



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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April 26, 2017

Jeremy Tolman, Administrator
Life Care Center Of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Mr. Tolman:

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

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 8, 2017**. Failure to submit an acceptable PoC by **May 8, 2017**, may result in the imposition of penalties by **May 16, 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 22, **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 24, 2017**. A change in the seriousness of the deficiencies on **May 22, 2017**, may result in a change

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in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 24, 2017** includes the following:

Denial of payment for new admissions effective **June 24, 2017**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 24, 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 24, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

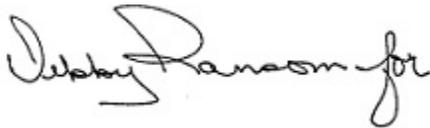
- BFS Letters (06/30/11)

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

This request must be received by **May 8, 2017**. If your request for informal dispute resolution is received after **May 8, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nina Sanderson, LSW, Supervisor
Long Term Care

ns/dr
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/24/2017
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF POST FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from March 20, 2017 to March 24, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Teresa Kobza, RDN, LD, Team Leader Edith Cecil, RN Beverly Briggs, RN Sandy Goins, RN</p> <p>Survey Definitions:</p> <p>ADON - Assistant Director of Nursing ARD - Assessment Reference Date BLE - Bilateral Lower Extremities [legs] BUE - Bilateral Upper Extremities [arms] CNA - Certified Nursing Assistant COPD - Chronic Obstructive Pulmonary Disease [Emphysema] CVA - Cerebral Vasuclar Accident [Stroke] DON - Director of Nursing DM - Diabetes Mellitus HTN - Hypertension HS - bedtime LPN - Licensed Practical Nurse MAR - Medication Administration Record MDS - Minimum Data Set Mg - milligram ml - milliliter RD - Registered Dietician RN - Registered Nurse PO - by mouth PRN - as needed PROM - Passive Range of Motion ROM - Range of Motion SLP - Speech Language Pathologist</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/05/2017
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 TBI - Traumatic Brain Injury Tbsp - Tablespoon tsp - Teaspoon oz - Ounce	F 000			
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff demonstrated respect for residents' dignity by providing regular utensils and plates in the dining room. This was true for 1 of 17 sample residents (#11) observed dining. This had the potential to diminish Resident #11's self-esteem and self-worth. Findings include: Resident #11 was admitted to the facility on 3/15/17, with diagnoses which included cerebral infarction [An area of dead tissues in the brain from narrowing or blocked arteries.], Diabetes Mellitus, diabetic retinopathy [damaged blood vessels to the eyes], and dementia. On 3/22/16 at 8:00 am, Resident #11 was observed sitting in the dining room waiting for his meal to arrive. At 8:22 am, his meal arrived on a Styrofoam plate and the staff took away the regular silverware and replaced it with plastic utensils.	F 241	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 of or agreement with the deficiencies or conclusions contained in the Department's inspection report." 1. Resident #11 was discharged from the facility 2. Review for any residents receiving plastic, Styrofoam or paper flatware/plates. Ensure that it is still required for clinical reasons and document their satisfaction with process. 3. An education was conducted by ED/DNS to educate staff regarding proper use of paper/plastic wear. LNs were trained on assessing for continued need and communicating to dietary when	5/19/17	

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F 241	Continued From page 2 On 3/23/17 at 12:00 pm, the Director of Nursing stated no resident should be receiving plastic utensils and Styrofoam plates, and she would in-service her staff.	F 241	restrictions are discontinued. 4. Audit for residents with plastic/Styrofoam weekly x8 weeks and monthly x2. Findings will be reviewed at monthly QAPI meeting.		
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. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (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 (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.	F 278		5/19/17	

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F 278	<p>Continued From page 3</p> <p>(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure 1 of 17 (#6) sampled residents' needs and conditions were accurately assessed to provide ongoing care to maintain and/or improve their medical status. This deficient practice placed Resident #6 at risk for not receiving appropriate care for a pressure ulcer. Findings include:</p> <p>Resident #6 was re-admitted to the facility on 3/19/17, with diagnoses which included heart failure and diabetes.</p> <p>Resident #6's Admission MDS assessment, dated 3/19/17, documented Resident #6 had a Stage II pressure sore [partial thickness skin loss that is superficial and presents as an abrasion, blister or shallow crater] on his coccyx [tailbone].</p> <p>On 3/22/17 at 11:10 am, Resident #6's wound was observed to be a Stage IV pressure sore on his coccyx. The wound was identified at that time as being 2.8 centimeters wide, 1.2 centimeters in length and 0.5 centimeters in depth with undermining [undermining occurs when the tissue under the wound edges becomes eroded, resulting in a pocket beneath the skin at the wound's edge].</p> <p>On 3/22/17 at 3:00 pm, the MDS Nurse stated that there must have been a problem with the information that was given for the MDS</p>	F 278	<ol style="list-style-type: none"> 1. Resident #6 MDS was modified to reflect accurate coding of stage IV pressure wound 2. Residents with current pressure wounds were reviewed to ensure accurate coding. Modifications were completed if needed 3. MDS nurses were educated on accurate coding of section M per RAI guidelines related to pressure wounds . 4. DNS or designee will audit per MDS schedule & wound report the MDS of residents with pressure wounds to ensure accuracy. Audits to occur 3x week x 8 weeks then monthly x2 		

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F 278	Continued From page 4 assessment as all of the other documentation showed that the resident had a Stage IV pressure sore. The MDS Nurse stated that a correction would be made to the MDS assessment.	F 278			
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or	F 280		5/19/17	

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F 280	<p>Continued From page 5 resident representative.</p> <p>(ii) Include an assessment of the resident's strengths and needs.</p> <p>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.</p> <p>483.21 (b) Comprehensive Care Plans</p> <p>(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in</p>	F 280			

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F 280	<p>Continued From page 6</p> <p>disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure a resident's care plan was revised to reflect her current needs. This was true for 1 of 12 (#2) sampled residents whose care plans were reviewed. This had the potential to result in unnecessary dependence of staff for performance of tasks the resident had demonstrated increased independence in performing. It also placed Resident #2 at risk of psychosocial harm if the resident was not encouraged to perform tasks independently and enhance her self-esteem. Findings include:</p> <p>Resident #2 was admitted to the facility on 2/26/17, with diagnoses which included osteoarthritis and osteoporosis.</p> <p>Resident #2's Activities of Daily Living [ADL] - Self Care Deficit Care Plan, dated 2/26/17, documented she had a decline in her self-care ability related to weakness, pain, and a decline in mobility. Interventions included:</p> <p>* Resident #2 required extensive assistance with bathing 1-2 times per week. * Resident #2 required extensive assistance of one with transfers, toileting, and when using her walker or wheelchair.</p>	F 280	<ol style="list-style-type: none"> 1. Resident #2 discharged from the facility. 2. Audit transfer status of residents working with therapy to ensure that it is accurately reflected on the care plan 3. DNS will inservice therapy, nursing and MDS that when there is a change in the transfer status the care plan and 24 hour report must be updated to reflect current change 4. DNS or designee will review 24 hour report 5 days/week x 2 months for changes in transfer status and compare to care plan. Results of audits will be reviewed at QAPI meeting monthly 		

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F 280	<p>Continued From page 7</p> <p>* Resident #2 required extensive assistance with dressing and putting on shoes.</p> <p>* Staff was to monitor and report any changes in Resident #2's ADL's to a nurse.</p> <p>On 3/20/17 at 3:40 pm, Resident #2 was observed in her room transferring from her wheelchair to her bed. Resident #2 stated she performed all of her own ADL care with no staff assistance. She stated she was just cleared by therapy to transfer without supervision. Resident #2 stated she could take herself to the restroom when she needed to.</p> <p>On 3/21/17 at 8:42 am, Resident #2 was using her walker to walk the halls. She had a therapist standing behind her and they were not providing assistance.</p> <p>On 3/22/17 at 9:55 am, Resident #2 was using her walker to walk the halls. She had a therapist standing behind her and they were not providing assistance.</p> <p>On 3/23/17 at 10:45 am, CNA #6 stated when a resident declined or improved in their ADL function the improvement or decline would get put onto a 24 hour report. She stated the Nurse Care Manager would update that residents care plan and the care guide. CNA #6 stated Resident #2 was independent with transfers and her ADL cares. CNA #6 did not know what Resident #2's ADL Care Plan documented as her current level of function.</p> <p>On 3/23/17 at 11:00 am, the DON stated the facility's process was to have therapy staff write changes in residents' ADL function on a 24 hour</p>	F 280			

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F 280	Continued From page 8 report; and then the Nursing Care Manager updated the resident's care plan. She did not know why Resident #2's ADL Care Plan did not reflect her current level of function. She stated she would look into it.	F 280			
F 281 SS=D	<p>On 3/23/17 at 11:53 am, the DON stated the update from therapy staff came in on 3/23/17 and did not make it to the Nurse Care Manager when the change occurred. She stated she would be in-servicing her staff.</p> <p>483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>(b)(3) Comprehensive Care Plans</p> <p>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, policy review, and record review, it was determined the facility failed to ensure medications were observed being taken and swallowed for 1 (Resident #5) of 12 residents observed during medication pass. Failure to observe medications being swallowed placed residents at risk for not receiving medications per physician orders and failed to ensure therapeutic doses for those medications was attained. Findings include:</p> <p>1. On 3/21/17 at 2:30 pm, Resident #5 was observed in bed with a plastic cup with pills mixed with cookie crumbs on the bedside table</p>	F 281	<p>1. #5 – was assessed for self administration of medication</p> <p>2. Residents on each unit will be audited for meds at bedside to ensure policy is followed.</p> <p>3. SDC or designee educated LN's on policy on leaving medications at bedside.</p> <p>4. Random resident rooms/halls audit for meds at bedside will be conducted 3x weekly x 8 weeks then twice/month for 2 months. Results reported to QAPI monthly</p>	5/19/17	

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F 281	<p>Continued From page 9</p> <p>next to her. When questioned, Resident #5 stated she took her pills a little at a time and staff knew she would eventually take them. At 2:35 pm, the ADON [Assistant Director on Nursing] was shown the cup at Resident #5's bedside, agreed that there were medications in the cup, and this practice was not acceptable.</p> <p>Resident #5's MAR [Medication Administration Record] for 3/21/17, documented LPN #6 had administered her medications at 1:00 pm.</p> <p>On 3/21/17 at 2:40 pm, LPN #6 stated she had administered medications to Resident #5 without observing her swallow the medications. LPN #6 stated she had documented in Resident #5's MAR that the medication had been taken without visual confirmation of such. When questioned as to the training she had received concerning medication administration, LPN #6 stated that she was to observe them (medications) being taken and not document that they were swallowed until then.</p> <p>On 3/21/17 at 3:00 pm, Resident #5 stated staff put her medications at bedside for her "all of the time", as she is slow and they trust her to take them.</p> <p>A review of the facility policy for Administration of Medication (undated) under Procedure #10 and #11 documented: "Give resident the medication" and "remain with the resident to ensure that medication is swallowed." Procedure #13 documented, "initial each medication in the correct box on the MAR after the medication is given." The procedure stated staff were to document after the medication was "given" but</p>	F 281			

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F 281	Continued From page 10	F 281			
F 318 SS=D	<p>did not delineate to document "after" the medication was observed to be swallowed.</p> <p>483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>(c) Mobility.</p> <p>(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.</p> <p>(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, staff interview, record review, and policy review, it was determined the facility failed to ensure that services and treatment were provided to increase range of motion, or prevent further decline in range of motion, for 1 of 20 sampled residents (Resident #9) reviewed for restorative services. The deficient practice created the potential for Resident #9 to experience worsening contractures when splints were not applied and range of motion exercises not performed for 3 days. Findings include: Resident #9 was admitted to the facility on 6/12/13, with diagnoses which included chronic contractures and multiple sclerosis. Resident #9's March 2017 physician's recapitulation orders documented the resident</p>	F 318	<ol style="list-style-type: none"> 1. Resident #9's restorative program and care plan has been updated. 2. Resident's that are on a restorative splinting & ROM program reviewed for splint placement & ROM and documentation 3. Restorative staff educated on providing program, splinting, preventing decline in ROM and documenting per orders. Additional RNA added to ensure restorative completed per MD order. 4. Residents on restorative for ROM and splinting will be audited weekly 3x week x8 weeks then monthly x 2 months to ensure compliance. Findings presented to QAPI meeting monthly 	5/19/17	

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F 318	<p>Continued From page 11</p> <p>was to receive a restorative nursing program for passive range of motion to her extremities daily.</p> <p>Resident #9's quarterly MDS assessment, dated 3/5/17, documented the resident had impaired range of motion to upper and lower extremities on both the right and left sides, and did not communicate needs to staff.</p> <p>Resident #9's March 2017 physician's recapitulation orders documented, "Restorative nursing level II program 5-7 days a week for BUE [bilateral upper extremities] and BLE [bilateral lower extremities] PROM [passive range of motion] with flex and hold for contracture prevention. Daily...Use Carrot Orthotic, anti spasticity device to the left hand. Use to left thumb web space as educated to reduce spasticity of left ring finger. Daily. Provide mild passive ROM to fingers to left hand prior to applying."</p> <p>Resident #9's care plan, dated 11/19/13, documented the resident had actual contractures/impaired functional range of motion of the bilateral hands/fingers. The plan directed the restorative aide to apply bilateral hand splints after PROM to the bilateral upper extremities and to provide PROM to extremities.</p> <p>On 3/20/17 at 3:20 pm, 3/21/17 at 8:35 am, 11:00 am, 1:50 pm, 2:45 pm, and 3/22/17 at 7:55 am and 9:15 am, Resident #9 was observed resting in bed with no hand splints in place.</p> <p>Resident #9's "Restorative Administration Record" did not document the resident had received the hand splints or the PROM from</p>	F 318			

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F 318	<p>Continued From page 12 3/19/17 through the morning of 3/22/17.</p> <p>On 3/22/17 at 1:00 pm, CNA #1, who was designated as a restorative aide, stated currently Resident #9 was receiving restorative services. CNA #1 said she when she worked she placed a carrot-shaped orthotic devices in Resident #9's hands, which were scheduled to remain in place for 3 hours in each hand. CNA #1 said she had not provided the resident with the carrots or PROM for the past three days because she was not working. According to CNA #1, she was the only restorative aide working this week as the other restorative aide had taken another position.</p> <p>On 3/22/17 at 1:30 pm, CNA #2, who was caring for Resident #9 stated she did not provide the resident's PROM exercises nor did she place the splints on the resident's hands. CNA #2 said the restorative aide provided those services for the resident.</p> <p>On 3/24/17 at 9:35 am, the DON stated she and the Resident Care Managers monitored care during rounds each morning and as needed throughout the day. The DON said she was not aware that Resident #9 did not receive restorative services per the plan of care/orders on 3/19/17, 3/20/17 and 3/22/17. The DON said the Restorative Nurse scheduled the restorative aides and monitored to ensure that restorative services were provided. According to the DON, the Restorative Nurse was off on leave and would not be at the facility this week.</p> <p>The facility's Restorative Nursing policy, revision date 11/2016, documented the facility would, "Implement a restorative nursing system that</p>	F 318			

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F 318	Continued From page 13 meets the individual needs of each patient and assist each patient in reaching the highest practical level of physical, mental, and psychosocial functioning...The facility is responsible for providing maintenance and restorative programs that will not only maintain, but improve, as indicted by the patient's comprehensive assessment to achieve and maintain the highest practicable outcome."	F 318			
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--	F 329		5/19/17	

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F 329	<p>Continued From page 14</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 record review and staff interview, it was determined the facility failed to ensure residents were administered anti-anxiety medications only a) in response to identified target behaviors, b) when non-pharmacological interventions were initiated and found to be ineffective, and c) the effectiveness of the anti-anxiety medication was assessed and documented. This was true for 1 of 9 (#3) sampled residents who received psychoactive medications. This deficient practice created the potential for more than minimal harm if residents received medications that may result in negative outcomes without clear indication of need and benefit. Findings include:</p> <p>Resident #3 was admitted to the facility on 11/2/17 with diagnoses of CVA [stroke], left-sided paralysis, COPD [progressive lung disease characterized by increasing breathlessness], depression, dementia, and anxiety disorder.</p> <p>A physician order for Resident #3 dated 12/19/16 documented the resident could have Ativan 0.5 mg orally two times a day as needed for</p>	F 329	<ol style="list-style-type: none"> 1. Residents #3,had medications reviewed for accurate target behaviors and non-pharmacological interventions, with documentation of effectiveness of anti-anxiety medication 2. Review residents on anti anxiety medications to ensure they receive these medications only in response to target behaviors. Also review documentation of effectiveness of non-pharmacological interventions . 3. Education conducted by SDC or designee to LNs and SS on use of antianxiety medication to ensure these are used only in response to target behaviors, and after nonpharmacological interventions have been tried and the effectiveness of use is documented. Education included that the behavior monitor must be filled out completely and accurately. 4. DON, LSW to audit residents who use antianxiety medications behavior monitor & mar to ensure that target behaviors were displayed and non-pharmacological 		

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F 329	<p>Continued From page 15 diagnosis of anxiety.</p> <p>Resident #3's Alteration in Mood care plan, dated 12/20/16, documented the resident was having episodes of anxiety exhibited by crying, verbalized feelings of nervousness, restlessness, becoming "overly demanding" with frequent requests of staff, and had frequent health concerns. The Care Plan directed staff to assess and medicate for pain as needed; offer food and fluid; check for signs and symptoms of constipation; ensure a calm, quiet environment; assist with position changes as appropriate; to place the resident in bed or assist out of bed; turn side to side, raise head/legs, etc. The Care Plan directed staff to monitor for adverse side effects of medication use, and document every shift.</p> <p>The Behavior/Intervention Monthly Flow Record for February 2017 and March 2017 tracked episodes of crying/tearfulness and sad/negative statements. The interventions listed redirection, 1:1 [for supervision or attention], activity, position change, backrub, toilet, return to room, give food/fluids, adjust room temperature, refer to nurse's notes, and medication. Hand written interventions for Resident #3 directed staff to reassure her, listen to her, and accentuate the positive. The Flow Record directed staff to see the Care Plan.</p> <p>Between 2/1/17 and 3/20/17, Resident #3 received Ativan 0.5 mg on 40 occasions.</p> <p>* For 18 of the 40 occasions, no target behaviors were documented on the Behavior/Intervention Records.</p>	F 329	<p>interventions attempted. Audits to be conducted 3x week x 8 weeks and review antianxiety med use in QAPI x3 months.</p>		

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F 329	Continued From page 16 *For 20 of the 40 occasions, there was no documentation on the Behavior/Intervention Records to show non-pharmacological interventions were attempted prior to giving Resident #3 Ativan. *For 26 of the 40 occasions, the effectiveness of the Ativan was not documented on the Behavior/Intervention Record. The facility failed to ensure target behaviors were displayed and non-pharmacological interventions attempted before the use of an "as needed" psychotropic medication, and the effectiveness of the psychotropic medication was not consistently documented.	F 329			
F 364 SS=E	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, menu review, and staff and resident interview, it was determined the facility failed to ensure meals were served that were flavorful and appealing for 16 of 17 (#1-#5, and #7-#17) sampled residents residing in the facility; 9 of 13 residents in the group interview; 15 residents who required pureed or mechanically altered diets; and 51 of 52 other	F 364	1. Residents #2, 7, 11, 13 and 16 no longer reside in the facility. 2. A review of the last 30 days of resident concern cards was conducted to identify food concerns. Those individual residents had food preferences updated as needed. 3. The RD, SLP and designee	5/19/17	

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F 364	<p>Continued From page 17</p> <p>residents who ate food prepared by the kitchen. Foods were not sufficiently hot, recipes were not followed resulting in foods being under-seasoned, and mechanically altered and pureed foods were not prepared in a manner enhancing flavor. This deficient practice created the potential for residents to experience unplanned weight loss, diminished nutritional health, and decreased sense of control of their environment. Findings include:</p> <p>1. A Resident Group Interview was held on 3/21/17 at 10:30 am with 13 residents in attendance. Nine residents expressed concerns with the menu. Issues included menu items not always being provided. Residents' comments included:</p> <ul style="list-style-type: none"> * Nine residents complained of "bad" food; one resident stated "If this was a restaurant it would be out of business." * Two residents reported meats like chicken and pork were dry and tough. In addition, they stated sometimes the meat was "raw looking" on the bottom but brown on top as if it had not been turned during the cooking process. * Six residents complained that the food did not have good flavor and lacked spices. * Three residents in group reported the spaghetti lacked flavor and the noodles were sometimes undercooked. * Four residents stated they did not get what was on the menu because the kitchen did not have the menu item. * Four resident stated hashbrowns or whole potatoes were usually raw and could not be cut easily. * Four residents reported meals that were 	F 364	<p>conducted education with the dietary personnel on maintaining temperature, following menus/recipes and preparing mechanically altered/pureed foods in a manner to enhance flavor.</p> <p>4. RD, SLP or designee will conduct audits 3x week x 8 weeks then monthly x 2 months to monitor for food consistency, following recipes and temperatures. Resident food committee meetings will be held monthly x 3 months as well as resident council to identify opportunities for improvement. Negative findings of both audits will be reviewed in QAPI x 3 months for further training and education</p>		

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F 364	<p>Continued From page 18</p> <p>delivered to their rooms were usually cold by the time they were served.</p> <p>* Six residents stated there were too many starches on the menu. They stated the facility served rice and potatoes during the same meal.</p> <p>Residents stated there was a food committee with the Dietary department for discussing food concerns, but some of the problems still existed.</p> <p>2. On 3/21/17, the lunch option for residents was as follows:</p> <ul style="list-style-type: none"> * Italian Meat Sauce * Parsley Spaghetti * Italian Vegetables * Garlic Toast * Margarine spread/ butter * Banana Pudding with topping * Beverage of choice * Milk <p>The lunch pureed option was the same options as above.</p> <p>On 3/21/17 at 9:45 am, the kitchen staff was preparing 5 servings of pureed Italian Meat sauce.</p> <p>*The recipe for the Puree Italian Meat Sauce included instructions for staff to prepare the sauce according to the regular recipe. The recipe stated staff was to place five 4 ounce portions of meat into the blender and process the meat sauce until smooth.</p> <p>* The Regular Italian Meat Sauce recipe included instructions for staff to cook the meat,</p>	F 364			

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F 364	<p>Continued From page 19</p> <p>mushrooms, onion, green pepper, and garlic until the meat was brown. The instructions documented in the Notes section of the menu was for staff to omit the mushrooms for ground and puree textured diet modifications.</p> <p>* The Puree Bread recipe included instructions for staff to use puree bread mix, water and margarine. The recipe did not include garlic and the menu showed garlic toast being served.</p> <p>* The Garlic Toast recipe included instructions for staff to use white bread, margarine, and garlic powder.</p> <p>* The Puree Spaghetti recipe included instructions for staff to prepare according to the regular recipe.</p> <p>* The Regular Spaghetti recipe included instructions for staff to use water, salt, oil, and spaghetti pasta. The recipe did not include the use of parsley like stated on the menu or how much parsley to use.</p> <p>During the observation of the meal preparation, Cook #2 had one pan which contained cooked onions, mushrooms, garlic, and peppers. A second pan contained the meat with tomatoes. When Cook #2 was making the puree spaghetti sauce the cook placed 5 servings of the meat/tomato mixture into the blender and then used a large slotted spoon to add two heaping spoonfuls of the vegetable mixture to the blender. Cook #2 stated the vegetables in the pan were mushrooms, onions, and peppers. The recipe stated to omit the mushroom for the pureed option. In addition, Cook #2 did not add the</p>	F 364			

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F 364	<p>Continued From page 20</p> <p>vegetables to the meat mixture from the beginning; as stated in the recipe. It could not be determined if the amount of vegetables was adequate for sufficient nutritive value.</p> <p>On 3/21/17 at 1:00 pm, both regular texture and a puree texture test tray were sampled, with the Dietary Manager in attendance.</p> <ul style="list-style-type: none"> * The regular texture pasta had a strong parsley flavor. * The puree pasta was bland, with no parsley flavor noted. * The meat sauce had a white gravy on top of it. The gravy tasted out of place with the pasta and meat sauce. The Dietary Manager stated the gravy was on top to ensure it was moist enough. The Dietary Manager stated he would not normally eat spaghetti with gravy on top of it. * The pureed bread had a sweet flavor, with no garlic detected. The Dietary Manager stated the staff did not use the same bread as the garlic toast. He stated the pureed bread was a mixture they used to make sure it was the correct consistency. <p>On 3/21/17 at 1:10 pm, the Dietary Manager stated Cook #2 was "nervous" and that was why the cook put the gravy on top of the meat sauce.</p> <p>3. On 3/22/17 at 12:55 pm, a test tray was sampled, with the Dietary Manager in attendance. The tray included Lemon Baked Chicken, Garlic Mashed Potatoes, Green Beans, a Dinner Roll, and Fruit Pie with Whipped Topping. The mashed potatoes were bland, and no garlic flavor was detected.</p>	F 364			

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F 364	<p>Continued From page 21</p> <p>4. On 3/22/17 the dinner option for residents included:</p> <ul style="list-style-type: none"> * Steak Teriyaki * Steamed Rice * Stir Fry Vegetables * Dinner Roll * Margarine Spread/ Butter * Strawberry Shortcake * Beverage of Choice * Milk <p>Alternate Meal:</p> <ul style="list-style-type: none"> * Shrimp Fettuccini * Marinated Tomato Salad <p>On 3/22/17 at 1:22 pm, Cook #1 started preparing the Marinated Tomato Salad, Stewed Tomato Salad [mechanically altered option], and Pureed Stewed Tomato Salad [puree option]. The Marinated Tomato Salad recipe ingredient list included green peppers, fresh parsley, and red wine vinegar. Cook #1 was observed to use red peppers, dried parsley, and white wine vinegar when preparing the salad, as the ingredients identified in the recipe were not currently available in the facility. The Stewed Tomato salad recipe ingredient list included white vinegar and green peppers; as well as instructions for the salad to marinate overnight. The amount of onion to be used was not specified. Cook #1 prepared the recipe using white wine vinegar, omitted the onion, and prepared the salad just hours before it was to be served without allowing time to marinate.</p> <p>On 3/22/17 at 1:22 pm, Dietary Aide #1 started</p>	F 364			

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F 364	<p>Continued From page 22</p> <p>preparing the dessert for dinner. The Strawberry Shortcake recipe called for ingredients of white cake, frozen strawberries, and whipped topping. Each portion was to be topped with 2 ounces of strawberries.</p> <p>At 1:25 pm, Dietary Aide #1 was observed telling the Dietary Manager that there was not enough strawberries for the topping to the Strawberry Shortcake and he would wait for the strawberries to get there before finishing this preparation. The strawberries were not observed to be provided. Dietary Aide #1 completed the preparation without the strawberries.</p> <p>On 3/22/17 at 5:48 pm, a test tray was sampled, with the Dietary Manager in attendance. The Strawberry Shortcake was a plain piece of cake with a dollop of whipped topping and a red liquid drizzled on top. There were no strawberries on top of the cake. The Dietary Manager stated he did not believe that strawberries should be on the cake.</p> <p>On 3/22/17 at 6:01 pm, the Dietary Manager stated he thought he had enough foods items available for meal prep and he would be starting an audit to make sure this was the case in the future.</p> <p>The facility failed to ensure menu items were available for residents; recipes were followed to be able to provide the adequate nutritive content of the menu items, and that of mechanically altered diets; and that the foods provided to residents were flavorful.</p>	F 364			
F 368 SS=E	483.60(f)(1)-(3) FREQUENCY OF MEALS/SNACKS AT BEDTIME	F 368		5/19/17	

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F 368	Continued From page 23 (f) Frequency of Meals (f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. (f)(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. (f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on resident interviews it was determined the facility failed to ensure 10 of 13 residents in the group interview and 1 random resident (#26) were offered bedtime snacks. This deficient practice created the potential for residents in the facility to experience hunger or not have their nutritional needs met. Findings include: During group interview on 3/21/17 at 10:30 am, 10 of 13 residents present stated they were not offered bedtime During the group interview on 3/21/17 at 10:30 am, 10 of the 13 residents indicated they were not offered bedtime snacks at night. They identified they knew snacks were	F 368	1. Resident #26 was interviewed for HS snack preferences and is offered preferred snack. 2. Review of last 7 days of HS snack documentation was conducted to identify residents who were not offered an HS snack. Those residents had food preferences updated as needed and are offered HS snack. 3. SDC or designee provided education to nursing assistants on the facility practice for offering/documenting HS snacks to residents		

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F 368	Continued From page 24 available if they wanted to go down to the Nurses' station and ask for them. Follow-up interviews with 4 residents who attended the formal group interview included: On 3/23/17 at 10:10 am, one resident stated she had not been offered bedtime snacks. On 3/23/17 at 10:20 am, one resident stated he did not get offered bedtime snacks. He stated if you ask for a snack they will bring one to you but they are not offered. On 3/23/17 at 10:30 am, one resident stated that she did not get offered bedtime snacks. On 3/23/17 at 10:40 am, one resident stated, "you have to ask for snacks" but, they are not offered. During a random interview with alert Resident #26 on 3/23/17 at 10:45 am, she stated if she asked for a snack she could get one, but that they were not offered.	F 368	4. Nursing leadership or designee will conduct HS snack audits 3x week x 8 weeks then monthly x2 months. Findings will be presented to monthly QAPI meetings x3 months for further training opportunities.		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 371		5/19/17	

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F 371	<p>Continued From page 25</p> <p>gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure measures were in place to prevent possible cross-contamination a) of dirty to clean areas in the kitchen and b) during food preparation and service. This was true for 16 of 17 (#1-#5 and #7-#17) sampled residents and 79 of 80 other residents who ate food prepared by the kitchen. This had the potential for harm if residents contracted foodborne illnesses or contagious diseases. Findings include: Residents #1-#5 and #7-#17 ate food prepared in the facility's kitchen. The facility's Sanitation and Maintenance Policy, dated 11/11/16, documented when staff utilized a three compartment sink, all items were air dried before storing. The facility's Hand Washing Policy, dated</p>	F 371	<ol style="list-style-type: none"> Residents #2, 7, 11, 13 and 16 no longer reside in the facility. Residents #1, 3, 4, 5, 7, 9, 10, 12, 14, 15 and 17 had their medical records reviewed for potential negative medical changes related to food sanitation. None were noted A review of the April infection control log was completed to identify potential trends related to foodborne illnesses as a result of sanitation practices. None were noted RD, SDC or designee conducted education with dietary personnel on sanitation practices in the kitchen. This included, but not limited to: hand washing, sanitation of equipment, cross contamination and personal hygiene. RD or designee to audit sanitation in dietary department 3x week x 8 weeks 		

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F 371	<p>Continued From page 26</p> <p>11/11/16, documented staff should wash their hands as necessary. Hand washing was to be performed at these times:</p> <ul style="list-style-type: none"> * Staff was to wash hands after handling food. * Staff was to wash hands between working with raw foods to cooked foods. * Staff was to wash hands after contacting any soiled utensils. * Staff was to wash hands after engaging in activities that contaminated the hands. <p>1. Food Preparation and Service:</p> <p>a. On 3/21/17 at 9:45 am, the Dietary Manager's beard restraint was under his beard and not containing it.</p> <p>b. On 3/21/17 at 12:55 pm, Cook #2's beard restraint was under his beard while he was serving residents meals at lunch. The Dietary Manager asked him to please put it around his beard.</p> <p>c. On 3/22/17 at 12:54 pm, the kitchen staff was preparing the dinner meal. The following was observed:</p> <p>i. Cook #1 was preparing the Stir Fry Vegetables. After Cook #1 finished with the vegetables she took a dirty pan over to a three compartment sink and washed the pan. She placed the pan on a rack to dry and proceeded to get a container of rice to begin the rice preparation.</p> <p>ii. After Cook #1 got the rice she went into the cleaning area to retrieve the pan she had cleaned minutes before; the pan was still wet and</p>	F 371	then monthly x2. Findings to be reviewed in monthly QAPI x3 months		

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F 371	<p>Continued From page 27</p> <p>she proceeded to place the rice into the wet pan.</p> <p>iii. On 3/22/17 at 1:22 pm, Cook #1 started preparing the Marinated Tomato Salad, Stewed Tomato Salad, and Pureed Stewed Tomato Salad. She used various measuring tools and pieces of equipment throughout.</p> <p>iv. On 3/22/17 at 2:49 pm, Cook #1 finished preparing the Steak Teriyaki. The front of her apron was covered with flour which she had used to coat the raw steaks; she took her apron off and obtained a clean one. The meat was sitting out uncovered and she proceeded to cover the raw floured meat with plastic wrap. Cook #1 leaned over the pan of raw meat and the front of her clean apron touched the meat as she was placing the plastic wrap on it. Flour could be seen on the clean apron. Cook #1 continued to move on to other tasks while wearing this apron.</p> <p>Throughout the four above observations Cook #1 was observed using the three compartment sink to sanitize the measuring tools used and other items. The front of Cook #1's apron was touching the edges of the sinks and water could be seen splashing up on her apron. She did not wait for the items sanitized to dry before using them again.</p> <p>e. On 3/22/17 at 1:22 pm, Dietary Aide #1 started preparing the dessert for dinner and bedtime snacks.</p> <p>Throughout the observation of Dietary Aide #1 he was noted to use the three compartment sink to sanitize equipment he used, and then went directly back to the food. This occurred three</p>	F 371			

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F 371	<p>Continued From page 28</p> <p>times and he was not observed to wash his hands between sanitizing the equipment and going back to food preparation.</p> <p>f. On 3/22/17 at 1:22 pm, Dietary Aide #2 started preparing the afternoon snacks. Snacks being prepared included applesauce and pudding.</p> <p>i. When Dietary Aide #2 was preparing the applesauce. Dietary Aide #2 finished preparing the applesauce he placed a gray handled scoop he was using on the work surface area and went to the refrigerator and got the pudding out. The aide did not wash his hands between tasks. Dietary Aide #2 began filling cups with pudding, using the same scoop he had used in the applesauce, without washing it. He stopped after about 20 containers were full and got a clean scoop to finish the pudding cups. Dietary Aide #2 was observed not washing his hands 4 times after going from one task to another, such as entering the dish room, entering dry storage, the refrigerator, and exiting the kitchen.</p> <p>ii. On 3/22/17 at 5:13 pm, Dietary Aide #2 left his station at tray-line during service; entered the dish room once; got items from the refrigerator and pantry; and left the kitchen, without washing his hands. He then returned to his station during food service.</p> <p>On 3/23/17 at 3:20 pm, the Dietary Manager could not remember what the facility practice was on hand hygiene during food prep and tray-line. He stated he would find out.</p> <p>On 3/23/17 at 3:47 pm, the Executive Director stated if staff members leave the line during</p>	F 371			

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F 371	Continued From page 29 tray-line staff members were to wash their hands. 2. Dishware washing: On 3/22/17 at 2:00 pm, two staff members were in the dish room. Dietary Aide #4 was on the dirty side of the dish room; she was not wearing protective equipment over her uniform. At 2:45 pm, she was seen coming into the kitchen with clean dishes and was putting them away. She did not have anything on to protect the dishes from her contaminated uniform. On 3/22/17 at 2:49 pm, the Dietary Manager stated the facility's practice was to have two people doing dishes, one on the clean side and one on the dirty side. He asked Dietary Aide #4 to please rewash the dishes brought back over and had Dietary Aide #3 put them away. The facility failed to ensure sanitary practices were followed with food preparation, sanitation of dishware, and food service. These failed practices placed residents at greater risk for acquiring foodborne illnesses and infections.	F 371			
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures	F 431		5/19/17	

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F 431	<p>Continued From page 30 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--</p> <p>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>(g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>(h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the</p>	F 431			

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F 431	<p>Continued From page 31</p> <p>quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview and policy review, it was determined the facility failed to ensure that medications were secure and stored in a locked compartment when not under continuous staff supervision. The deficient practice created the potential for any of the 17 residents living on the 300 hall, including sample Residents #2 and #12, to experience uncontrolled bleeding when they had unsupervised access to anti-coagulant medication [thins the blood to prevent blood clots and strokes. side effects may include increased bleeding]. Findings include:</p> <p>During the medication pass on the 300 unit on 3/21/17, at 3:00 pm, LPN #1 took a card of Warfarin [anti-coagulant medication] out of the medication cart. The medication cart was beside the nursing station. LPN #1 took two tablets from the card and left the card lying on the cart while administering the medication. LPN #1 then stated she was going to check to see if another resident was in his/her room. There were no other staff in sight of the cart while the nurse was checking on the other resident. The nurse returned to the medication cart and the surveyor asked about the Warfarin medication lying on the cart. LPN #1 stated she thought it was an empty card of medication and she proceeded to place the medication in the cart and lock it.</p> <p>On 3/24/17 at 9:35 am, the Director of Nursing stated all staff were to observe to ensure medications were properly stored.</p>	F 431	<ol style="list-style-type: none"> 1. Resident #2 no longer resides in the facility Resident #12 was reviewed for s/sx of bruising and bleeding. None were noted 2. Residents have the potential to be impacted by this practice and medications will be secured when not in direct supervision of an LN 3. SDC or designee provided education to LNs of medication storage and securement 4. Nursing leadership will conduct audits 3x week x8 weeks then monthly x2 of medication storage. Negative findings will be corrected at time of discovery. Audits will be presented to DON for review and in QAPI meeting x 3 months 		

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F 431	Continued From page 32	F 431			
F 441 SS=D	<p>On 3/23/17 at 9:40 am, LPN # 2 stated there were 17 residents on the 300 unit [including sample Residents #2 and #12] and all of residents on that unit were ambulatory or mobile non-ambulatory. The LPN #2 stated that she was usually at the nurse's station and would watch the medication cart if needed.</p> <p>The facility policy Medication Storage, last revised 6/21/06, documented, "Medications must be kept under continuous supervision."</p> <p>483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>(a) Infection prevention and control program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</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</p>	F 441		5/19/17	

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F 441	<p>Continued From page 33 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 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</p>	F 441			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 34</p> <p>annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure staff performed standard hand hygiene measures to reduce the risk for infection. This was true for 1 of 10 (CNA #3) staff members observed interacting with residents who sat in the main dining room. This deficient practice directly impacted 2 of 37 sampled residents (#33 and #34). This failure created the potential for residents to develop infections from cross-contamination. Findings include:</p> <p>During a breakfast meal observation on 3/21/17, beginning at 7:48 am, the Floor Tech and CNA #3 were observed as they interacted and assisted residents before their meals arrived. Hand Hygiene was not performed during the following observation:</p> <p>* At 8:06 am, CNA #3 provided a clothing protector for one resident, brushed hair out of her face, and proceeded to assist another resident to butter his toast. CNA #3 then assisted Resident #33 with taking a drink of fluids and placed her hand onto his shoulder. CNA #3 was observed touching her own face 4 times throughout the observation and then returned to assisting residents with their food without performing hand hygiene.</p> <p>During a breakfast meal observation on 3/22/17, beginning at 8:00 am, the Floor Tech and CNA #3 were observed as they interacted and assisted residents before their meals arrived. Hand</p>	F 441	<ol style="list-style-type: none"> 1. Residents #33 and 34 were reviewed for s/sx of new infections related to hand hygiene and cross contamination and none were noted 2. Residents have the potential to be affected by this practice. Review of the April infection control log was conducted by the DON for trends and none were noted 3. SDC or designee provided staff education on infection control practices related to meal and dining room service. Education included but was not limited to: hand hygiene, cross contamination and personal hygiene. 4. Dining room audits related to infection control practices will be conducted 3 x week x 8 weeks and monthly x2. Findings will be presented and monitored monthly at QAPI meeting x3 months 		

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F 441	Continued From page 35 Hygiene was not performed during the following observation: * Beginning at 8:00 am, CNA #3 was observed placing clothing protectors on three residents, cut up food for four residents, and then started assisting Resident #34 with his meal. She reached over to the resident sitting next to him and used a napkin to wipe off the resident's mouth and then continued to assist Resident #34 with his meal. On 3/23/17 at 3:20 pm, the Executive Director stated hand hygiene in the dining room was a topic they had discussed often and sometimes people forgot to perform hand hygiene. He stated they would review it.	F 441			
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident;	F 514		5/19/17	

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F 514	Continued From page 36 (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 resident and staff interviews, it was determined the facility failed to ensure each resident's meal and snack intake was accurately documented. This was true for 2 of 20 sampled residents (#2 and #11) whose meal records were reviewed. This failed practice increased the risk for medical and dietary decisions to be based in inaccurate information. Findings include: 1. Resident #11 was admitted to the facility on 3/15/17, with diagnoses which included cerebral infarction [an area of dead tissues in the brain from narrowing or blocked arteries.], diabetes mellitus, diabetic retinopathy [damaged blood vessels to the eyes], dementia, and hyperlipidemia [high cholesterol in the blood]. Resident #11's March 2017 Physician Orders, documented he was on a regular diet with diet condiments, ordered 3/15/17.	F 514	1. Res #2 and 11 have both been discharged from the facility 2. Residents have the potential to be affected by this practice. A review of last 30 day weight change report was completed as well as Resident at Risk for weight loss meeting (RAR) for any needed follow up. 3. SDC or designee completed education with LNs and C.NAs related to meal and snack documentation 4. Facility leadership will conduct random audits 3x week x8 weeks and bi monthly x2 on meal/snack record documentation. Findings will be reviewed by DON/ED and presented to QAPI meeting x3 months.		

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F 514	Continued From page 37 Resident #11's Nurses' notes, and Monthly Eating Flow Reports, from 3/15/17 through 3/22/17, documented conflicting information related to his meal and snack intake. Examples include: * Resident #11's Nurses' note, dated 3/15/17, documented he did not eat dinner and declined a bedtime snack. Resident #11's Eating Monthly Flow Report, dated 3/15/17, documented he consumed 100% of dinner and his HS snack. * Resident #11's Nurses' note, dated 3/19/17, documented he did not eat dinner and he declined a snack at bedtime. The note documented he had not been eating well over the weekend. Resident #11's Eating Monthly Flow Report, dated 3/19/17, documented he consumed 75% of dinner and 100% of his bedtime snack. * Resident #11's Nurses' note, dated 3/21/17 at 3:01 pm, documented he did not eat breakfast and had an episode of emesis [vomiting] at lunch. Resident #11's Nurses' note, dated 3/21/17 at 11:09 pm, documented his appetite was poor but he drank two shakes at dinner. Resident #11's Eating Monthly Flow Report, dated 3/21/17, documented he consumed 75% of breakfast, 50% of lunch, and 75% of dinner. On 3/21/17 at 3:30 pm, the Director of Nursing [DON] stated staff was to look at the percentage of the whole meal that was included on the menu. She stated the meal percentages documented on Resident #11's Eating Monthly Flow Reports were incorrect.	F 514			

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F 514	<p>Continued From page 38</p> <p>2. Resident #2 was admitted to the facility on 2/26/17, with diagnoses which included osteoarthritis and osteoporosis.</p> <p>Resident #2's March 2017 Physician Orders, documented she was on a regular diet, ordered 2/26/17.</p> <p>Review of Resident #2's Nurses' notes, and Monthly Eating Flow Reports, from 2/26/17 through 3/23/17, documented conflicting information related to her meal intake. Examples include:</p> <ul style="list-style-type: none"> * Resident #2's Nurses' note, dated 3/1/17 at 2:31 pm, documented she ate 25% of breakfast and lunch meals. Resident #2's Eating Monthly Flow Report, dated 3/1/17, documented she consumed 75% of breakfast and 50% of lunch. * Resident #2's Nurses' note, dated 3/6/17, documented she ate 45% of all her meals that day. Resident #2's Eating Monthly Flow Report, dated 3/6/17, documented she consumed 100% of breakfast, 75% of lunch and 50% of dinner. * Resident #2's Nurses' note, dated 3/7/17, documented she ate 25% of her breakfast. Resident #2's Eating Monthly Flow Report, dated 3/7/17, documented she consumed 75% of breakfast. * Resident #2's Nurses' note, dated 3/8/17, documented she ate 25% of all her meal. Resident #2's Eating Monthly Flow Report, dated 3/8/17, documented she consumed 25% of breakfast, 100% of lunch and 75% of dinner. 	F 514			

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F 514	<p>Continued From page 39</p> <p>* Resident #2's Nurses' note, dated 3/9/17 at 4:03 pm, documented she ate 25% of the breakfast and lunch meals. Resident #2's Eating Monthly Flow Report, dated 3/9/17, documented she consumed 100% of breakfast and 75% of lunch.</p> <p>Conflicting intake documentation for Resident #2 was also found for the following dates: 3/11/17, 3/13/17, 3/14/17, 3/15/17, 3/16/17, 3/17/17, 3/19/17, 3/20/17, and 3/21/17.</p> <p>Resident #2's Nutrition Note, dated 3/13/17, documented she had lost 5.2% of weight since admission to the facility on 2/27/17.</p> <p>On 3/20/17 at 3:40 pm, Resident #2 stated she did not have much of an appetite and she stated she ate on average 25% of her meals. She stated she did not like the food the facility was providing. She stated she liked her foods on the blander side. She stated she enjoyed the shakes and the fortified cereals. She stated she knew she had lost weight , however, she was ok with the weight loss. She stated she wanted to be 110 pounds.</p> <p>On 3/21/17 at 4:00 pm, the Registered Dietitian [RD] stated she based her dietary assessments of residents' food consumption on the information documented by Certified Nursing Assistants [CNAs] on the Eating Monthly Flow Reports. She stated if this information was inaccurate it would affect her assessments. The RD stated if she knew a resident was not eating well, and the resident's weight was decreasing, she would investigate the reason the CNA flow-sheets</p>	F 514			

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

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F 514	Continued From page 40 showed the resident was eating 100%.	F 514			

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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 from March 20, 2017 to March 24, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Teresa Kozba RDN/LD, Team Coordinator Edith Cecil, RN Beverly Briggs, RN Sandy Goins, RN</p> <p>Abbreviations:</p> <p>RN = Registered Nurse</p>	C 000		
C 631	<p>02.122,01,a Individual Resident Bed Requirments</p> <p>a. Each patient/resident shall be provided with his own bed which shall be at least thirty-six (36) inches wide, have a head and a footboard, be substantially constructed, and in good repair. Bedrails shall be provided when needed. Roll-away type beds, cots, folding beds, double beds, or hollywood-type beds shall not be used. Adjustable-height beds are recommended.</p> <p>This Rule is not met as evidenced by: Based on observation, resident interview, and staff interview, it was determined that 1 of 97 residents (Resident # 32) utilized a recliner chair for sleep instead of a bed. A bed waiver was not found for this facility. Findings include:</p> <p>Resident #32 was admitted to the facility on</p>	C 631	Resident #32 was interviewed for preference with recliner only and care plan was reviewed. No changes per resident preference. Waiver was filed and approved with the State of Idaho. Executive Director provided education to facility leadership on the requirements of	5/19/17

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE
05/05/17

Bureau of Facility Standards

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C 631	Continued From page 1 12/9/10 with diagnoses of congested heart failure and chronic obstructive pulmonary disease. On 3/20/17 at 3:00 pm, a recliner chair was observed in Resident #32's room. Daily observation on 3/21/17 at 10:00 am, 3/22/17 at 7:45 am, and 3/23/17 at 10:00 am, a recliner chair was observed in Resident #32's room. There was not a bed in the room. On 3/23/17 at 9:30 am, Resident #32 stated he used the recliner because he was not physically able to lie on a bed. He stated he was as comfortable as he could be using the recliner. Resident #32 stated he did not want a bed in his room. "I want the recliner." On 3/23/17 at 10:00 am, the Administrator stated "The resident had the recliner in his room when I arrived about a year ago." The Administrator stated he was not aware of a bed waiver. The Administrator indicated the facility would request a bed waiver based on resident preference and need.	C 631	filing a waiver when a resident's bed is removed. Executive Director will review for waiver compliance when a resident requests the removal of their bed and submit necessary documentation at that time or annually as indicated.	
C 763	02.200,02,c,iii When Average Census 90 or More iii. In SNFs with an average occupancy rate of ninety (90) or more patients/residents a registered professional nurse shall be on duty at all times. This Rule is not met as evidenced by: Based on review of the facility nursing schedule, timesheets, and staff interview, it was determined the facility failed to ensure an RN [Registered Nurse] Charge nurse was staffed on all shifts when the Resident census was 90 and above. This was true for 10 out of 21 days that were	C 763	Facility will continue to recruit for 24-hour RN coverage to meet regulatory compliance when census is 90 or more. The DON and ED will review staffing weekly x4 and monthly x2 to identify open shifts requiring RN coverage and adjust	5/19/17

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C 763	<p>Continued From page 2</p> <p>reviewed between 2/26/17 through 3/18/17. The census during that time ranged from 96 to 108 residents. Findings included:</p> <p>The facility Nursing Schedule dated 2/26/17 through 3/18/17 were reviewed and indicated that with the census of 96 and above, RN coverage was not provided on the following night shifts:</p> <p>2/26/17 3/2/17 3/4/17 3/9/17 3/10/17 3/11/17 3/12/17 3/16/17 3/17/17 3/18/17</p> <p>On 3/22/17 at 2:00 pm, the Administrator stated it was, at times, difficult to get RN coverage on the night shift. He confirmed the schedule was correct.</p>	C 763	<p>schedule to ensure compliance. Staffing schedules related to RN coverage will be reviewed in QAPI monthly x3 for further opportunities.</p>	
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