appropriate diagnoses related to ordered antipsychotic regimens.</p> <p>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur: Clinical management team and the licensed nurses have been inserviced on antipsychotic medications including diagnoses, non-pharmacological and care planning.</p> <p>Residents with initiation of/ or change in physician order of anti-psychotic medication will be followed up through the daily IDT (interdisciplinary team) review to ensure appropriate diagnoses and non-pharmacological interventions are attempted prior to use of antipsychotic medication as indicated.</p> <p>How the nursing home plans to monitor its performance to make sure that solutions are sustained: Residents receiving antipsychotics will be reviewed weekly X 12 to include GDR's, diagnoses, and non-pharmacological interventions prior to use to comply with unnecessary drug regimens related to the use of anti-psychotics X 3. Findings will be corrected and presented to QAPI for further corrective opportunities.</p> <p>Dates when corrective action will be completed and title of person responsible</p>		

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F 329	<p>Continued From page 28 w/c [wheelchair] assisted to bed [after] brkfst [breakfast]. Slept remainder of shift. Refused lunch, Held noon Zyprexa d/t [due to] drowsiness & called MD for orders."</p> <p>On 8/26/16, the physician changed Resident #9's daily Zyprexa 5 mg dosage from noon to bedtime.</p> <p>A pharmacist Consultation Report for Resident #9, dated 9/15/16, documented, "If appropriate, please consider a gradual dose reduction" of Zyprexa. The physician responded, "Risk of taper [greater than] risk of on-going use."</p> <p>A pharmacist Consultation Report, dated 2/13/17, asked Resident #9's physician to document a gradual dose reduction was not desired or warranted at that time due to "ongoing behaviors." The physician responded, "Risk of taper [greater than] risk of on-going use based on prior exposure."</p> <p>Resident #9's care plan, dated 2/16/17, documented she experienced a delusional disorder of looking for her husband and trying to get to work or home. Triggers for these behaviors were listed as "crowded areas and evening hours." The care plan did not address non-pharmacological interventions.</p> <p>Resident #9 was observed on 3/20/17 at 2:15 pm, in her bed with her eyes closed. At 3:25 pm, the same day, she was observed in her wheelchair by the lobby fireplace.</p> <p>On 3/21/17 at 8:00 am, Resident #9 was observed in the dining room drinking coffee. She</p>	F 329	to ensure correction: 05/05/2017 Director of Nursing		

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F 329	<p>Continued From page 29</p> <p>stated, "I think I'm waiting on breakfast." At noon on 3/21/17, Resident #9 was observed in the dining room eating lunch. She appeared friendly and calm and stated lunch tasted "good."</p> <p>On 3/22/17 at 8:30 am, Resident #9 was observed propelling herself in a wheelchair in the dining area and on 3/24/17 at 9:25 am, she was observed in a wheelchair in the hall by her room. Resident #9 was friendly and appeared calm. No anxiety or exit seeking behaviors were noted during the above observations.</p> <p>A Physician Progress Note, dated 3/22/17, documented Resident #9 was able to self-propel in a wheelchair throughout the facility; was not calling out "nearly as often;" was sleeping at night; allowed caregivers to help; and was easily redirectable when restless. The Progress Note documented staff reported Resident #9 did not tend to wander outside when weather was cold or wet; experienced significant short-term memory loss; and can become anxious any time of day if "overwhelmed with her surroundings." The Progress Note stated Resident #9's behaviors had improved and documented, "I would not recommend a GDR [gradual dose reduction] in the future as it causes her significantly increased anxiety and unnecessary restlessness/ paranoia/fear." The Progress Note documented Resident #9's delusional thoughts were "under much better control since increasing Zyprexa."</p> <p>On 3/24/17 at 9:35 am, LN #1 said Resident #9 was ordered Zyprexa for anxiety and wandering in the afternoons.</p>	F 329			

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F 329	Continued From page 30 On 3/24/17 at 9:40 am, RCM #1 stated Resident #9 had a diagnosis of delusional thoughts, anxiety, and tried to leave the building. On 3/24/17 at 9:50 am, the Resident Service Coordinator said Resident #9's delusional thoughts consisted of believing she [resident] worked at the facility, her husband was alive, and her son would come get her; none of which was true. The Resident Service Coordinator stated Resident #9 wanted to go home and that the Zyprexa was increased in August because of an increase in Resident #9 attempting to exit the building. The facility did not provide a policy to address the use of non-pharmacological interventions prior to antipsychotic use. The Black Box Warning for Zyprexa documented, "Not approved for dementia-related psychosis; elderly patients with dementia-related psychosis who are treated with antipsychotic drugs are at increased risk of death."	F 329			
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, policy and record review, and staff interview, it was determined the facility failed to ensure medications were administered at the correct times, resulting in a medication	F 332	How the nursing home will correct the deficiency as it relates to the resident: Residents # 13 and #16 are receiving	5/5/17	

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F 332	<p>Continued From page 31</p> <p>administration error rate that exceeded 5-percent. This was true for 2 of 27 medications (7.4%) administered during medication pass observations and effected 2 of 3 residents (#13 and #16) observed during medication pass. Administering medications to residents at the incorrect times had the potential to reduce the effectiveness of the medications administered to them. Findings include:</p> <p>1. Resident #13 was admitted to the facility on 8/18/16, with diagnoses including ESRD [End Stage Renal Disease], insulin dependent diabetes, and high blood pressure.</p> <p>On 3/21/17 at 8:20 am, Resident #13 had finished breakfast in her room when a total of 10 oral medications were administered during medication pass, including Renvela 800 mg, 2 tablets.</p> <p>Resident #13's physician orders, dated 10/20/16, directed staff to administer Renvela 800 mg, 2 tablets, orally three times daily with meals.</p> <p>A 3/6/17 physician's order documented, "Please make sure patient is taking Renvela with meals, while eating."</p> <p>Resident #13's MAR for January, February, and March 2017 did not identify the specific time Renvela was to be administered.</p> <p>The Nursing 2017 Drug Handbook documented Renvela is a medication to help control phosphorus levels for those with chronic kidney disease receiving dialysis. The Handbook states the medication is to be administered with meals;</p>	F 332	<p>medications as per physician order and per administration guidelines.</p> <p>How the nursing home will act to protect residents in similar situations: Residents residing at the facility have the potential to be affected by this deficiency. Pharmacy consultant has reviewed residents utilizing renvela and omeprazole related to timing requirements and directions on the Medication Administration Record.</p> <p>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur: Licensed nurses have been inserviced on the use of renvela and omprezone per MD order and guidelines from the Nursing 2017 Drug Handbook.</p> <p>How the nursing home plans to monitor its performance to make sure that solutions are sustained: Through observation and medication administration record review residents utilizing renvela and omeprazole will be monitored by the Assistant Director of Nursing daily Monday through Friday X 30 days and then 2 X a week for 8 weeks. Findings will be corrected as identified and then reviewed through QAPI monthly X 3 for further educational opportunities.</p> <p>Dates when corrective action will be completed and title of person responsible to ensure correction: 05/05/2017 Director of Nursing</p>		

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F 332	<p>Continued From page 32</p> <p>and other medications are to be given 1 hour before, or 3 hours after, Renvela.</p> <p>On 2/23/17 at 2:30 pm, LN #4 stated she was not aware Renvela was to be administered with meals or that the medication could not be administered with other medications. LN #4 immediately wrote "administer while eating, and not with other medications" to the Renvela entry on Resident #13's current MAR.</p> <p>2. The Nursing 2017 Drug Handbook documents Omeprazole [medication used to reduce stomach acid] is to be administered at least 1 hour before meals.</p> <p>Resident #16 was observed during medication pass on 3/21/17 at 8:10 am. He had just finished his breakfast in his room. A total of 11 oral medications were administered to Resident #16 during the observation.</p> <p>Resident #16's March 2017 recapitulated physician orders directed staff to administer Omeprazole, 20 mg, 1 capsule orally once a day. Neither the order or the March 2017 MAR included a specific administration time.</p> <p>The facility's undated medication administration policy documented morning medications were to be administered between 6 am and 10 am, and that the 6:00 am administration time was for medications that were to be administered on an empty stomach.</p> <p>On 3/24/17 at 10:00 am, RCM #2 stated Omeprazole was a medication that should be administered on an empty stomach, and she was</p>	F 332			

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F 332	Continued From page 33 working with the pharmacist towards changing the times of Omeprazole administration throughout the entire facility.	F 332			
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, policy and record review, and staff interview, it was determined the facility failed to prevent significant medication errors. This was true for 1 of 1 sampled residents who received dialysis treatments (#13) and had the potential to result in less than therapeutic drug effectiveness for Resident #13 and for her to experience shortness of breath, abdominal cramps, muscle cramps, nausea or vomiting, due to hypotension during dialysis treatments. Findings include: 1. On 3/21/17 at 8:20 am, Resident #13 had finished breakfast in her room when a total of 10 oral medications were administered during medication pass, including Renvela 800 mg, 2 tablets. a. Resident #13's physician orders, dated 10/20/16, directed staff to administer Renvela 800 mg, 2 tablets, orally three times daily with meals. A 3/6/17 physician's order documented, "Please	F 333	How the nursing home will correct the deficiency as it relates to the resident: Resident #13 is receiving renvela per MD order and consistent with guidelines from the Nursing 2017 Drug Handbook How the nursing home will act to protect residents in similar situations: Residents utilizing renvela/midodrine have the potential to be affected by this deficiency. Residents utilizing renvela/ midodrine are receiving medication as per MD order and in compliance with the Nursing 2017 Drug Handbook. Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur: Licensed Nurses have been educated on the administration of renvela/midodrine. Medication records have been updated to reflect guidelines from the	5/5/17	

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F 333	<p>Continued From page 34</p> <p>make sure patient is taking Renvela with meals, while eating."</p> <p>Resident #13's MAR for January, February, and March 2017 did not identify the specific time Renvela was to be administered.</p> <p>The Nursing 2017 Drug Handbook documented Renvela is a medication to help control phosphorus levels for those with chronic kidney disease receiving dialysis. The Handbook states the medication is to be administered with meals; and other medications are to be given 1 hour before, or 3 hours after, Renvela.</p> <p>On 2/23/17 at 2:30 pm, LN #4 stated she was not aware Renvela was to be administered with meals or that the medication could not be administered with other medications. LN #4 immediately wrote "administer while eating, and not with other medications" to the Renvela entry on Resident #13's current MAR.</p> <p>b. Resident #13 left the facility every Monday, Wednesday, and Friday to receive dialysis. Her March 2017 MAR documented she was to be dropped off at the dialysis center at 10:00 am, and received dialysis from 10:15 am to 1:15 pm.</p> <p>Her record included a physician order dated 3/6/17, for Midodrine 10 mg, 1 orally, 30 minutes before dialysis. The website www.mayoclinic.com states a drop in blood pressure is a common side effect of hemodialysis, particularly for people who are diabetic. Low blood pressure may be accompanied by shortness of breath, abdominal cramps, muscle cramps, nausea or vomiting. According to PubMed, a search engine for the</p>	F 333	<p>Nursing 2017 Drug Handbook as ordered by MD.</p> <p>How the nursing home plans to monitor its performance to make sure that solutions are sustained: Through direct observation and medical record review residents receiving renvela/midodrine will be monitored daily by the Assistant Director of Nursing Monday through Friday X 30 days and then 2 X a week for 8 weeks for compliance. Findings will be corrected upon identification and then reviewed at QAPI for 3 months for further educational/corrective actions.</p> <p>Dates when corrective action will be completed and title of person responsible to ensure correction: 05/05/2017 Director of Nursing</p>		

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F 333	Continued From page 35 National Institutes of Health, Midodrine is an oral medication used for the treatment of hypotension associated with dialysis. The PubMed information directs that the medication be administered 30 minutes before each dialysis session, as it is rapidly metabolized. Its onset of action was listed at 1 hour, and duration of action was listed as 2 to 3 hours. Resident #13's March 2017 MAR included the order for Midodrine, with the physician ordered instructions for time of administration. However, the scheduled time of administration on the MAR was "AM" [morning]. There was no documentation on the MAR as to the time Resident #13 actually received the medication. On 3/23/17 at 2:30 pm, LN #4 stated she administered medications approximately the same time each day. She said the Midodrine was administered to Resident #13 on the days she received dialysis, and that she gave the Midodrine together with her other medications during the morning medication pass. She stated she was not aware of the significance of the medication timing. LN #4 stated the MAR should include a space for the time of administration to ensure it was given within 30 minutes before the scheduled dialysis.	F 333			
F 441 SS=E	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:	F 441		5/5/17	

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F 441	<p>Continued From page 36</p> <p>(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);</p> <p>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based 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</p>	F 441			

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F 441	<p>Continued From page 37</p> <p>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, staff interview, and review of policies and procedures and residents' records, it was determined the facility failed to ensure appropriate infection prevention and control procedures were implemented for 9 of 20 residents (#3, #6, #7, #9, #10, #17, #18, #19, #20) reviewed for infection control. The deficient practices placed all residents in the facility at risk of C-diff when:</p> <p>* Resident #6 and Resident #19 were not placed on contact precautions when Clostridium Difficile [C-diff] was suspected. * Resident #9 and Resident #18 were not relocated when their roommates were diagnosed with C-diff and Resident #9 was observed exiting her room unassisted.</p>	F 441	<p>How the nursing home will correct the deficiency as it relates to the resident: Resident # 6 is no longer at the facility Resident #19 has precautions in place as per MD order as indicated.</p> <p>Residents #9 and #18 have room placement as per infection control policy and procedure for C-dif.</p> <p>Infection Control measures are in practice for residents #3, #10, #17, and #20. How the nursing home will act to protect residents in similar situations: Residents and staff have the potential to be affected by this deficiency. There are no other residents identified</p>		

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F 441	<p>Continued From page 38</p> <p>* Staff did not thoroughly sanitize equipment used with Resident #17 who was in contact isolation related to C-diff.</p> <p>Additionally, the following practices placed Residents #7, #10, and #20 at risk of infection when:</p> <p>* Staff potentially contaminated Resident #7's wound by using paper towels previously used as a barrier.</p> <p>* Resident #10 did not receive the second step of a 2-step tuberculosis test.</p> <p>* Staff did not perform complete handwashing prior to, or after, providing cares for Resident #3.</p> <p>* Resident 20's urinary catheter bag was observed on the floor.</p> <p>Findings include:</p> <p>The facility January 2017 Infection Prevention and Control Manual documented, "The center will utilize contact precaution...for specified residents known or suspected to be infected with...microorganisms that can be transmitted by direct contact with the resident...or indirect contact (touching) with environmental surfaces or resident care items in the resident environment...place the resident in a private room if possible...dedicate the use of noncritical resident care equipment to a single resident...if use of common equipment or items is unavoidable, then clean and disinfect them before use with another resident...residents diagnosed with clostridium difficile shall be placed on contact precautions...use contact precautions until 48 hours after diarrhea has ceased...and until antibiotic therapy is</p>	F 441	<p>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur: Staff has been inserviced on infection control related to C-difficile. This includes but not limited to isolation procedure and hand/equipment sanitization.</p> <p>Residents with identified C-difficile will have isolation- identification, measures and sanitization instruction available to staff member to review prior to entering room as needed.</p> <p>Residents residing at the facility have a 2-step tuberculosis test in place</p> <p>Staff has been educated on correct handwashing with return demonstrations completed.</p> <p>LN's have been inserviced on hand hygiene with return demonstration related to wound care.</p> <p>Staff has been inserviced on urinary catheter bag placement with return demonstration.</p> <p>How the nursing home plans to monitor its performance to make sure that solutions are sustained: Through direct observation and medical record review isolation for C-difficile will be monitored daily by the Director of Nursing X 30 and then 2 X a week for 8 weeks to ensure compliance with</p>		

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F 441	<p>Continued From page 39 completed."</p> <p>The website for the Centers for Disease Control, www.cdc.gov, states C-diff is a contagious bacteria with symptoms including watery diarrhea, which may become life-threatening, fever, abdominal pain/tenderness, and nausea. The bacteria are found in the feces. People can become infected if they touch items or surfaces that are contaminated with feces and then touch their mouth or mucous membranes.</p> <p>1. During the initial tour on 3/20/17 at 11:13 am, Resident #6 and Resident #18, who were roommates, were observed to be on contact precautions, with personal protective equipment for staff on a cart located outside the residents' room.</p> <p>A Nurse's Note, dated 3/17/17, documented Resident #6 was febrile [feverish, hot, flushed] and experiencing diarrhea and abdominal pain. A physician order was obtained for a C-Diff culture, which on 3/18/17, was determined to be positive for C-Diff.</p> <p>On 3/20/17 at 11:40 am, RCM #1 stated Resident #6 had C-Diff, and she would discuss a room change later in the morning with the Director of Nursing [DON].</p> <p>On 3/22/17 at 8:22 am, the DON said facility policy required a resident diagnosed with C-Diff to be housed in a private room if possible, the facility currently had empty rooms, and contact procedures should be initiated. The DON stated Resident #6 should have been relocated to a private room when C-Diff was suspected.</p>	F 441	<p>C-difficile precautions.</p> <p>Per medical record review, 2-step tuberculosis screening will be monitored weekly by the Director of Nursing X 12 to ensure completion.</p> <p>Through direct observation Licensed Nurses will be monitored by the Field Director of Education and Training on hand hygiene related to dressing changes 2 X a week to ensure correct hand hygiene related to dressing changes.</p> <p>Through direct observation, residents utilizing foley catheters bags will be monitored daily by the Assitant Director of Nursing Monday through Friday and by the Manager on Duty on the weekends X 30 and then weekly X 8 to ensure correct placement of the foley catheter bag to maintain compliance with infection control policies.</p> <p>Through return demonstration by the Field Director of Education and Training staff will be observed for appropriate hand washing during cares 2 X a week X 12 weeks</p> <p>Above negative findings will be corrected upon identification and reported to the Director of Nursing. Policy and procedure for Infection control related to hand washing, c-difficile, foley catheter placement and 2-step tuberculosis testing will be reviewed through QAPI monthly X 3 for further educational opportunities.</p>		

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F 441	<p>Continued From page 40</p> <p>Resident #6 was not isolated from his roommate [Resident #18] when C-Diff was suspected on 3/17/17 and confirmed on 3/18/17.</p> <p>2. Resident #17's physician admission orders, dated 3/13/17, documented he/she was diagnosed with C-Diff as determined through lab tests on 3/10/17.</p> <p>On 3/20/17 at 11:21 am, Resident #17 was observed in a private room with contact precautions in place. A Physician Telephone Order, dated 3/20/17, documented Resident #17 had diarrhea and directed staff to obtain stool for C-Diff cultures.</p> <p>On 3/22/17 at 3:40 pm, CNA #1 was observed entering Resident #17's room with an electronic blood pressure [BP] machine on wheels. While assessing Resident #17's BP, the cord touched the resident's wheelchair and the cuff touched the resident and the wheelchair. CNA #1 had a clipboard and pen that she used to document the results of the BP. CNA #1 touched the resident and then the clipboard and pen with her gloved hands. CNA #1 exited the resident's room after removing the gown and gloves and wiping one side of the BP cuff with sanitizer, but not attempting to sanitize the clipboard or pen. She stated she did not clean the cord and tried to just touch the edges of the clipboard.</p> <p>On 3/22/17 at 4:05 pm, the DON said the facility had disposable BP cuffs, which should be used for residents with contact isolation precautions in place.</p>	F 441	<p>Dates when corrective action will be completed and title of person responsible to ensure correction: 05/05/2017 Administrator</p>		

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F 441	<p>Continued From page 41</p> <p>3. On 3/22/17 at 4:35 pm, the DON provided a list of current residents with a diagnosis of C-Diff. This list included the room Resident #9 was occupying with Resident #19. Resident #19 was listed with C-Diff. There was no documentation the resident's room was identified as an isolation room.</p> <p>On 3/23/17 at 11:00 am, the DON said she was not aware Resident #19 had a roommate.</p> <p>Laboratory results, dated 3/22/17, documented Resident #19 was positive for C-diff.</p> <p>On 3/20/17 at 2:15 pm, Resident #9 was observed in her room in a low bed by the window.</p> <p>On 3/21/17 at 10:17 am, Resident #9 was observed exiting her room unassisted in a wheelchair.</p> <p>Resident #9 was put at risk for C-Diff when she was not separated from her roommate who had tested positive for the highly contagious infection, and she put other residents at risk by coming into contact with other residents in the facility.</p> <p>4. On 3/21/17 at 4:00 pm, LN #5 was observed placing Resident #7's left calf on 2 brown paper towels from a towel dispenser in the room. After removing the old dressing, LN #5 squirted normal saline from single use vials into the wound. LN #5 then used the paper towels under Resident #17's calf to dry off the normal saline and cut a 4-inch by 2-inch piece of Kerlix which she then packed in wound with her gloved finger. An absorbent dressing was then applied and</p>	F 441			

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F 441	<p>Continued From page 42 secured with Coban elastic wrap.</p> <p>A 12/29/16 physician's order directed staff to cleanse Resident #7's wound with normal saline, pack the wound with Kerlix, loosely wrap it with an absorbent padded dressing, and apply an Ace wrap/Coban daily. The order did not specify whether the dressing change was a "clean" or "sterile" procedure.</p> <p>LN #5 stated she performed Resident #7's daily wound dressing changes, and the wound care team was scheduled weekly to evaluate the wound and take measurements. She stated she used paper towels under Resident #7's leg as the wound dressing change was a "clean" rather than "sterile" procedure.</p> <p>On 3/24/17 at 9:30 am, the corporate consultant provided a copy of the facility's wound care procedure. She stated the facility followed Lippincott Procedures, (a nationally recognized resource for nursing procedures). The procedure documented wound dressing were a "sterile" procedure that required sterile supplies to prevent contamination; wound irrigation was to be performed with sterile gauze pads saturated with the cleaning agent (normal saline); and wound packing was to involve a sterile 2 x 2 or 4 x 4 gauze pad folded and placed into the wound with sterile forceps as cotton fibers can adhere to the wound surface and cause complications.</p> <p>Wound care provided to Resident #7 was not consistent with the facility's procedures.</p> <p>5. Resident #10 was admitted to the facility on 2/23/17 with admission orders for a 2-step TB</p>	F 441			

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

PRINTED: 05/03/2017
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 43</p> <p>[tuberculosis] test. The February MAR documented Resident #10's initial TB test was administered on 2/18/17, and read on 2/21/17. Resident #10's March 2017 MAR included an order for the second TB test to be given on 3/5/17 and read on 3/8/17. The MAR included space for documentation of the lot # of the test solution, the expiration date of the solution, and the site of administration. These sections were blank.</p> <p>On 3/23/17 at 3:05 pm, RCM #2 reviewed the Resident #10's complete record and stated she was unable to find evidence the second stage of testing for TB was performed. She stated the record did not include documentation of why the test was not done.</p> <p>6. Resident #20 was admitted to the facility on 1/19/17 with multiple diagnoses including obstructive and reflux uropathy [blocked urine flow and urine flowing back towards the kidneys].</p> <p>On 3/20/17 at 10:40 am, Resident #20 was observed in bed awake with his uncovered catheter bag on the floor. Resident #20 at this time said he was not aware his catheter bag was on the floor.</p> <p>On 3/20/17 at 11:05 am, when shown Resident #20's catheter bag, LN #4 said the catheter bag should not be on the floor and then hung the bag on the bed.</p> <p>On 3/23/17 at 2:20 pm, the DON said the catheter bag should not be left on the floor.</p> <p>7. Resident #3 was admitted to the facility on</p>	F 441			

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F 441	Continued From page 44 10/8/15, with multiple diagnoses including Alzheimer's disease. The facility's Hand Hygiene policy directed staff to wash hands: "After contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident. After removing gloves. Rub hands together vigorously for...20 seconds generating friction on all surfaces of the hands and fingers." On 3/21/17 at 9:58 am, CNAs #2 and #3 were observed assisting Resident #3 transfer from his wheelchair to bed using a mechanical lift. Both CNAs used gloves and handled the mechanical lift and the resident's pillows. CNA #3 removed her gloves and washed her hands with soap and water for 10 seconds, retrieved a box of Kleenex, donned a glove to her right hand and wiped Resident #3's nose with a Kleenex with her gloved hand. CNA #3 then threw away the Kleenex and the glove and washed her hands for eight seconds and left the room. On 3/21/17 at 10:05 am, CNA #3 said she was not sure how long she washed her hands either time, but had not sung the "Twinkle, Twinkle" song when washing her hands and should have washed for about 20 seconds. On 3/23/17 at 2:25 pm, the DON said staff were taught to sing "Twinkle, Twinkle Little Star" slowly in their heads while washing their hands to make sure they washed at least 20 seconds. The DON said CNA #3 should have washed her hands longer than what she had.	F 441			
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514		5/5/17	

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F 514	Continued From page 45 LE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure	F 514	How the nursing home will correct the deficiency as it relates to the resident:		

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F 514	<p>Continued From page 46</p> <p>residents' MARs were complete and accurate. This was true for 1 of 15 sampled residents (#10) whose records were reviewed. This failed practice had the potential to increase the risk for medication errors. Findings include:</p> <p>Resident #10 was admitted to the facility on 2/23/17, after hospitalization for chronic respiratory failure, with diagnoses that included COPD, major depressive disorder, generalized anxiety disorder, and fibromyalgia.</p> <p>Resident #10's admission orders, dated 2/23/17, included Flexeril 10 mg, 1 tablet daily, as needed for muscle spasms.</p> <p>A physician's order, dated 3/14/17, increased the Flexeril to 10 mg, 1 tablet twice daily, for muscle spasms, with a minimum of 8 hours between doses.</p> <p>The March 2017 MAR included Resident #10's admission order for Flexeril 10 mg, once a day as needed for muscle spasms, however, the MAR was modified with pen/pencil slash through "once a day," and BID [twice daily] was written in. The date of the original order of 2/23/17 was crossed out and the new order date of 3/14/17 was written in. The "new" order did not include the physician's instructions of a minimum of 8 hours between doses.</p> <p>On 3/23/17 at 3:30 pm, the RCM #2 stated the original order should have been discontinued and the new order for Flexeril and the physician's instructions documented on the MAR.</p>	F 514	<p>Required documentation is in Resident #10's medical record.</p> <p>How the nursing home will act to protect residents in similar situations: There are no other residents identified</p> <p>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur: Medical Records and Unit managers have been inserviced by the Field Educator on policy and procedure related to MD orders. MD orders will be reviewed during the daily nurses meeting to ensure orders have been correctly noted in the medical record.</p> <p>How the nursing home plans to monitor its performance to make sure that solutions are sustained: MD to Medication Administration profile will be monitored by Director of Nursing 2 X a week to ensure accuracy of MD orders for 12 weeks. Findings will be corrected upon identification and then reviewed through QAPI monthly X 3 for further corrective opportunities.</p> <p>Dates when corrective action will be completed and title of person responsible to ensure correction: 05/05/2017 Director of Nursing</p>		

Bureau of Facility Standards

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State licensure survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Brad Perry, LSW, Team Coordinator Susan Costa, RN Brenda Cross, RN, BSN</p>	C 000		
C 882	<p>02.203,02,a Resident Identification Requirements</p> <p>a. Patient's/resident's name and date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service (if applicable); name, address and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and disposition, signed by the attending physician, shall be part of the medical record.</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to obtain a physician-signed cause of death for residents who expired in the facility. This was true for 1 of 1 resident (#15) reviewed for admission, transfer, and discharge from the facility. Findings include:</p>	C 882	<p>How the nursing home will correct the deficiency as it relates to the resident: Records for resident #15 are available in the medical record.</p> <p>How the nursing home will act to protect</p>	5/5/17

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 04/21/17
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Bureau of Facility Standards

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C 882	<p>Continued From page 1</p> <p>Resident #15 expired on 2/19/17 at 8:20 am. The area on the resident's facesheet reserved for the physician to sign and document the cause of death were blank.</p> <p>On 3/24/17 at 9:45 am, Medical Records provided a signed cause of death form, dated 3/23/17, with the physician's signature and the cause of death. The Medical Records staff member said the facility had not received the completed form until after the surveyor requested it the previous day.</p>	C 882	<p>residents in similar situations: All facility deaths have been reviewed by the last 30 days and have the cause of death with MD signature on the back of the face sheet. There are no other residents identified</p> <p>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur: Medical Records staff was educated by the administrator on physician-signed cause of death for residents who expire in the facility to be obtained and placed in the medical record.</p> <p>How the nursing home plans to monitor its performance to make sure that solutions are sustained: Resident records will be monitored by the Administrator weekly X 12 to ensure required documentation related to cause of death and MD signature are present as indicated. Findings will be reviewed monthly X 3 through QAPI for further corrective actions.</p> <p>Dates when corrective action will be completed and title of person responsible to ensure correction: 05/05/2017 Administrator</p>	