



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

May 5, 2017

Daniel Kennick, Administrator
Teton Post Acute Care & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404-7534

Provider #: 135138

Dear Mr. Kennick:

On **April 10, 2017**, a survey was conducted at Teton Post Acute Care & Rehabilitation 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 an isolated deficiency that constitutes actual 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 15, 2017**. Failure to submit an acceptable PoC by **May 15, 2017**, may result in the imposition of penalties by **June 10, 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 20, 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 **July 9, 2017**. A change in the seriousness of the deficiencies on **May 30, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **July 9, 2017** includes the following:

Denial of payment for new admissions effective **July 9, 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 **October 7, 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 **July 9, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **May 15, 2017**. If your request for informal dispute resolution is received after **May 15, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

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

PRINTED: 05/24/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2017
NAME OF PROVIDER OR SUPPLIER TETON POST ACUTE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint investigation survey conducted at the facility from April 3, 2017 to April 7, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Presie Billington, RN Edith Cecil, RN</p> <p>Abbreviations:</p> <p>BID = Twice a day Bi-PAP = Bilevel Positive Airway Pressure BG = Blood Glucose BM = Bowel Movement CNA = Certified Nursing Assistant CDI = Clean, Dry, Intact CHF = congestive heart failure cm = centimeter CPAP = Continuous positive airway pressure CVA = Cerebrovascular accident (stroke) DC('d) = Discontinue/Discontinued DM = Dietary Manager DON = Director of Nursing Drsg = dressing DTI = Deep tissue injury ED = Executive Director ER = Emergency Room Fax = Facsimile GDR = Gradual dose reduction HS = at bedtime I&A = Incident and Accident IDDM = Insulin Dependent Diabetes Mellitus IDT = Interdisciplinary Team L = Liter(s)</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

05/15/2017

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 LAL = Low air loss (mattress) LPM = Liters Per Minute LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MD = Medical Doctor mg = milligram MDS = Minimum Data Set NC = Nasal Cannula NHSC = Nutrition, Hydration, Skin Committee NOC = at night NS = Normal saline O2 = Oxygen OT = Occupational Therapist PRN = As Needed PA = Physician Assistant PT = Physical Therapy PU = Pressure ulcer Q = every QI = Quality Improvement QID = four times a day RD = Registered Dietician Res = Resident RCM = Resident Care Manager RDCO = Regional Director of Clinical Operations SDC = Staff Development Coordinator S/S = Signs and Symptoms SNF = Skilled Nursing Facility TAR = Treatment Administration Record TBI = Traumatic brain injury TCU = Transitional Care Unit TID = Three times daily TO = Telephone order x = by	F 000			
F 155 SS=D	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10	F 155		5/17/17	

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F 155	<p>Continued From page 2</p> <p>(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.</p> <p>(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.</p>	F 155			

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F 155	<p>Continued From page 3</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>483.24</p> <p>(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure physician orders were consistent with residents' wishes. This was true for 1 of 15 residents (#13) reviewed for resident rights. The failure created the potential for Resident #13 to experience side effects, including sedation, when "narcotic" pain medication was ordered and administered against the resident's expressed wishes. Findings include:</p> <p>The closed clinical record documented Resident #13 was admitted to the facility on 12/15/16 with multiple diagnoses, including acute and subacute compression fractures at 3 levels in the thoracic spine, status/post vertebroplasty [procedure in which a special cement is injected into a fractured vertebra], and sensitivity to narcotic pain medication. The resident was discharged on 12/30/16.</p> <p>Resident #13's Admission Care Plan</p>	F 155	<p>F-155</p> <p>Corrective Action: No further corrective action is warranted as Resident #13 discharged from the facility on 12/30/16.</p> <p>Identification of Others: As this has the potential to affect other residents, a review of each resident's medications will be conducted between the nurse and the resident or responsible party on or before 5/17/17. The nurse will verify that the resident wants the medications that are ordered and understands that the resident or responsible party has the right to refuse each medication.</p> <p>Systematic Changes: Licensed nurses will be in-serviced by the Staff Development Coordinator regarding the resident's right to refuse medications and the procedure to notify the physician of the residents refusal of said medication</p>		

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F 155	<p>Continued From page 4</p> <p>documented compression fractures and vertebroplasty as problem areas on 12/15/16. Approaches included medications per orders and staff were to monitor for pain and medicate as needed each shift.</p> <p>Resident #13's Transitional Care Unit/Skilled Nursing Facility (TCU/SNF) Admission Orders and facility Admission Orders, each dated 12/15/16, both documented Percocet [narcotic pain medication] 5/325 mg 1 tablet every 4 hours prn for pain, Ibuprofen 600 mg TID [3 times a day] prn for pain, and Baclofen 10 mg TID prn muscle spasms.</p> <p>A 12/21/16 Physician's Telephone Order changed the prn Percocet to a scheduled Percocet every 6 hours. On 12/23/16, the scheduled Percocet was discontinued and Ibuprofen 600 mg was ordered TID.</p> <p>Resident #13's nursing notes documentation included: *12/16/16 at 5:00 pm - "...she has asked for pain medication for pain of 5/10 and this has been helpful..." *12/19/16 at 6:00 pm (noted as a late entry) - "...Res doesn't want Baclofen or narcotics..." *12/20/16 at 5:30 pm - "...takes prn Ibuprofen only..." *12/21/16 at 4:00 pm - "...Ibuprofen not effective..." *12/22/16 at 7:11 pm - "...she does not want to take percocet (sic)..." *12/23/17 at 5:00 pm - "...Resident does not like to take percocet (sic)...snow's (sic) her..."</p> <p>Resident #13's "Admission Orders -</p>	F 155	<p>on or before 5/17/17. When a resident expresses that they do not want to continue with a scheduled or PRN medication, the Director of Nursing or designee will contact the physician for guidance regarding changing or discontinuing the medication.</p> <p>A revised copy of resident rights was provided to each resident and/or responsible party by the facility social worker on or before 4/28/17. The revised form, which specifies that residents have the right to request, refuse or discontinue treatment, is included as a part of the each admission packet for all new admissions effective 4/28/17.</p> <p>Monitoring: 5 random residents will be interviewed weekly by the Director of Nursing or designee x 4 weeks beginning 5/17/17 and monthly for 2 months thereafter to validate that nurses continue to honor the resident's right as required. The results of the interviews will be brought to the monthly Quality Assurance meeting for review and recommendation for 3 months and as needed beginning with the next Quality Assurance meeting scheduled for 5/17/17. The Director of Nursing will be responsible for ongoing compliance.</p>		

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F 155	Continued From page 5 Administration Record..." documented prn Percocet was administered once on 12/16/16 and scheduled Percocet was administered twice on 12/21/16. On 4/7/17 at 1:10 pm, the Director of Nursing (DON) said Percocet was administered after Resident #13 said she did not want "narcotic" pain medication.	F 155			
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 157		5/17/17	

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F 157	<p>Continued From page 6</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure family members were notified of significant changes in residents' clinical conditions. This was true for 1 of 1 (#14) resident reviewed for physician/family notification. The deficient practice created the potential for missed opportunities for medical intervention and family involvement. Findings include:</p> <p>Resident #14 was admitted to the facility on 1/19/17, with multiple diagnoses, including a fall with left rib fractures that required "rib plating" [surgery where plates and screws are used to stabilize broken ribs] and cognitive decline/early dementia.</p>	F 157	<p>Corrective Action: No further corrective action is warranted for Resident #14 as he discharged from the facility on 1/31/17.</p> <p>Identification of Others: As this has the potential to affect other residents, an audit of incident reports and resident changes in condition that occurred within the past 30 days was conducted by the MDS Coordinator on 4/30/17 to validate that responsible parties were notified of the incident or change of condition.</p> <p>Systematic Changes:</p>		

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F 157	Continued From page 7 a. A 1/19/17 Occurrence Report documented Resident #14 had a fall at 6:00 pm and went by ambulance to an Emergency Room (ER) at 6:20 pm. The report also documented, "(Forgot)" regarding family notification. b. Resident #14's care plan documented gastroenteritis with diarrhea as a problem on 1/28/17. Interventions included cohorting with residents with the same condition if possible, direct care staff in-service on contact isolation techniques, and education to the resident and family on standard precautions. Nurses' Notes, dated 1/19/17 through 1/31/17, documented there was no evidence Resident #14's family was notified of the fall on 1/19/17 or of isolation precautions on 1/28/17. On 4/7/17 at 11:00 am, the Regional Director Clinical Operations (RDCO) said Resident #14's family was not notified when isolation was started on 1/28/17. At 11:10 am, the DON said the family was not notified of Resident #14's fall and transport to an ER on 1/19/17.	F 157	To prevent a recurrence, licensed nurses were in-serviced on 4/24/17 by the Director of Nursing and Staff Development Coordinator. The in-service included guidance on when to notify a responsible party, how to document that a responsible party has been notified and how to determine who the responsible party is. Monitoring: Audits will be conducted weekly by the Director of Nursing or designee for 4 weeks beginning 5/17/17 and monthly for 2 months thereafter to validate that staff continue timely notifications when an event or change in condition occurs. The results of the audits will be brought to the monthly Quality Assurance meeting for review and recommendation for 3 months and as needed beginning with the next Quality Assurance meeting scheduled for 5/17/17. The Director of Nursing will be responsible for ongoing compliance.		
F 202 SS=D	483.15(c)(2)(ii) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES (c)(2) Documentation. (ii) The documentation required by paragraph (c) (2)(i) of this section must be made by- [483.15(c)(2)(i) will be implemented beginning November 28, 2017 (Phase 2)] (A) The resident's physician when transfer or discharge is necessary under paragraph	F 202		5/17/17	

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F 202	<p>Continued From page 8 483.15(c)(1)(A) or (B) of this and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph 483.15(c)(1)(i)(C) or (D). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure pertinent information, including a resident's condition and all ordered medications and treatments, was provided to the receiving health care provider upon discharge. This was true for 1 of 3 resident's (#13) reviewed for discharge or transfer from the facility. The failure created the potential for a lack in continuity of care and omission of needed care and services. Findings include:</p> <p>Resident #13 was admitted to the facility on 12/15/16, with multiple diagnoses including acute and subacute compression fractures, status/post vertebroplasty, and sensitivity to narcotic pain medication. The resident was discharged on 12/30/16.</p> <p>Resident #13's clinical record documented two Stage II pressure ulcers (PUs) were noted on the buttocks during the Nursing Admission Evaluation of 12/15/16. There was no documented evidence in the clinical record that the PUs had resolved.</p> <p>A facsimile (fax) transmission from the facility to a home health care provider, dated 12/30/16, documented Resident #13 was discharged from the facility that day and requested specific home health staff. The fax included the resident's</p>	F 202	<p>Corrective Action: No further action is warranted for resident #13 as she discharged from the facility on 12/30/16.</p> <p>Identification of Others: A records review audit for residents discharged in the past 30 days was completed by the Assistant Nursing Home Administrator on 4/21/17 to identify other residents who may have discharged from the facility with incomplete discharge information.</p> <p>Systematic Changes: An in-service was conducted by the Regional Director of Clinical Operations on 5/4/17 for staff who participate in the discharge planning and documentation process. The in-service covered the required discharge documentation that must be completed before a resident departs the facility, how to provide discharge instructions to the resident and/or responsible party, and how to coordinate care with home health agencies and other entities once the resident discharges. The Staff Development Coordinator or designee will provide an in-service to the licensed nurses on the discharge process on or</p>		

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F 202	Continued From page 9 facility Face Sheet, physician orders for discharge on 12/30/16, and page 1 of a 2-page "Your Medication Profile." Resident #13's condition at discharge, including the status of the 2 PUs, was not included in the faxed information. On 4/7/17 at 1:55 pm, Licensed Social Worker (LSW) #1 and LSW #2 both said they were not involved in Resident #13's discharge. LSW #1 said another LSW, who was no longer with the facility, had faxed the information to the home health care provider and a nurse should have communicated the resident's condition to the receiving entity. On 4/7/17 at 3:00 pm, the DON and RDCO said the status of Resident #13's PUs was not documented upon discharge and that page 2 of the "Your Medication Profile" was missing.	F 202	before 5/17/17. Monitoring: Effective 5/17/17, a weekly audit will be conducted by the Social Services Director or designee to validate that discharge documentation is present and thorough as required. The results of these audits will be logged and shared monthly at the Quality Assurance/Performance Improvement (QAPI) meeting for 3 months, beginning with the next meeting scheduled for 5/17/17. After 3 months, the need for continued review of discharges will be re-evaluated. The Social Service Director is responsible for ongoing compliance.		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that	F 279		5/17/17	

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F 279	<p>Continued From page 10</p> <p>includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative (s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care</p>	F 279			

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F 279	<p>Continued From page 11</p> <p>plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure care plans based on residents' comprehensive assessments were developed and implemented. This was true for 3 of 8 residents (Residents #3, #6, and #7) reviewed for initial care plans. This deficient practice created the potential for residents to receive inappropriate or inadequate care with a subsequent decline in health. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 5/5/16 with diagnoses of history of cerebrovascular accident (CVA) [stroke], aphasia [loss of ability to understand or express speech,] anemia, depression, and schizophrenia.</p> <p>Resident #3's Admission Minimum Data Set (MDS) assessment, dated 5/17/16, documented his cognition was severely impaired, his speech was unclear with slurred or mumbled words, and that he usually understood others. The assessment stated Resident #3 did not exhibit behaviors that interfered with staff providing cares, and he was dependent on at least 2 staff for bed mobility, transfers, dressing, and toileting. The MDS assessment documented communication was reviewed as an area of concern and would be addressed in a care plan.</p> <p>A significant change MDS assessment, dated 3/7/17, documented Resident #3's cognition was severely impaired, he had unclear speech with</p>	F 279	<p>Corrective Action:</p> <p>Resident #3's care plan related to communication was updated on 4/17/17 by the Resident Care Manager. The care plan related to CPAP settings for Resident # 7 was updated by the Staff Development Coordinator on 4/6/17. Resident #6 was evaluated by the Physician Assistant on 4/5/17 and determined that CPAP is no long clinically indicated at this time.</p> <p>Identification of Others:</p> <p>As this has the potential to affect other residents, a comprehensive care plan review and update was completed by the Interdisciplinary Team for residents residing in the facility on or before 5/2/17.</p> <p>Systematic Changes:</p> <p>Licensed nurses were in-serviced on care-planning and the process of updating a care plan by the Staff Development Coordinator and Director of Nursing on 4/24/17. Additionally, care plans will be reviewed for accuracy in the clinical meeting by the Interdisciplinary Team and updated as necessary based on changes in orders and the changing needs or condition of the resident.</p> <p>Monitoring:</p> <p>10 care plans will be randomly selected</p>		

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F 279	<p>Continued From page 12</p> <p>slurred or mumbled words, and he usually understood others. The MDS assessment stated Resident #3 had not exhibited behaviors that interfered with staff providing cares, and he was dependent on at least 2 staff for bed mobility, transfers, dressing, and toileting. The MDS assessment documented communication was reviewed as an area of concern and would be addressed in a care plan.</p> <p>A Physician Progress Note, dated 7/13/16, documented Resident #3 was "not communicating well."</p> <p>An acute care History and Physical, dated 2/10/17, documented Resident #3 was "not interactive."</p> <p>An acute care History and Physical, dated 3/19/17, documented Resident #3 did "not attempt to communicate."</p> <p>A Behavior Monitoring Flowsheet, dated 4/2017, identified isolation and refusal to talk as behaviors. The trigger identified for this behavior was not recognizing staff members, and staff were directed to:</p> <ul style="list-style-type: none"> * Introduce self * Explain plan of care * Ask yes/no questions * Make eye contact when talking to Resident #3. <p>On 4/3/17 at 2:07 pm, Resident #3 did not respond when greeted.</p> <p>On 4/4/17 at 8:15 am, Resident #3 was observed lying in bed. Resident #3 did not respond verbally</p>	F 279	<p>and audited per week by the Director of Nursing or designee for 4 weeks beginning 5/17/17 and monthly for 2 months thereafter to validate that care plans continue to be accurate and comprehensive. The results of the audits will be brought to the monthly Quality Assurance meeting for review and recommendation for 3 months and as needed beginning with the next Quality Assurance meeting scheduled for 5/17/17. The Director of Nursing will be responsible for ongoing compliance.</p>		

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F 279	<p>Continued From page 13 to communication, but turned his head to make eye contact without attempting to speak.</p> <p>On 4/5/17 at 7:50 pm, Certified Nursing Assistant (CNA) #4 stated Resident #3 was not "super talkative." She stated Resident #3 sometimes spoke to other CNAs, but that was primarily by stating or nodding "yes" or "no."</p> <p>On 4/6/17 at 11:30 am, Resident Care Manager #2 stated the behavior monitoring flowsheet for Resident #3 refusing to talk was incorrect and there should have been a communication care plan addressing his diagnosis of aphasia related to the CVA.</p> <p>2. Resident #6 was admitted to the facility on 1/25/17, with multiple diagnoses including traumatic brain injury (TBI).</p> <p>An Admission MDS Assessment, dated 1/25/17, documented the Resident #6 used a BiPAP/CPAP.</p> <p>A physician's telephone order, dated 1/26/17, documented, "Res to use CPAP per home settings at HS..."</p> <p>Resident #6's Respiratory Care Plan documented the resident was to wear the CPAP "as ordered by MD"</p> <p>A Nurse's Note, dated 1/25/17, documented "[Family member] states CPAP at home and that he wears O2 [at] 2 L [liters] via NC [nasal cannula]..."</p> <p>Resident #6's January 2017 Treatment</p>	F 279			

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F 279	<p>Continued From page 14</p> <p>Administration Record [TAR] documented, "CPAP/BiPAP machine by shift starting 1/30/17 - Obstructive Sleep Apnea, CPAP machine [at] NOC [night] per home settings."</p> <p>Resident #6's care plan did not include information related to the CPAP's setting, type of water to be used, or related to the care and cleaning of the CPAP machine.</p> <p>On 4/6/17 at 11:45 am, the Staff Development Coordinator said Resident #6's Respiratory Care Plan should have included information about the CPAP's setting, water type, and care and cleaning of the machine.</p> <p>3. Resident #7 was admitted to the facility on 3/27/17 with multiple diagnoses, including rehabilitation after a surgical repair of multiple fractured ribs, sleep apnea, and diabetes.</p> <p>Resident #7's Admission MDS assessment, dated 3/27/17, documented he used a BiPAP/CPAP.</p> <p>The Respiratory Care Plan documented Resident #7 had sleep apnea and used a CPAP.</p> <p>Resident #7's admission orders, dated 3/27/17, included an order for the use of a CPAP machine with 1.5 liters per minute of oxygen at bedtime.</p> <p>A physician assistant's progress note, dated 3/29/17, documented Resident #6 had sleep apnea and was to continue using a CPAP machine.</p> <p>A Nurse's Admitting Note, dated, 3/27/17 at 6:00</p>	F 279			

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F 279	Continued From page 15 pm, documented Resident #6 used a CPAP at bedtime with 1.5 liters of oxygen. Resident #7's April 2017 TAR did not include information that he was using a CPAP at night. On 4/5/17 at 3:40 pm, Resident #7 said he was using his CPAP machine every night at bedtime in the facility, but the staff was not adding water to the machine prior to him using it. Resident #7 said he informed the staff that the machine required distilled water but he was told that distilled water was not available in the facility. Resident #7 said he often awoke at night from a dry mouth and throat. Resident #7 said he recently slept uninterrupted through the night for the first time since admission to the facility because staff had added distilled water to his CPAP machine. Resident #7's care plan did not include information related to the CPAP's setting, type of water to be used, or related to the care and cleaning of the CPAP machine. On 4/6/17 at 11:21 am, the DON said Resident # 7's TAR should have documented that he was using a CPAP. She stated the CPAP was included in Resident #7's 3/27/17 admission orders, but the order was unintentionally left off of the April 2017 physician's orders.	F 279			
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 281		5/17/17	

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F 281	<p>Continued From page 16</p> <p>must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure physician orders for dosages of sliding scale insulin were transcribed correctly and neurological assessments were done/completed after unwitnessed falls. This was true for 1 of 3 residents (#1) reviewed for diabetes management and 1 of 4 residents reviewed (#2) for falls. The failures created the potential for more than minimal harm if Resident #1 received the wrong dose of insulin due to the incorrect transcription and for neurological changes to go undetected and untreated when Resident #2's neurological status was not monitored and/or neuro checks were not completed. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 2/3/14, and was readmitted on 3/28/17, with diagnoses including chronic kidney disease and dialysis.</p> <p>A physician's "clarification" telephone order, dated 3/28/17, documented the following Novolog insulin dosages for the corresponding blood glucose [BG] mg/dl [milligram per deciliter] levels:</p> <p>0-150 = 0 unit 151 - 200 = 2 units 201 - 250 = 3 units 251 - 300 = 4 units 301 - 350 = 5 units</p>	F 281	<p>Corrective Action: A clarification order for Resident #1's sliding scale insulin was obtained on 4/6/17 by the Resident Care Manager assigned to that resident. A neurological assessment was conducted by Resident #2's assigned nurse on 5/8/17 with no change in condition noted.</p> <p>Identification of Others: As this has the potential to affect other residents, a comprehensive review of all physician orders was conducted by the resident care managers in conjunction with the monthly recapitulation of orders on or before 5/3/17 to validate that the orders were transcribed as written. An audit of events in the past 45 days requiring neurological assessments was conducted by the Director of Nursing on or before 5/12/17 to validate neurological assessments were conducted as required.</p> <p>Systematic Changes: A licensed nurse in-service was conducted by the DNS and Staff Development Coordinator on 4/24/17. The in-service included directions on how to transcribe orders. Licensed nurses will have another in-service conducted by the DNS or designee on or before 5/17/17. This in-service will include instructions on</p>		

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F 281	<p>Continued From page 17</p> <p>Staff were to contact the physician for BG levels less than 80 mg/dl, or greater than 350 mg/dl.</p> <p>Resident #1's April 2017 electronic recapitulated physician's orders, dated 3/28/17, directed staff to provide Novolog insulin four times daily per sliding scale. The number of units of insulin for each of the sliding scale parameters was overwritten with a different number of units. The number of units overwritten matched the 3/28/17 clarification order.</p> <p>Resident #1's April 2017 electronic Medications record documented the 3/28/17 clarification order for insulin per sliding scale. The overwritten units were crossed out and another insulin sliding scale was written as follows:</p> <p>0 - 150 = 0 unit 151 - 200 = 1 units 201 - 250 = 2 units 251 - 300 = 3 units 301 - 350 = 4 units</p> <p>Again, staff were to contact the physician for BGs less than 80 mg/dl, or greater than 350 mg/dl.</p> <p>On 4/6/17 at 11:15 am, RCM #1 said she did not know why the order was crossed out. She stated the previous order should have been discontinued and the new order should have been written anew.</p> <p>2. Resident #2 was admitted to the facility on 9/23/16 with multiple diagnoses, including falls, altered mental status, rhabdomyolysis (rapid destruction of muscle tissue) and 2 deep tissue injuries (DTIs).</p>	F 281	<p>when and how to perform neurological assessments.</p> <p>Monitoring: Audits will be conducted 3 times weekly by the Director of Nursing or designee beginning 5/17/17 to validate that orders are transcribed as required and neurological assessments are completed as required. The results of these audits will be shared at the Quality Assurance Performance Improvement (QAPI) meeting for 3 months, starting with the next QAPI meeting scheduled for 5/17/17. After 3 months, the need for continued auditing will be reviewed. The Director of Nursing is responsible for ongoing compliance.</p>		

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F 281	<p>Continued From page 18</p> <p>Resident #2's admission Minimum Data Set (MDS) assessment, dated 9/30/16, documented short and long-term memory impairment, moderately impaired cognition, total assistance with bed mobility, extensive assistance with transfers, dressing and toileting, a history of falls and 2 falls without injury. His most recent quarterly MDS assessment, dated 3/13/17, documented severely impaired cognition, extensive assistance with bed mobility, transfers, dressing and toileting, 2 falls without injury and 1 fall with a non-major injury.</p> <p>A Fall Risk Care Plan, dated 9/27/16, identified Resident #2's history of falls and high risk for falls as problem areas. Approaches included neurological checks at time of fall(s).</p> <p>Resident #2's Anticoagulation Therapy Care Plan, dated 9/27/16, identified the potential for injury, bleeding, and bruising. Approaches included Lovenox [blood-thinning medication] per physician orders and to report new bruising. The resident's 9/23/16 admission orders included daily Lovenox injections.</p> <p>Resident #2's Fall Event Investigation Reports documented:</p> <ul style="list-style-type: none"> * 10/1/16 at 8:15 pm - unwitnessed fall from bed, neuro checks 8:15 pm to 10:00 pm, blank from 10:30 pm to 2:30 am on 10/2/16 (4 hours), then resumed from 6:30 am to 6:00 pm. * 10/3/16 at 10:00 pm - unwitnessed fall from bed, neuro checks initiated at 10:00 pm and done until 10/5/16 at 2:00 pm, then blank at 10:00 pm on 10/5/16, and done at 6:00 am, 2:00 pm and 	F 281			

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F 281	<p>Continued From page 19 10:00 pm on 10/6/16.</p> <p>* 11/12/16 at 3:00 pm - unwitnessed fall from wheelchair while "alone and unattended" in his room, 5 cm by 4 cm hematoma to the right forehead, sent to Emergency Room (ER), returned to the facility, neurological checks initiated but not completed per the guidelines for every 15 minutes times 4, every 30 minutes times 2, every hour times 2, and every 4 hours times 5.</p> <p>* 11/17/16 at 12:20 am - unwitnessed fall from bed, last toileted at 9:50 pm, sustained "large swollen area" and a laceration in the swollen area above the (R) eye, sent to ER, neurological checks were done on "9/17/16" at 9:30 am, 1:30 pm, 5:30 pm, 9:00 pm, and on "9/18/16" at 1:00 am. No other neuro check documentation was found with this fall event report and none was provided by the facility.</p> <p>* 12/27/16 at 9:15 pm - unwitnessed fall and the Licensed Nurse (LN) and Certified Nursing Assistant (CNA) assigned to the hall were "both in other resident's [sic] rooms during the time of fall. He stated he...went looking for some water. Resident is unaware of own limitations and attempted to ambulate without supervision...Water mug to be place [sic] close to patient when he is by nurse cart or by nurse station..." Neurological checks were not attached to the event report and none were provided after requested of the Director of Nursing (DON) on 4/7/17 at 10:00 am.</p> <p>* 1/4/17 at 1:30 pm - unwitnessed fall, left forehead hematoma "without laceration, small gap with very little blood out of area" and "...to</p>	F 281			

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F 281	Continued From page 20 lunch...brought back and left next to nurse med cart...Nurse gone to assist in another room...heard patient calling for help from his rest room...Neuro[logical]'s were started, first aid provided...transported to ER for further evaluation..." The neuro checks resumed when the resident returned to the facility at 5:30 pm; but were not done every 8 hours for the remaining 72 hours after the fall, per the guidelines on the Neurological Check Flowsheet.	F 281			
F 309 SS=G	On 4/7/17 at 11:00 am, the DON said neuro checks were not always performed or not always completed after Resident #2's falls. 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:	F 309		5/17/17	

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F 309	<p>Continued From page 21</p> <p>(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, and record review, it was determined the facility failed to:</p> <p>a) Clarify vague surgical incision care orders and/or follow subsequent incision care orders, consistently monitor surgical incisions, or develop a surgical incision care plan; b) Obtain wound care orders, consistently monitor, or develop a care plan for a laceration with staples; c) Consistently monitor residents' pain and/or the efficacy of prn medications after administration; d) Ensure residents' bowel care needs were met; and e) Ensure an access device for dialysis was monitored.</p> <p>This was true for 2 of 3 residents (#7 & #14) reviewed for surgical incisions or lacerations; 2 of 15 residents (#13 & #14) reviewed for pain and/or prn medication use; for 1 of 15 residents (#13) reviewed for bowel care, and 1 of 2</p>	F 309	<p>Corrective Action: No further action is warranted for Resident #14 as he was discharged on 1/31/17. No further action is warranted for resident #13 as she was discharged on 12/30/16. Resident #7 was discharged from the facility on 4/14/17 and readmitted to the facility on 4/21/17. Upon readmission, orders for surgical site monitoring were obtained and a care plan for monitoring was initiated by the resident care manager. Resident #1's dialysis monitoring flowsheet was revised on 4/7/17 by the licensed nurse.</p> <p>Identification of Others: A comprehensive surgical incision and wound audit will be completed by the Director on Nursing or designee on or before 5/17/17. The auditor will validate that surgical incision care orders and wound care orders are present and clear,</p>		

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F 309	<p>Continued From page 22</p> <p>residents (#1) reviewed for dialysis. Resident #14 was harmed when his surgical incision became infected and dehiscd (separation of all layers of an incision) requiring emergency room (ER) care and hospitalization for a wound infection and renal [kidney] failure. The residents were also at risk for more than minimal harm when Resident #7's surgical incision and #14's stapled head laceration were not consistently monitored and assessed; Resident #13 and #14's pain was not recognized and/or adequately managed; Resident #13's bowel care needs were not recognized or addressed; and Resident #1's dialysis access device was not care planned or monitored. Findings include:</p> <p>1. Resident #14 was admitted to the facility on 1/19/17, with multiple diagnoses including left rib fractures that required "rib plating" [surgery where plates and screws are used to stabilize broken ribs] related to a fall, left pneumothorax [collapsed lung], and cognitive decline/early dementia.</p> <p>a. Resident #14's admission nursing note, dated 1/19/17 at 9:35 pm, documented, "Surgical sites at left side of spine."</p> <p>Resident #14's Transitional Care Unit/Skilled Nursing Facility (TCU/SNF) Admission Orders, dated 1/19/17, documented, "Dressing/Wound Instructions: Cover [with] Dressing." However, his facility Admission Orders, also dated 1/19/17, documented, "L (left) thoracic incision - keep drsg (dressing) clean, dry, and intact (CDI). Only change prn (as needed) for drsg failure."</p> <p>On 4/5/17 at 5:45 pm, the Director of Nursing</p>	F 309	<p>that surgical incisions and wounds are routinely monitored and that each resident with a surgical incision or wound has a surgical incision or wound care plan present.</p> <p>An audit by the Assistant Nursing Home Administrator was conducted on 4/19/17 to validate that pain monitoring flowsheets and bowel monitoring flowsheets were present for each resident within the facility. An audit was conducted on 4/25/17 by the Regional Vice President and the Assistant Nursing Home Administrator to validate that efficacy of as-needed medications are documented as required. An audit will be completed by the DNS or designee on or before 5/17/17 to ensure that resident bowel care needs are met as required.</p> <p>An audit of dialysis flowsheets for all residents receiving dialysis was conducted by the Assistant Nursing Home Administrator on 4/24/17 to validate that required monitoring is in place.</p> <p>Systematic Changes: A root cause analysis was conducted by the Interdisciplinary Team on 5/12/17 and an in-service will be conducted for licensed nurses by the Director of Nursing, Staff Development Coordinator or designee on or before 5/17/17. The in-service will include assessment, monitoring, care planning and treatment of surgical incisions and wounds. The in-service will also include pain monitoring, documentation of as needed medication efficacy after administration,</p>		

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F 309	<p>Continued From page 23</p> <p>(DON) said a Hospitalist "clarified" the surgical incision wound care orders when he signed the facility Admission Orders on 1/20/17, the day after admission to the facility. The DON said that some physicians do not want the dressing removed unless the dressing fails. The DON said there were no other orders or documentation of facility attempts or requests for clarification of Resident #14's surgical incision wound care/dressing orders. The DON did not explain how the 1/19/17 TCU/SNF order, to cover the surgical incision with a dressing, was changed to the facility's 1/19/17 Admission Orders to keep the dressing CDI and change only for dressing failure.</p> <p>Resident #14's care plan identified the potential for alteration in skin integrity on 1/20/17, with a goal to maintain skin integrity. The 1/20/17 "Admit Care Plan" identified a decline in health status, left rib fractures, and falls as problem areas. However, the care plan did not address the surgical site.</p> <p>Resident #14's January 2017 Treatments record included the order to keep the left thoracic dressing CDI and only change the dressing prn for dressing failure. All of the spaces to document prn dressing changes were blank from 1/19/17 to 1/31/17.</p> <p>One Nurse's Note, dated 1/21/17 at 10:15 pm, documented the dressing was changed due to failure and "leaking."</p> <p>Resident 14's general surgeon documented on 1/25/17, "...some delayed healing at the superior part of his incision please replace steri strips as</p>	F 309	<p>management of resident bowel care needs and monitoring of dialysis access devices.</p> <p>Monitoring: Compliance audits will be conducted 5 times a week for 4 weeks and weekly thereafter by the Director of Nursing or designee beginning 5/17/17 to validate that surgical wounds are assessed, monitored and care planned, pain is monitored and efficacy of as needed medications are documented, resident bowel care needs are met and dialysis access devices continue to be monitored by licensed nurses as required. The results of these audits will be shared at the Quality Assurance Performance Improvement (QAPI) meeting for 3 months, starting with the next QAPI meeting scheduled for 5/17/17. After 3 months, the need for continued auditing will be reviewed. The Director of Nursing is responsible for ongoing compliance.</p>		

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F 309	<p>Continued From page 24 they fall off."</p> <p>Resident #14's January 2017 Medications and Treatments records did not include the order to replace the steri strips as they fell off. Nor was it included on Resident #14's care plan or mentioned in Nurse's Notes for January 2017.</p> <p>There was no documented evidence that facility nurses were aware of the 1/25/17 order to replace the steri strips and no evidence Resident #14's back incision was consistently monitored by facility staff.</p> <p>A 1/30/17 at 10:10 pm Nurse's Note documented, "Surgical incision on back has s/s of infection. MD (Medical Doctor) aware, MD gave instructions to set-up appointment with [general surgeon]." The next evening, a 1/31/17 at 7:00 pm Nurse's Note documented Resident #14's back incision dehisced (separated) and there was purulent drainage [drainage that green, yellow, brown or white in color and is a thick liquid, almost always a clear sign of infection], in the wound for which the resident was sent to an ER. A 1/31/17 at 11:00 pm Nurse's Note documented Resident #14 was admitted to the hospital for an infection to the wound and renal failure.</p> <p>On 4/7/17 at 10:00 am, the Regional Director of Clinical Operations (RDCO) said there was no documentation that the status of the steri strips was monitored or that steri strips were replaced.</p> <p>Resident #14 was harmed when the facility failed to clarify wound care orders, consistently monitor a surgical incision and to follow subsequent</p>	F 309			

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F 309	<p>Continued From page 25</p> <p>orders forsteri strips to be replaced as they fell off. The resident's surgical incision became infected and dehiscd (opened) requiring transport for emergent care and hospitalization for an infected incision and renal failure.</p> <p>b. A 1/19/17 facility Occurrence Report documented Resident #14 had an unwitnessed fall in the bathroom at 6:00 pm, which resulted in a head injury with a "2 cm laceration with minor bleeding." The report documented Resident #14 was transported by ambulance to a hospital ER at 6:20 pm.</p> <p>A Nurse's Note, dated 1/19/17 at 9:35 pm, documented Resident #14 returned to the facility on 1/19/17 with "3 staples" in place to the head laceration. The head laceration with staples was not mentioned in other Nurse's Notes through 1/31/17, nor was it addressed in Resident #14's care plan or Medications and Treatments records for January 2017. No orders regarding the care/treatment of the head laceration with staples and no documented evidence of attempts to contact the physician for orders were found in the resident's clinical record.</p> <p>Resident #14's January 2017 Medications and Treatment records did not include monitoring or care/treatment of the head laceration with staples. In addition, "no new skin impairment" was added to Resident #14's Treatments record on 1/26/17.</p> <p>There was no documented evidence the facility monitored the head laceration with staples from 1/20/17 to 1/31/17 (11 days) or provided any type of care or treatment to the wound.</p>	F 309			

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F 309	<p>Continued From page 26</p> <p>c. Resident #14's pain care plan, dated 1/20/17, identified statements of pain and facial grimaces as problem/concern areas with goals for relief from pain within one hour of administration of pain medication(s) and for pain to be controlled at "0-4" on a scale of "1-10."</p> <p>Resident #14's TCU/SNF Admission Orders and facility Admission Orders, both dated 1/19/17, documented Tramadol 1 tablet every 4 hours prn pain.</p> <p>Resident #14's January 2017 Medications record included orders to monitor pain every shift (days and nights) beginning 1/19/17. The pain monitoring flow sheet for the 1/26/17 day shift was blank, and pain was documented as zero on both shifts thereafter through the day shift on 1/31/17.</p> <p>Occupational Therapy (OT) Treatment Encounter Notes documented, "...high level of pain today...progress is limited by pain and confusion" on 1/26/17; "...pain increased throughout session to high...reduced alertness today" on 1/27/17, and "...greatly limited by pain..." on 1/30/17.</p> <p>Resident #14's prn Tramadol was not monitored for efficacy 4 of 17 times (24%) after it was administered. The space to document the "result" of the prn pain medication was blank following administration on 1/19/17 at 10:20 pm, 1/21/17 at 4:00 am, 1/24/17 (time illegible), and 1/31/17 at 7:15 am. The efficacy of the prn medication was not documented in Nurse's Notes for those dates and times.</p>	F 309			

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F 309	<p>Continued From page 27</p> <p>On 4/7/17 at 11:00 am, the RDCO said Resident #14's prn Tramadol was not consistently monitored for efficacy.</p> <p>2. Resident #13 was admitted to the facility on 12/15/16, with multiple diagnoses including acute and subacute compression fractures in the thoracic spine, status/post vertebroplasty [a special cement is injected into a fractured vertebra to relieve pain and restore mobility], and sensitivity to narcotic pain medication. Resident #13 was discharged home on 12/30/16.</p> <p>Resident #13's "Admit Care Plan" documented compression fractures and vertebroplasty as problem areas on 12/15/16, with approaches of medications per orders and monitor pain every shift and medicate prn. A 12/15/16 "Pain - IDT [Interdisciplinary Team] Care Plan" also documented "Statements of pain" as a problem with a goal for relief from pain within one hour of administration pain medications. In addition, an Initial Care Plan: At Risk for Constipation, identified on 12/18/16, included an intervention to monitor bowel function daily.</p> <p>Resident #13's TCU/SNF Admission Orders and facility Admission Orders, both dated 12/15/16, documented orders for Percocet 5/325 mg, one tablet every 4 hours prn pain, Ibuprofen 600 mg TID prn pain, and Baclofen 10 mg TID prn muscle spasms. No bowel medications or protocols were included in Resident #13's admission orders, or in subsequent orders.</p> <p>Attached to the facility Admission Orders was an "Admission Orders - Administration Record" which documented APAP (Acetaminophen) 325</p>	F 309			

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F 309	<p>Continued From page 28</p> <p>mg/Oxycodone 7.5 mg every 4 hours prn, was also ordered. A single line was drawn through the order. The single line was not dated or initialed.</p> <p>a. Resident #13's prn pain and muscle relaxant medications were not consistently monitored for efficacy as follows:</p> <ul style="list-style-type: none"> * The facility "Admission Orders - Administration Record" documented APAP/oxycodone was administered on 12/16/16. The efficacy of the medication was not monitored. * The December 2016 Medications record contained documentation that the efficacy of prn Baclofen (muscle relaxant) was not monitored 2 of the 3 times it was administered. * The December 2016 Medications record contained documentation that the efficacy of prn ibuprofen was not monitored 2 of the 6 times it was administered. <p>The efficacy of the prn APAP/oxycodone, Baclofen, and ibuprofen medications was not documented in Resident #13's Nurse's Notes from 12/15/16 through 12/30/16. In addition, Nurse's Notes, dated 12/15/16 to 12/30/16, and the December 2016 MAR, contained documentation that the resident's pain was not assessed for 8 days from 12/15/16 through the day shift on 12/24/16.</p> <p>b. Resident #13's Bowel Monitor Flowsheet was blank from 12/15/16 to 12/23/16, indicating Resident #13 did not have a bowel movement (BM) for 8 days. In addition, Resident #13's undated Bowel Monitor for Continence or Incontinence form was blank 7 of 48 opportunities for documentation (15%) with a</p>	F 309			

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F 309	<p>Continued From page 29</p> <p>minus sign documented to note bowel continence the other times. The minus sign did not indicate whether the resident had a BM or not.</p> <p>Nurse's Notes, for 12/15/16 through 12/30/16, did not document whether Resident #13 had a BM. In addition, no orders for a bowel protocol/medication(s) were located in the resident's clinical record.</p> <p>On 4/7/17 at 12:40 pm, the DON said the efficacy of Resident #13's pain was not monitored every shift and prn pain and muscle relaxant medications were not always monitored for efficacy. The DON said Resident #13's BM flowsheet was blank from 12/15/16 to 12/23/16, and that BMs were not documented elsewhere in the clinical record. At 3:00 pm, the DON said there were no orders for bowel medications or a bowel protocol.</p> <p>3. Resident #7 was admitted to the facility on 3/27/17, with multiple diagnoses including rehabilitation after a surgical repair of multiple fractured ribs, sleep apnea, and diabetes.</p> <p>Resident #7's Admitting Nurse's Notes, dated 3/27/17 at 6:00 pm, documented a surgical incision under the left arm with staples described as clean, dry, intact, and open to air.</p> <p>Resident #7's care plan documented pain as a problem related to a fractured clavicle and ribs, and the potential for skin impairment. Resident #7's care plan did not address the surgical incision.</p> <p>Resident #7's Weekly Skin Evaluations, dated</p>	F 309			

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F 309	<p>Continued From page 30</p> <p>3/27/17 and 4/5/17, documented the surgical wound was pink and measured 0.75 cm in length x 20 cm in width x 0 cm in depth, no discharge, had no odor, and the surrounding skin was described as normal.</p> <p>Resident #7's April 2017 Treatment Administration Record (TAR) directed staff to conduct weekly "head-to-toe" skin assessment and initiate a wound form for any new impairment. Other than documentation that no new impairment was noted on 4/5/17, Resident #7's clinical record contained no evidence the surgical wound was assessed or monitored for signs and symptoms of infection.</p> <p>On 4/7/17 at 11:21 am, the Regional Director of Clinical Services said facility nurses were responsible for monitoring any surgical wound for signs/symptoms of infection every shift.</p> <p>4. Resident #1 was admitted to the facility on 2/3/14, and was readmitted on 3/28/17, with diagnoses including chronic kidney disease and dialysis.</p> <p>Resident #1's Dialysis Care Plan, dated 3/29/17, documented the following interventions:</p> <ul style="list-style-type: none"> * Dialysis Mondays, Wednesdays and Fridays * Facility to provide sack lunch for the resident * Monitor dialysis catheter on the right chest permacath [external catheter placed into the large central veins of the chest or upper arm as a dialysis access site] for signs and symptoms of infection, edema, ischemia [insufficient blood supply to an organ usually due to obstruction], bleeding, dislodgement, and presence of catheter 	F 309			

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F 309	<p>Continued From page 31</p> <p>cap in place every shift, and document any change/abnormality in progress notes and notify physician.</p> <p>* Monitor extremity or area of fistula or graft</p> <p>Resident #1's Dialysis Flow Sheet, from 4/1/17 to 4/6/17, documented the following were being monitored:</p> <p>* Dialysis catheter on right upper chest for signs and symptoms infection, edema, ischemia, bleeding, dislodgement and presence of catheter cap in place each shift</p> <p>* Palpate fistula or graft for presence or absence of thrill [vibration of blood going through your arm] every shift and document</p> <p>* Auscultate [listening for sounds produced within the body with a stethoscope] fistula or graft for bruit (rushing sound), presence or absence every shift</p> <p>* Monitor extremity [arms or legs] or area of fistula or graft for changes in circulation, movement, and sensation</p> <p>* Document any changes in progress notes and notify MD</p> <p>On 4/5/17 at 9:50 am, two catheter ports were observed on Resident #1's upper chest. The resident said they were used for dialysis. There was no dialysis access device, such as a fistula or graft, on either of the resident's arms.</p> <p>On 4/7/17 at 3:30 pm, the Regional Director of Clinical Services, when shown Resident #6's Dialysis Flow Sheet, shook her head and said nurses should have only monitored the permacath for signs and symptoms of infection and/or bleeding, and to ensure the dressing was</p>	F 309			

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F 309	Continued From page 32 intact.	F 309			
F 314 SS=G	<p>483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>(b) Skin Integrity -</p> <p>(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and interested party interview, and record review, it was determined the facility failed to thoroughly assess and monitor existing pressure ulcers (PU)s in a timely manner, clarify vague orders, and/or follow PU treatment orders, and prevent the development of avoidable PUs. This was true for 2 of 5 sample residents (#2 & #3) reviewed for PUs. Resident #2 was harmed when one of two existing deep tissue injury (DTI) PUs deteriorated and required surgical debridement and Resident #3 was at risk for more than minimal harm when an avoidable Stage II PU developed. Findings include:</p> <p>1. Resident #2 was admitted to the facility on</p>	F 314	<p>Corrective Action: An assessment by the RN Resident Care Manager of Resident #2 was conducted and documented 5/8/17 and Resident #3's pressure ulcer was assessed and documented on 5/9/17. At that time, wound care orders were reviewed and verified by the Resident Care Manager and the care plan was reviewed and updated as appropriate.</p> <p>Identification of Others: As this has the potential to affect other residents, a house-wide audit was conducted by the Staff Development</p>	5/17/17	

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F 314	<p>Continued From page 33</p> <p>9/23/16 with multiple diagnoses, including falls, altered mental status, rhabdomyolysis with a right thorax DTI and a right greater trochanter (hip) DTI.</p> <p>Resident #2's 9/30/16 admission Minimum Data Set (MDS) assessment documented short and long-term memory impairment, moderately impaired cognition, and 2 unstageable PUs with eschar. The resident's 10/24/16 significant change MDS assessment documented the same as well as a surgical incision; and, the 3/13/17 quarterly MDS assessment documented healed PUs and 1 Stage IV PU with granulation tissue in the wound bed.</p> <p>Resident #2's 9/26/16 Alteration in Skin Integrity initial care plan documented DTIs at the right shoulder and right hip. Approaches included treatment per orders and weekly skin evaluations. On 11/22/16, "hematoma surg[ical] site self inflicted scratch," was added to the care plan.</p> <p>Resident #2's Transitional Care Unit/Skilled Nursing Facility (TCU/SNF) Admission Orders, dated 9/23/16, documented "Wound Care," however, the space for the wound care instructions was blank.</p> <p>Resident #2's facility Admission Orders, also dated 9/23/16, did not include wound care treatment orders or instructions. In addition, there was no documentation in the resident's clinical record of attempts to contact the physician or Wound Clinic for clarification of the vague wound care order.</p>	F 314	<p>Coordinator on or before 5/17/17 to identify any other residents with pressure ulcers in the facility and validate that assessments are being conducted timely and thoroughly, that ongoing monitoring is being conducted, that treatment orders for pressure ulcers are in place and adhered to, and that preventative measures are in place to prevent the development of avoidable pressure ulcers.</p> <p>Systematic Changes: A root cause analysis was conducted on 5/12/17 by the Interdisciplinary Team. On 4/24/17, licensed nurses were in-serviced by the Director of Nursing and Staff Development Coordinator on the procedures of how to assess and monitor existing pressure ulcers, how to request, clarify and follow pressure ulcer treatment orders, and how to prevent the development of avoidable pressure ulcers.</p> <p>Monitoring: Compliance audits will be conducted 5 times a week for 4 weeks and weekly thereafter by the DNS or designee beginning 5/17/17 to validate that nurses continue to assess and monitor pressure ulcers, clarify and follow pressure ulcer treatment orders, and implement interventions to prevent pressure ulcers from developing as required. The results of these audits will be shared at the Quality Assurance Performance Improvement (QAPI) meeting for 3 months, starting with the next QAPI</p>		

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F 314	<p>Continued From page 34</p> <p>Resident #2's Nursing Admission Evaluation, dated 9/23/16 at 3:34 pm, documented a back view of a body diagram with a vertical line below the right shoulder to the waist and a vertical line below the right gluteal fold to mid thigh. "Wound care" was written by each of these vertical lines.</p> <p>On 9/26/16, three days after admission, a Physician Assistant's (PA's) order for the right shoulder and right hip PUs documented staff were use normal saline, pat the PU dry, apply Bacitracin, non-stick dressing, and cover the PUs with exudry and tape every 3 days, and prn (as needed) for dressing failure.</p> <p>A Nurse's Note, dated 9/26/17 at 5:00 pm, documented measurements for the right shoulder and right hip PUs but did not include any other characteristics for either of the PUs, such as Stage, drainage, odor or condition of the periwound skin.</p> <p>An "Admission Body Assessment," dated 9/27/16, 4 days after Resident #2's admission, documented circled areas below the right posterior shoulder and at the right hip. "Stage II" with a single line drawn through it was written next to both of the circled areas. "Deep tissue" and "hematoma" was also written by the shoulder area and "Deep Tissue" was also written by the hip area.</p> <p>On 4/7/17 at 10:00 am, the Director of Nursing (DON) said an Licensed Practical Nurse (LPN) admitted the resident on 9/23/16 and the facility did not allow LPNs to stage PUs. The DON said the admission order for PU wound care was clarified on 9/26/16, and an RN reassessed</p>	F 314	meeting scheduled for 5/17/17. After 3 months, the need for continued auditing will be reviewed. The Director of Nursing is responsible for ongoing compliance.		

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F 314	<p>Continued From page 35 Resident #2's PUs on 9/27/16.</p> <p>Resident #2's September 2016 Treatments record documented the right shoulder and right hip PU wound care/dressing changes were completed on 9/26/16 and 9/28/16.</p> <p>On 9/28/16, a referral to a wound care clinic was ordered.</p> <p>On 10/4/16, Resident #2's PUs were assessed and treated at a wound clinic. The wound clinic changed the right hip wound care/dressing orders to daily, and prn for dressing failure, with an enzymatic debriding agent. The wound clinic also changed the right shoulder wound care/dressing orders to every other day, and prn dressing failure, using a barrier ointment and foam dressing. The wound clinic documented Resident #2 was to return to the wound clinic in one week.</p> <p>Resident #2's October Treatments record documented the 10/4/16 order for the right hip PU was implemented daily 10/6/16 through 10/8/16 and the right hip PU wound care with normal saline, pat dry, Bacitracin, non-stick dressing, exudry and tape was completed on 10/3/16, 10/6/16, 10/9/16, 10/12/16 "at wound care," on 10/15/16, and then "see new."</p> <p>The October Treatments record documented the 10/4/16 order for the right shoulder PU was implemented 10/7/16, 10/11/16, 10/13/16, 10/15/16 and 10/17/17. It also documented the right shoulder PU was cleaned with normal saline, lotion was applied to the surrounding skin, and the PU covered with a foam dressing on</p>	F 314			

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F 314	<p>Continued From page 36</p> <p>10/14/16 and 10/16/16. An order for this treatment was not found in Resident #2's clinical record and the DON did not provide the order after it was requested on 4/7/16 at 10:00 am.</p> <p>A 10/9/17 at 11:00 pm Nurse's Note, documented Resident #2's right hip "peri-wound is bright red and inflamed" and he presented with a "slight fever." The Nurse's Note documented that Tylenol reduced the fever and inflammation.</p> <p>A 10/12/16 at 4:30 pm Nurse's Note, documented the wound clinic talked to Resident #2's family about debriding [removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue] his the right hip PU and they were told it "may go to the bone."</p> <p>A 10/14/16 at 2:20 pm Nurse's Note, documented Resident #2 was seen by the physician and surgery to debride his right hip PU was scheduled for 10/17/16.</p> <p>A 10/15/16 at 8:45 pm Nurse's Note, documented black eschar in the middle of the right hip PU wound bed with "red inflamed peeling skin" around it. It also documented Resident #2 "did pull dressing off" and was "picking at the wound."</p> <p>A 10/17/16 untimed Nurse's Note documented, "surgical debridement of right (R) trochanter wound" and the facility was notified Resident #2 would stay at the hospital overnight for observation.</p> <p>On 4/6/17 at 10:30 am, Resident #2's Interested Party said that PU wound care "wasn't getting done" and frequently the dressings were not in</p>	F 314			

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F 314	<p>Continued From page 37</p> <p>place when Resident #2 arrived at the wound clinic. The Interested Party said the "lack of wound care may have contributed to delay in healing" of the right hip PU. The Interested Party said the wound clinic did all the PU wound care/dressing changes now.</p> <p>On 4/6/17 at 10:55 am, Resident #2's right hip PU dressing was observed to be clean, dry, and intact when Certified Nursing Assistant (CNA) #4 provided an incontinence brief check and there were no signs or symptoms of skin breakdown on Resident #2's right posterior shoulder/torso.</p> <p>Resident #2 was harmed when 1 of 2 DTI PUs deteriorated and required surgical debridement. The facility failed to clarify vague wound care orders on admission, did not thoroughly assess the right hip and right shoulder PUs until 4 days after admission, then performed 2 different orders for wound care and dressing changes for the right hip PU and two different orders for wound care and dressing changes to the right shoulder PU.</p> <p>2. Resident #3 was admitted to the facility on 5/5/16, with diagnoses of a history of cerebrovascular accident (CVA - stroke), aphasia (difficulty or inability to speak), anemia, depression, and schizophrenia.</p> <p>Facility staff completed a Braden Scale assessment [for predicting pressure ulcer risk], dated 5/6/16, and Resident #3 was determined to be at "high risk" for developing a pressure ulcer. Braden Scale assessments completed on 9/21/16, 2/24/17, 4/6/17, each determined he was at "high risk" of developing pressure ulcers.</p>	F 314			

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F 314	Continued From page 38 Resident #3's skin care plan related to immobility and incontinence, initiated on 5/6/16, directed staff to provide him treatment as ordered, complete weekly skin assessments, reposition him every 2 hours, make a referral to the Registered Dietician (RD), administer analgesics as ordered, monitor his nutrition and hydration status, provide him supplements as ordered, provide a pressure reduction mattress on his bed and a pressure reduction pad in the chair, and float his heels. The goal date was last reviewed and revised on 9/21/16. Resident #3's Admission Minimum Data (MDS) assessment, dated 5/17/16, documented he was severely cognitively impaired, exhibited no behaviors that interfered with staff providing cares, and was dependent on at least 2 staff for bed mobility, transfers, dressing, and toileting. The assessment documented Resident #3 had a Stage II pressure ulcer with an onset date of 5/9/16, 4 days after admission to the facility. Resident #3's physician orders, dated 5/16/16, documented, "Pressure sore to bottom: Cleanse with normal saline, cover with hydrocolloid, change every 3 days, and as needed for dressing failure." The treatment was discontinued on 5/27/16 with the notation, "Area resolved." A Nurse's Note, dated 5/27/16 at 1:40 am, documented the pressure ulcer was resolved. Resident #3's physician orders, dated 9/8/16, documented, "Wound to coccyx: Clean with normal saline, Cover with Mepilex, Change every 3 days and as needed."	F 314			

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F 314	<p>Continued From page 39</p> <p>On 9/9/16, the RD documented Resident #3 had a new Stage II pressure ulcer to the left of the coccyx and that treatment was in place.</p> <p>A Nurse's Note, dated 9/11/16, documented Resident #3's buttocks had been offloaded with pillows.</p> <p>A Nutrition, Hydration, Skin Committee (NHSC) Note, dated 9/22/16, documented Resident #3's coccyx wound had healed.</p> <p>A physician order, dated 12/17/16, directed staff to apply a hydrocolloid ultra-thin dressing to a blanchable red area of Resident #3's right buttock. Dressing changes were to take place every 3 days starting 12/28/16.</p> <p>A late entry Nurse's Note, dated 12/20/16 for 12/19/16, documented a purple area on Resident #3's buttock appeared to be healing with no open area noted. A Nurse's Note, dated 12/20/16 at 2:15 pm, documented increased skin breakdown.</p> <p>A Nurse's Note, dated 1/7/17, documented Resident #3 had no signs or symptoms of skin breakdown.</p> <p>On 4/6/17 at 10:25 am, LN #1 stated staff turned Resident #3 side-to-side, floated his heels, and used pillows to relieve pressure when the head of the bed was elevated.</p> <p>On 4/6/17 at 2:30 pm, LN #1 provided wound care to the sacral pressure ulcer. Upon completion, staff returned Resident #3 to a semi-sitting position and pushed a pillow under</p>	F 314			

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F 314	Continued From page 40 each hip/buttock. LN #1 stated the pillows were used to relieve pressure.	F 314			
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and Fall Event Investigation Reports, it was determined the facility failed to ensure supervision and toileting was provided as care planned. This was true for 2 of 4 sample residents (#2 & #6) reviewed for falls. Resident	F 323	Corrective Action: Resident #2's plan of care for toileting needs and fall prevention was reviewed and revised by the Director of Nursing on 5/9/17. Resident #6's plan of care for fall prevention was reviewed and revised by	5/17/17	

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F 323	<p>Continued From page 41</p> <p>#2 was harmed when an incision and debridement (I&D) was needed to reduce swelling and potential tissue damage from a hematoma above the right eye caused by falls. Resident #6 was at risk for more than minimal harm when the facility failed to consistently implement care planned supervision to prevent falls. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 9/23/16 with multiple diagnoses, including falls, altered mental status, rhabdomyolysis (rapid destruction of muscle tissue) and 2 deep tissue injuries (DTIs).</p> <p>Resident #2's admission Minimum Data Set (MDS) assessment, dated 9/30/16, documented short and long-term memory impairment, moderately impaired cognition, total assistance with bed mobility, extensive assistance with transfers, dressing and toileting, a history of falls and 2 falls without injury. His most recent quarterly MDS assessment, dated 3/13/17, documented severely impaired cognition, extensive assistance with bed mobility, transfers, dressing and toileting, 2 falls without injury and 1 fall with a non-major injury.</p> <p>A Fall Risk Care Plan, dated 9/27/16, identified Resident #2's history of falls and high risk for falls as problem areas. Approaches included neurological checks at time of fall(s). Care plan revisions included every 2 hour toileting, 10/3/16; the resident was to be in the common area when in his wheelchair or in bed when in his room, 10/10/16; "Not left unattended in room," 11/12/16; "Supervised while [up] in chair," 12/27/16; and water mug within reach, 12/28/16.</p>	F 323	<p>the Director of nursing on 5/9/17.</p> <p>Identification of Others: As this has the potential to affect others within the center an audit was conducted on 5/4/17 by the Interdisciplinary Team of resident fall prevention and toileting care plans with revisions completed as required.</p> <p>Systematic Changes: A root cause analysis was conducted by the Interdisciplinary Team on 5/12/17. Licensed nurses and direct care staff will be re-educated by the Staff Development Coordinator or designee on or before 5/17/17 regarding the requirement to provide supervision and toileting to prevent fall events.</p> <p>Monitoring: Beginning 5/17/17, observational audits will be conducted 5 times a week for 4 weeks and weekly for 2 months thereafter to validate that staff continue to provide supervision and toileting as required to prevent fall events. Results of these audits will be brought to the monthly Quality Assurance meeting beginning 5/17/17 for review and recommendations. After 3 months, the need for continued auditing will be re-evaluated. The Director of Nursing is responsible for ongoing compliance.</p>		

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F 323	Continued From page 42 Resident #2's Anticoagulation Therapy Care Plan, dated 9/27/16, identified the potential for injury, bleeding, and bruising. Approaches included Lovenox [blood-thinning medication] per physician orders and to report new bruising. His 9/23/16 admission orders included daily Lovenox injections. Resident #2's Fall Event Investigation Reports included: * 10/3/16 at 10:00 pm - unwitnessed fall from bed, found on floor between the bed and the wall, time last toileted was blank; root cause "Resident needed to use the restroom," initial interventions included, "Check resident every 2 hours and assist with urinal. The Interdisciplinary (IDT) Conclusion included "Toileting to be offered Q [every] 2 [hours]." * 11/12/16 at 3:00 pm - unwitnessed fall from wheelchair while "alone and unattended" in his room, 5 cm by 4 cm hematoma to the right forehead, sent to Emergency Room (ER), returned to the facility. The initial intervention was, "Resident will not be left in his room in chair." * 11/17/16 at 12:20 am - unwitnessed fall from bed, last toileted at 9:50 pm, sustained "large swollen area" and a laceration in the swollen area above the (R) eye, sent to ER; * 12/27/16 at 9:15 pm - unwitnessed fall and the Licensed Nurse (LN) and Certified Nursing Assistant (CNA) assigned to the hall were "both in other resident's [sic] rooms during the time of	F 323			

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F 323	<p>Continued From page 43</p> <p>fall. He...went looking for some water. Resident is unaware of own limitations and attempted to ambulate without supervision...Water mug to be place [sic] close to patient when he is by nurse cart or by nurse station...;"</p> <p>* 1/4/17 at 1:30 pm - unwitnessed fall, left forehead hematoma "without laceration, small gap with very little blood out of area" and "...to lunch...brought back and left next to nurse med cart...Nurse gone to assist in another room...heard patient calling for help from his rest room...first aid provided...transported to ER for further evaluation..."</p> <p>Resident #2's Nursing Notes documented:</p> <p>* 11/17/16 at 12:50 am - "...very swollen area just above his right eye...laceration to that area which was bleeding...EMT dispatch was called...left facility via ambulance at 0045 [12:45 am]."</p> <p>* 11/17/16 at 4:20 am - "...returned...Steri strips in place to wound above right (R) eye."</p> <p>* 11/17/16 at 7:10 pm - neuro checks done "this shift" and "(R) frontal lob [sic] swollen and dark purple (R) eye swollen shut."</p> <p>* 11/22/16 at 11:00 am - "...to day surgery for decompression and debridement [removal of damaged tissue or foreign objects from a wound] of forehead hematoma..."</p> <p>An 11/23/16 physician Progress Note documented, "Chief Complaint: Status post evacuation of hematoma on right superior orbital region. History Of Present Illness: ...multiple falls</p>	F 323			

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F 323	<p>Continued From page 44</p> <p>in our facility...latest one being approximately a week ago...did sustain multiple hematomas and significant bruising to the orbital regions...right one was more severe than his left...seen at Wound Care...yesterday. It was felt at that time that...right side superior orbital region needed to be debrided in order to avoid necrotic [dead] tissue. This was done last night..."</p> <p>Resident #2 was observed in his wheelchair near the nurses' station, in the common area, or the activity room with staff present on 4/4/17 at 8:30 am, 8:35 am, and 1:30 pm; on 4/5/17 at 9:30 am, 9:35 am, 10:25 am, 11:30 am, 12:40 pm, 3:00 pm, 5:35 pm, 6:00 pm, 6:30 pm, 7:30 pm, 7:50 pm and 8:00 pm; and on 4/6/17 at 9:45 am. He was observed in bed on 4/4/17 at 10:00 am and 11:15 am. He was observed in his wheelchair in his room with CNA #4 present on 4/6/17 at 10:50 am. There were no signs or symptoms (s/s) of skin breakdown on the resident's forehead during these observations.</p> <p>On 4/7/17 at 11:00 am, the DON said Resident #2's condition had improved and he was more mobile since admission. She said the staff "tried" to keep an eye on him when he was in his wheelchair.</p> <p>Resident #2 was harmed when a hematoma to his right forehead, sustained on 11/12/16, when the facility failed to provide supervision while the resident was in his wheelchair alone in his room and when the hematoma was reinjured and lacerated 5 days later, on 11/17/16, when the facility failed to toilet him for 2 and a half hours and required an incision and debridement to reduce swelling and potential tissue damage.</p>	F 323			

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F 323	<p>Continued From page 45</p> <p>2. Resident #6 was admitted to the facility on 1/25/17, with multiple diagnoses which included traumatic brain injury and acute kidney failure.</p> <p>Resident #6's Significant Change Minimum Data Set (MDS) assessment, dated 2/15/17, documented he had severely impaired cognition, a suprapubic catheter, was frequently incontinent of bowel, and required extensive assistance of 2 staff for bed mobility, transfers and toileting.</p> <p>Resident #6's current Fall Care Plan documented he experienced intermittent confusion and 1-2 falls in the month prior to admission. Interventions included:</p> <ul style="list-style-type: none"> *Complete Resident Fall Risk Assessment form every quarter and review as needed *Resident assistive device(s) to be within easy reach *Well lit, clutter free environment *Encourage resident to wear non-slip safety shoes *Keep resident clean and dry *Toileting every two hours, after meals, and before preparing for bed *Non-slip mats at bedside *Refer to therapy *Encourage resident to reposition frequently *Padded side rails x 2 *Diversional activities - 2/2/17 *During moments of distress and agitation, transport resident to nurse's station or by nurse's cart - 3/14/17 <p>On 4/4/17 at 9:00 am, Resident #6 was observed sitting in his Tilt N Space wheelchair in the TV room, with the foot rest in the elevated position,</p>	F 323			

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F 323	<p>Continued From page 46</p> <p>and trying to bend to reach his legs. At times he was observed reaching for his catheter bag which was inside the privacy bag. Resident #6's representative was with him at that time and said Resident #6 had experienced five falls since his admission to the facility.</p> <p>An Accident and Incident (I&A) Report documented Resident #6 experienced falls on:</p> <p>* 2/16/17 at 1:00 am - Resident #6 was found lying on the floor of his bedroom. He had been restless throughout the night prior to being found on the floor despite receiving PRN Ativan. Recommended intervention was to offer snacks to him at night if he was awake.</p> <p>*2/25/17 at 11:05 pm - Resident #6 was found lying on the floor of his bedroom next to his bed. The report documented he was toileted and placed in bed approximately 30 minutes prior to the fall. Recommended interventions were to consult with the physician to review and possibly change the resident's medications.</p> <p>*3/14/17 at 11:30 pm - Resident #6 was found on the floor of his bedroom. The I&A report documented, "Resident was assisted to bed at 11:00 pm. Resident became very anxious and was witnessed standing next to his bed immediately after being repositioned. Resident assisted back to bed, attends were changed...Five minutes later resident was found sitting on his bottom on the floor..." Recommended intervention was to assist the resident to the nurse's station or by the nurse's cart when he was agitated.</p>	F 323			

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F 323	<p>Continued From page 47</p> <p>*3/18/17 at 11:55 pm - Resident #6 was found on the floor of his bedroom. Recommended intervention following this fall was to review his chart for metabolic diagnosis; A1C and Blood Glucose (BG) checks for 14 days were requested.</p> <p>*3/22/17 at 6:00 pm - Resident #6 was assisted to floor after losing balance during a state of "combativeness." He was sent to the hospital to have his suprapubic catheter replaced as it was pulled during this period of agitation. The report also documented Resident #6 was in staff line-of-sight to help minimize the risk of fall. Recommended intervention following this fall were to increase his Seroquel to three times a day (TID), and continue to seek placement for him in a facility that specialized in TBI/behaviors.</p> <p>*3/27/17 at 6:00 pm - Resident #6 was found on the floor of his bedroom. An I&A documented he likely attempted to self-transfer out of bed after family left without notifying staff that they were leaving. Recommendation after this fall were to remind family to notify nurse when they were done visiting with the resident and continue to pursue placement options at facilities that specialized in TBI and behaviors.</p> <p>On 4/4/17 at 3:00 pm, Resident #6 was observed sitting by the nurse's station in his Tilt N Space wheelchair. He was sitting forward and pushing himself up as if attempting to rise. The ED approached Resident #6 and wheeled him to the Activity Room.</p> <p>On 4/4/17 at 3:10 pm, Resident #6 was observed being wheeled from the Activity Room. The</p>	F 323			

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F 323	<p>Continued From page 48</p> <p>Activity Director said Resident #6 was getting agitated and she would bring him outside.</p> <p>Resident #6 was observed in the dining room on 4/5/17 at following times:</p> <p>*5:30 pm - Resident #6 was observed in the dining room, sitting at a table by himself. The DON, Resident Care Manager (RCM) #2, Staff Development Coordinator (SDC), and two Certified Nursing Assistants (CNAs) were observed in the dining room distributing drinks to residents. Resident #6 was observed drinking a glass of milk, and on his table were two empty glasses. When he finished drinking his milk, Resident #6 moved his chair back from the table and tried to push himself up to stand. He was able to turn his chair around when a female resident on the other table yelled at him. RCM #2 walk hurriedly to Resident #6, who at this time had his left leg over the arm rest. RCM #2 spoke to Resident #6 and positioned him back at the table. The RCM left Resident #6 alone at the table and continued to help other residents.</p> <p>*5:40 pm - Resident #6 was observed eating a hamburger.</p> <p>*5:45 pm - Resident #6 dropped his left leg off the foot rest and removed the left foot pedal of the wheelchair. He then tried to push his chair away from the table, but RCM #2 approached and put his foot pedal back onto his wheelchair.</p> <p>*5:52 pm - Resident #6 was observed sitting sideways on his wheelchair with his legs hanging over the left arm rest. Resident #6 was able to turn his chair around and attempted to stand up.</p>	F 323			

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F 323	<p>Continued From page 49</p> <p>The DON approached, but was unable to calm him. The DON called RCM #2 over and the two talked with Resident #6.</p> <p>*5:59 pm - CNA #2 wheeled Resident #6 out of the dining room.</p> <p>*Between 6:01 pm and 7:02 pm, Resident #6 was observed being wheeled in the wheelchair back and forth in the 300 Hall and 400 Hall. At times, Resident #6 and CNA #2 were observed at the Internet Cafe, where Resident #6 appeared calm.</p> <p>Physician Assistant's progress notes documented:</p> <p>*3/15/17 - "Increased agitation. We did change his Ativan dose to 0.5 mg qid prn...I do not see an improvement in his agitation however we may need to look elsewhere to another facility to offer more higher staff to patient ratio..."</p> <p>*3/27/17 - "We are also looking to transition patient to another facility which will allow for higher staffing and increased one to one treatments to discourage falls as well as any behaviors associated with his traumatic brain injury..."</p> <p>On 4/6/17 at 12:15 pm, the Physician Assistant [PA] was asked if one-to-one supervision was considered for Resident #6. The PA said the facility's fall risk protocol was in place for Resident #6 and she had seen him by the nurse's station or by the nurse's med cart, where he received increased supervision. She said Resident #6 had increased agitation and was</p>	F 323			

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F 323	Continued From page 50 reportedly hitting some staff so his medications were adjusted. On 4/6/17 at 12:35 pm, the DON, said "frequent checks" for all of residents was every two hours and that would increase to every hour or more as needed. She said Resident #6 had increased agitation and became combative recently so staff was still attempting to assess the cause for this increased agitation and behaviors such as kicking and hitting staff. The DON then provided documentation where Resident #6 was provided with a sitter on 3/5/17. When asked if the resident was provided consistently with a one-to-one supervision, the DON said Resident #6 was placed by the nurse's station or med cart for close supervision. Resident #6 experienced 6 falls while at the facility, 5 of which were unwitnessed and occurred while he was in his bedroom. Four of the unwitnessed falls occurred between the times of 11:00 pm and 1:00 am, and the I&A reports consistently documented Resident #6 had periods of agitation, difficulty following direction, and required frequent redirection and reassurance. Resident #6's 2/16/17 and 3/14/17 I&A reports documented he was restless during the shift prior to those falls. Although Resident #6's care plan was updated to bring him to the nurse's station or by the nurse's cart during moments of agitation, Resident #6 fell while in line-of-sight of staff. The facility failed to consistently provide supervision to Resident #6 and left him in his room unattended.	F 323			
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		5/17/17	

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F 329	<p>Continued From page 51</p> <p>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--</p> <p>(1) In excessive dose (including duplicate drug therapy); or</p> <p>(2) For excessive duration; or</p> <p>(3) Without adequate monitoring; or</p> <p>(4) Without adequate indications for its use; or</p> <p>(5) In the presence of adverse consequences 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</p>	F 329			

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F 329	<p>Continued From page 52</p> <p>by: Based on record review and staff interview, it was determined the facility failed to ensure gradual dose reductions were attempted for residents receiving psychotropic medications. This was true for 1 of 15 residents (#5) reviewed for psychoactive medications. Receiving psychoactive medications at higher doses than may be necessary, increased the risk of residents experiencing adverse medication side effects. Findings include:</p> <p>Resident #5 was admitted to the facility on 8/4/16, and re-admitted on 8/17/16, with diagnoses that included Congested Heart Failure (CHF,) insulin-dependent diabetes mellitus, depression, and insomnia.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 2/8/17, documented Resident #5 was cognitively intact, independent with activities of daily living, and did not exhibit disruptive behaviors.</p> <p>A comprehensive MDS assessment, dated 8/29/16, documented Resident #5 received psychotropic medications, which would be part of his care plan.</p> <p>Physician orders, dated 10/6/16, documented Ambien 10 mg was to be given to Resident #5 daily and that staff were to monitor for adverse reactions.</p> <p>The Nursing 2017 Drug Handbook documented Ambien is indicated for short-term management of insomnia, usually for 7 to 10 days.</p>	F 329	<p>Corrective Action: Resident #5 was discharged from this center on 4/18/17.</p> <p>Identification of Others: As this has the potential to affect residents with orders for psychoactive medications, the Interdisciplinary Team conducted an audit on 4/26/17 to validate gradual dose reductions were attempted as required.</p> <p>Systematic Changes: The Interdisciplinary Team was re-educated regarding the requirements of gradual dose reductions with the use of psychoactive medications on or before 5/17/17 by the Staff Development Coordinator.</p> <p>Monitoring: Beginning 5/17/17 audits will be conducted by the Social Service Director or designee to validate that staff continue to attempt and document gradual dose reductions as required. The results of these audits will be brought to the monthly Quality Assurance meeting beginning 5/17/17 for 3 months and as needed for review and recommendation. The Social Service Director is responsible for ongoing compliance.</p>		

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F 329	Continued From page 53 Resident #5's insomnia care plan, dated 9/29/16, documented he was unable to sleep 6 to 8 hours every night and directed staff to monitor him to determine potential causes of insomnia, monitor actual hours of sleep nightly, provide hypnotic medication, and monitor for possible side-effects. A Consultant Pharmacist Recommendation to Resident #5's physician, dated 11/28/16, documented, "This resident is due for [a] gradual dose reduction [GDR]" and recommended a trial dose reduction of Ambien from 10 mg to 5 mg." The section for the pharmacist's Recommendation titled, Physician/Provider Response, for the physician to agree, disagree, or provide a rationale for not attempting a GDR, was blank. On 4/6/17 at 10:30 am, the Director of Nursing (DON) stated she completed chart audits and placed the Insomnia care plan in Resident #5's chart when one was not found. The DON and Resident Care Manager (RCM) #1 were unable to provide documentation of non-pharmacological interventions were attempted, or a physician rationale for continued use of Ambien 10 mg. On 4/6/17 at 2:30 pm, the DON stated the physician's response to the Consultant Pharmacist Recommendation, dated 11/28/16, could not be found. The DON stated Resident #5 received Ambien 5 mg when first admitted and the Ambien was increased to 10 mg on 10/6/16. The DON stated there had not been a dose reduction attempted.	F 329			
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431			5/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2017
NAME OF PROVIDER OR SUPPLIER TETON POST ACUTE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
(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 431	<p>Continued From page 54</p> <p>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.</p> <p>(a) Procedures. A facility must provide pharmaceutical services (including procedures 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</p>	F 431			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2017
NAME OF PROVIDER OR SUPPLIER TETON POST ACUTE CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
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F 431	<p>Continued From page 55 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 quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure medications were properly labeled. This was true for 1 of 17 sampled resident (#16), whose medications were reviewed. This deficient practice had the potential to place Resident #16 at risk for infections from cross contamination with another resident's nasal medication.</p> <p>Findings include:</p> <p>On 4/4/17 at 10:05 am, Licensed Nurse #1 was observed as she removed Flonase from a medication cart and administered one spray of Flonase to each of Resident #16's nostrils. The Flonase was not labeled with Resident #16's name.</p> <p>On 4/4/16 at 10:15 am, LN #1 said the Flonase should have been labeled with Resident #16's name.</p>	F 431	<p>Corrective Action: Resident #16's unlabeled nasal spray was replaced with a labeled nasal spray on 4/4/17 by the Resident Care Manager.</p> <p>Identification of Others: An inspection of all medication carts was performed by Nursing Home Administrator on 4/25/17. No other unlabeled medications were identified.</p> <p>Systemic Changes: The Director of Nursing or designee will conduct an in-service with licensed nurses regarding the labeling requirements for medications on or before 5/17/17.</p> <p>Monitoring: Medication cart audits will be conducted by the Director of Nursing or designee beginning 5/17/17. The audits will continue weekly for 4 weeks and then monthly for 2 months to validate that staff</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2017
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F 431	Continued From page 56	F 431	continue to label medications as required. The results of the audits will be shared at the monthly Quality Assurance meeting beginning with the next meeting scheduled for 5/17/17. After 3 months, the need for continued medication cart auditing will be reassessed. The Director of Nursing is responsible for ongoing compliance.		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001775	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/10/2017
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NAME OF PROVIDER OR SUPPLIER TETON POST ACUTE CARE & REHABILITATIO	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404
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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) COMPLETE DATE
C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State licensure and complaint investigation survey conducted at the facility from April 3, 2017 to April 7, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Presie Billington, RN Edith Cecil, RN</p> <p>Abbreviations:</p> <p>ED = Executive Director ICC = Infection Control Committee SDC = Staff Development Coordinator</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure all required participants attended the facility's Infection Control Committee (ICC) meetings. This failure had the potential to affect all residents, staff and visitors to the facility if not all persons or departments responsible for infection control were represented at the committee's meetings. Findings include:</p> <p>On 4/4/17 at 10:25 am, the Staff Development Coordinator stated the facility conducted monthly</p>	C 664	<p>Corrective Action: The infection control committee convened on 4/19/17. All required participants, including the consulting pharmacist, were present and signed the attendance roster.</p> <p>Identification of Others: This has the potential to affect all residents within the facility.</p> <p>Systematic Changes: Effective 4/19/17, the infection control</p>	5/17/17

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/15/17
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001775	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/10/2017
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NAME OF PROVIDER OR SUPPLIER TETON POST ACUTE CARE & REHABILITATIO	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404
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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) COMPLETE DATE
C 664	<p>Continued From page 1</p> <p>ICC meetings. Sign-in sheets for the ICC meetings documented the pharmacist not attended monthly meeting from September 2016 through March 2017.</p> <p>On 4/5/17, the Executive Director provided a written statement from the pharmacist that asserted he attended the February 2017 ICC meeting, however, no documentation was provided by the facility confirming the pharmacist's written statement.</p>	C 664	<p>meeting will convene no less than quarterly. The Nursing Home Administrator or designee will determine the date and time of each meeting and notify the required participants prior to the meeting to confirm that their schedule permits them to attend.</p> <p>Monitoring: Effective 4/19/17, all participants will sign the committee meeting attendance roster at the time that the committee convenes to verify attendance. The Infection Control Nurse will be responsible for maintaining the attendance roster and for ensuring that each participant signs the roster.</p>	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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

May 24, 2017

Daniel Kennick, Administrator
Teton Post Acute Care & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404-7534

Provider #: 135138

Dear Mr. Kennick:

On **April 10, 2017**, an unannounced on-site complaint survey was conducted at Teton Post Acute Care & Rehabilitation. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007495

ALLEGATION #1:

The facility did not notify the interested party when an identified resident fell and was sent via ambulance to an emergency room or when the resident was placed in isolation.

FINDINGS #1:

The identified resident's clinical record contained documented evidence that the interested party was not notified when the resident fell and was sent to an emergency room by ambulance or when the resident was placed in isolation.

The allegation was substantiated and cited at F 157. Please see federal 2567 federal report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Daniel Kennick, Administrator
May 24, 2017
Page 2 of 5

ALLEGATION #2:

There was a lack of supervision for an identified resident.

FINDINGS:

Based on clinical record reviews and review of incident and accident reports, it was determined the facility failed to ensure adequate supervision was provided to prevent accidents and hazards for all residents.

That was not the case for the identified resident but it was true for two other residents. The deficient practice was cited at F323. Please see federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility failed to monitor, care for, and manage an identified resident's surgical incision and pain.

FINDINGS #3:

The clinical records for the identified resident and another resident contained evidence that surgical incisions were not consistently monitored. Also, vague orders for the identified resident's wound care were not clarified and subsequent wound care orders were not consistently followed. The identified resident's stapled head laceration was not monitored or cared for, and the identified resident's pain and another resident's pain was not consistently monitored.

The allegations were substantiated and cited at F309. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

The facility failed to follow physician orders and apply compression stockings for an identified resident whose left leg was swollen.

FINDINGS #4:

Based on observations and interviews with four individual residents, twelve residents in a Resident Group interview, and the interested party for two other residents, compression stocking were applied for those residents who had physician orders for them.

Review of the identified resident's clinical record revealed compressions stocking were not ordered and there were no progress notes or other entries in the clinical record to indicate the resident's left leg was swollen. In addition, the physician did not note left leg swelling when he/she saw the resident five days before the resident was transferred from the facility.

The allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The facility did not provide services to prevent weight loss for an identified resident.

FINDINGS :

Based on observations during meal times, it was determined the facility provided eating assistance for those residents who needed it. Interviews with four individual residents, twelve residents in a Resident Group interview, and the interested party for two other residents, as well as Licensed Nurses and Certified Nursing Assistants, confirmed eating assistance was provided as ordered and/or care planned.

The identified resident's clinical record contained documented evidence that weight loss was immediately recognized and interventions implemented, including meal set-up and cueing as care planned.

Deficient practice was not identified and the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Daniel Kennick, Administrator
May 24, 2017
Page 4 of 5

ALLEGATION #6:

An identified resident's room and the entire facility was not clean. Feces was on the floor in the resident's room, which staff said would be cleaned and sanitized when isolation precautions had been removed.

FINDINGS:

The facility environment, including residents' rooms and common areas, was observed during all days of the survey. All areas, including the rooms of residents in isolation, were clean and tidy.

No concerns or issues were voiced regarding the cleanliness of individual resident rooms or the facility in general, when interviews were conducted with four individual residents, twelve residents in a Resident Group interview, the interested party for two other residents, and facility staff. In addition, there were no grievances concerning facility cleanliness.

The allegation was not substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The facility did not implement a physical therapy program to help an identified resident get stronger and discharge home.

FINDINGS:

The clinical record documented physical therapy and occupational therapy evaluations were completed one day after the identified resident's admission to the facility. Both therapies were provided almost daily, including when the resident was in isolation. The resident was able to participate in therapeutic exercises and strengthening activities during the therapy sessions, but experienced fatigue and was "limited by pain and confusion" at times.

Deficient practice regarding rehabilitation services was not identified and the allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Daniel Kennick, Administrator
May 24, 2017
Page 5 of 5

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

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

Sincerely,

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

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

DS/lj



IDAHO DEPARTMENT OF
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P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

July 18, 2017

Daniel Kennick, Administrator
Teton Post Acute Care & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404-7534

Provider #: 135138

Dear Mr. Kennick:

On **April 10, 2017**, an unannounced on-site complaint survey was conducted at Teton Post Acute Care & Rehabilitation. The complaint was investigated in conjunction with the facility's federal recertification and State licensure survey conducted from April 3, 2017 to April 7, 2017.

Licensed nurses were observed during medication administrations as well as, along with Certified Nursing Aides, Physical Therapists, and Occupational Therapists, the provision of direct cares and therapies to multiple individual residents.

The clinical records of fifteen residents, including that of the identified resident and three residents no longer residing at the facility, were reviewed for quality of life and quality of care concerns. Record reviews included physician orders, admission nursing assessments, interdisciplinary progress notes, medication and treatment records, pressure ulcer and other skin assessments/records, and discharge orders, notes, and referrals. The facility's grievance file, incident and accident reports, investigations of allegations of abuse, Resident Council meeting minutes, and staffing records were also reviewed.

Interviews were conducted with four individual residents, the interested party for two residents, and twelve residents in Resident Group interview. Interviews were also conducted with several licensed nurses and Certified Nursing Aides, therapists, the Director of Nursing Services, and the facility's Executive Director.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007456

ALLEGATION #1:

An identified resident was not assessed for five hours after admission and the nurse at that time said the aides would come in every two hours to remind and help the resident to change position, which did not occur.

FINDINGS #1:

Based on observation, record review, and staff, family, and resident interview, it was determined the allegation could not be substantiated due to a lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

A pressure sore on an identified resident's coccyx was discovered five hours after admission to the facility that was not properly treated by the facility. The resident was discharged from the facility to a home health agency with a Stage III pressure ulcer with tunneling to the coccyx.

FINDINGS #2:

A Stage II pressure ulcer on the coccyx was identified when the identified resident was admitted to the facility that was not reassessed for nine days. The facility failed to assess and monitor pressure ulcers in a timely manner for the identified resident and two other residents.

The allegation was substantiated and cited at F314. Please refer to the federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

An identified resident developed a severe pressure ulcer from neglect on the part of the facility.

FINDINGS #3:

Daniel Kennick, Administrator
July 18, 2017
Page 3 of 7

Based on review of the clinical record, two stage II pressure ulcers were identified when the identified resident was admitted to the facility. The facility monitored, assessed, and followed physician orders regarding the care and treatment of the pressure ulcers and both of the pressure ulcers were healed when the resident discharged from the facility.

Observations during the provision of care and treatments for individual residents by nurses, certified nursing assistants and therapists, revealed that individual plans of care and physician orders were followed related to skin care. And per interviews with individual residents and a group of residents, the facility staff were attentive, patient and promptly provided thorough skin assessments and treatments.

Review of the facility's grievances and investigations of allegations of abuse revealed there was no evidence the facility neglected residents.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

An identified resident specifically requested not to be given narcotics.

FINDINGS #4:

The identified resident's clinical record contained documentation that narcotic pain medication was ordered and administered after the resident requested no narcotic pain medication.

The allegation was substantiated and cited at F 155.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

An identified resident's ibuprofen was ordered three times a day and it was scheduled for 8 am, 2 pm and 8 pm. The resident did not receive the 2 pm dose for two days. The resident also asked that the scheduled time for ibuprofen be changed to one pill per shift. The resident was told the 8 am, 2 pm and 8 pm schedule "worked best for them." That left twelve hours without pain

Daniel Kennick, Administrator
July 18, 2017
Page 4 of 7

medication.

FINDINGS #5:

The identified resident's clinical record documented that ibuprofen was consistently administered after it was changed from as needed to scheduled times.

Per interviews with four individual residents, twelve residents in a Resident Group Interview with two surveyors, and the interested party for two residents, residents received their scheduled medications and the facility honored requests when possible.

Per observations of medications administered to four individual residents by three different nurses, their scheduled medications were administered as ordered.

Review of grievance files revealed there were no voiced or written concerns that scheduled medications were not administered or that requests for changes were not honored.

The allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

An identified resident requested a stool softener the second or third day after admission but never received one. The staff said there was not an order for one. The resident also requested an order for dry and cracking feet. The physician ordered Triamcinolone twice a day but the staff "just forgot" to apply it even when the resident reminded them.

FINDINGS #6:

The identified resident's clinical record contained documentation of no bowel movement for eight days and that the facility did not attempt to obtain orders for bowel medications or a bowel protocol.

The clinical record also contained documented evidence that there was no explanation when Triamcinolone was not consistently administered twice a day as ordered.

The allegations were substantiated and cited at F 309.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #7:

On Wednesday before an identified resident's discharge, the combination of working with a therapy ball, standing exercises, and "almost three hours" total time of therapy put a strain on the resident's muscles and set him/her back about 10 days. In addition, physical therapy never taught the resident "some of the basics" to improve his/her status, such as how to log roll into and out of bed, core strengthening exercises to help strengthen and maintain posture, etcetera.

FINDINGS #7:

Occupational Therapy records documented that two days before discharge, the identified resident "tolerated tasks well with occasional postural corrections for increased energy efficiency and to effectively manage pain...with high rest needed." The resident reported some soreness from the previous day's treatment session "otherwise no pain currently." The next day, the resident complained of "high pain level in torso" but was able to participate in the therapy session and demonstrated "decreased pain and increased ability to participate in activity." During this therapy session, the resident was also "educated on strategies to manage pain in home environment" and "strategies in home to reduce risk of pain."

Physical Therapy records documented that two days before discharge, the identified resident completed a six minute walk test of seven hundred feet and "another 250 feet after completion of test." The resident also completed standing and upper and lower extremity exercises with a sitting rest break. The next day, the resident walked seven hundred feet again and said that "walking tends to help relax" him/her when in pain. The resident demonstrated moderate independence in therapeutic activities, including bed mobility. "Discussed log rolling to decrease pain in thoracic." The resident reported increased pain "from longer session yesterday." Pacing self and alternating movement (bed, walking, chair, walking) every thirty minutes during the day was also discussed with the resident; and, electrical stimulation to the thoracic spine was provided to the resident's tolerance to facilitate a decrease in the pain.

The allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

The facility staff communications were lacking on several levels. They would ask questions or provide treatments that were inappropriate. An identified resident asked a staff member for medication and it sometimes took over an hour for anyone to respond. Other times the nurse never did respond and resident had to push the call light again. No one seemed to know why the resident was there, the diagnosis or care needs. The resident said on several occasions that staff "never pass on the message to anyone."

FINDINGS #8:

Throughout the survey, numerous staff, including Licensed Nurses, Certified Nursing Assistants, occupational and physical therapy staff, activity, dietary, and housekeeping staff were observed interacting with residents and with other staff. Also, residents' call lights were answered in six minutes or less. Residents' requests were promptly relayed to the appropriate staff member and quickly responded to.

Interviews were conducted with four individual residents, twelve residents in a Resident Group Interview with two surveyors, and the interested party/representative for two residents. No concerns were expressed that communicate with and between staff was lacking or that messages were not being relayed. And, review of Resident Council meeting minutes, grievance files, and facility investigations of allegations of abuse, revealed there were no written concerns about staff communications or messages not being relayed.

The allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #9:

The facility never sent referral orders to an identified resident's chosen home health provider. Two days before the resident's discharge, the facility's social worker was given "specific" instructions of where to send the orders and informed that home health was "already" arranged to begin Monday, January 2, 2016. The home health did not receive the orders. It took multiple calls to the facility before the orders were sent to the home health.

FINDINGS #9:

The identified resident's clinical record contained documentation that incomplete referral orders and information was sent to the receiving home health provider three days before the resident's discharge from the facility and interview with the facility's Director of Nursing and Regional

Daniel Kennick, Administrator
July 18, 2017
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Director of Clinical Operations confirmed that.

The allegation was substantiated and cited at F 202.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Thank you for the courtesies and assistance extended to us during our visit.

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

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

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

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

DS/lj