



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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May 2, 2017

Josh Smith, Administrator
Oak Creek Rehabilitation Center of Kimberly
500 Polk Street East
Kimberly, ID 83341-1618

Provider #: 135084

Dear Mr. Smith:

On **April 13, 2017**, a survey was conducted at Oak Creek Rehabilitation Center of Kimberly 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.) **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 12, 2017**. Failure to submit an acceptable PoC by **May 12, 2017**, may result in the imposition of additional civil monetary penalties by **June 6, 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.
- 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*.

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey. We are recommending to the CMS Regional Office that the following remedy(ies) be imposed:

Civil money penalty

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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 13, 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Your facility's noncompliance with the following:

F0226 -- S/S: F -- 483.12(b)(1)-(3), 483.95(c)(1)-(3) -- Develop/implement Abuse/neglect, Etc Policies; and,

F0225 -- S/S: F -- 483.12(a)(3)(4)(c)(1)-(4) -- Investigate/report Allegations/individuals

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents # **1, 5, and 6** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

If you believe the 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

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choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

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

This request must be received by **May 12, 2017**. If your request for informal dispute resolution is received after **May 12, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nina Sanderson, LSW, Supervisor
Long Term Care

NS/lj

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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: 135084	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/13/2017
NAME OF PROVIDER OR SUPPLIER OAK CREEK REHABILITATION CENTER OF KIMBERLY			STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
(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	INITIAL COMMENTS The following deficiencies were cited during a complaint investigation survey completed at the facility from April 12, 2017 to April 13, 2017. The surveyors conducting the survey were: Teresa Kobza, RDN, LD, Team Coordinator Marci Clare, RN Abbreviations include: CEO = Chief Executive Officer CNA = Certified Nursing Assistant COO = Chief Operating Officer DNS = Director of Nursing Services LCSW = Licensed Clinical Social Worker LPN = Licensed Practical Nurse MD = Medical Doctor RVPO = Regional Vice President of Operation VPHR = Vice President of Human Relations	F 000			
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 157		5/12/17	

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

TITLE

(X6) DATE

Electronically Signed

05/12/2017

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

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F 157	<p>Continued From page 1 status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility abuse investigations, and staff interview, it was determined the facility failed to ensure a resident's interested party was immediately</p>	F 157	<p>Letter was written and submitted to Dr. Gies on 5/8/17 informing him of the residents who received</p>		

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F 157	<p>Continued From page 2</p> <p>notified of an alleged incident of verbal and mental abuse. This was true for 1 of 6 (#1) sampled residents and created the potential for Resident #1 to experience psychosocial harm due to a lack of prompt emotional support, reassurance, and/or advocacy by her Interested Party. Findings include:</p> <p>Resident #1 was admitted to the facility on 3/21/17, with diagnoses which included Type II diabetes mellitus, altered mental status, and substance abuse.</p> <p>A facility abuse investigation involving Resident #1, dated 4/10/17, documented the Regional Vice President of Operation [RVPO] mentally and verbally abused Resident #1 at the facility on 4/3/17.</p> <p>A Resident Services Note, dated 4/6/17, documented the facility notified Resident #1's Interested Party on 4/6/17, of the abuse she experienced 4/3/17. Resident #1's Interested Party was notified of Resident #1's abuse three days after the abuse occurred.</p> <p>On 4/13/17 at 12:45 pm, the DNS stated she could not find documentation that Resident #1's Interested Party was notified of the 4/3/17 incident prior to the 4/6/17. Later the same day, the facility provided a late entry Resident Services Note, dated 4/13/17 at 3:09 pm, that documented LPN #2 spoke with Resident #1's Interested Party on 4/5/17, about the verbal/mental abuse of Resident #1 on 4/3/17.</p> <p>The facility failed to notify Resident #1's Interested Party immediately following an</p>	F 157	<p>substandard care, for which he is the primary care physician.</p> <p>1) Resident #1 was affected by this deficient practice. Resident #1's interested family member was notified of the incident.</p> <p>2) All residents had the potential to be affected by the deficient practice. All resident's charts were reviewed and demographics updated to list the appropriate resident representative and HIPAA consents obtained as necessary.</p> <p>3) In order to ensure a resident's interested party is immediately notified of an incident, all licensed Nursing staff will be in-serviced on comprehensive Incident and Accident reports(I&A), with specific emphasis on notifications to all appropriate parties. All I&A's will be reviewed by IDT/clinical team on the next business day to ensure documentation of notifications, interventions and completion. All admissions include determining who the resident's representative is and identifying this individual on the demographics sheet.</p>		

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F 157	Continued From page 3 allegation of abuse to her.	F 157	4) Audits for I&A completion and proper notifications will be done by DNS or designee months once a week for 4 weeks, then monthly for 3 and quarterly there after to ensure compliance. Results will be reviewed and acted on appropriately and taken to QAPI monthly for review and any necessary appropriate actions. Date Certain 5/12/17		
F 223 SS=G	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, and review of facility policies and Incident Reports and investigations, it was determined the facility failed to ensure 3 of 6 (#1,	F 223	1) Residents 1, 5 and 6 were impacted by this deficient practice. RVPO was suspended and	5/12/17	

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F 223	<p>Continued From page 4</p> <p>#5, and #6) sampled residents were free from all forms of abuse, including verbal and mental abuse. Specifically:</p> <p>a) Resident #1 sustained psychosocial harm when she was verbally and mentally abused by the Regional Vice-President of Operations [RVPO], when he threatened her in a loud derogatory manner, with involuntary discharge from the facility. Following the abuse Resident #1 began to exhibit physical assault, socially inappropriate behavior, and refusal of meals and cares, and her incidents of verbal assault increased. Resident #1 was remained visibly upset when interviewed on 4/12/17, and continued to cry during daily counseling sessions when recounting the abuse.</p> <p>b) When the investigation into the abuse of Resident #1 identified potential abuse of Residents #5 and #6 by the RVPO, the facility did not interview, or otherwise review, all residents in the facility to identify, or rule out, further abuse.</p> <p>c) Resident #5 was at risk of psychosocial harm when the RVPO confronted her and the Activity Aide and told them the activity they were engaged in was "stupid" and when Resident #5 asked who he was, his response to her was "I'm the donut man." Resident #5 reported she was "very upset" by the interaction.</p> <p>d) Resident #6 was at risk of psychosocial harm when the RVPO threatened her with discharge from the facility if she did not start taking showers, as the smell was offending other residents. Resident #6 reported she was "ashamed and afraid she would have to leave the</p>	F 223	<p>terminated.</p> <p>2) All residents had the potential to be affected by this deficient practice. RVPO was suspended and terminated.</p> <p>3) In order to ensure all residents are free from all forms of abuse, all staff will be in-serviced regarding identification and documentation of behaviors. All documented behaviors will be reviewed each business day in clinical team meeting. Based on this review, RSD or designee will be responsible for implementing appropriate interventions and care plan modifications are made as necessary. These actions will be documented in the clinical meeting form. Any time potential abuse is identified, 100% follow up with resident to identify or rule out further abuse. All staff will have resident abuse training with initial orientation, and not less than quarterly thereafter. An all staff in service was completed with each required to pass a post test following. All contractors, volunteers, and corporate</p>		

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F 223	<p>Continued From page 5 facility.</p> <p>The above deficient practices placed all 38 residents residing in the facility at risk of abuse. Findings include:</p> <p>The facility's Abuse Prohibition Policy and Procedure, revised 11/21/16, defined verbal or mental abuse as "any use of oral, written, or gestured language that willfully included disparaging and derogatory terms to residents...examples include humiliation, threats of physical abuse or deprivation, or use of derogatory names." The policy documented the facility would not tolerate any abuse of a resident.</p> <p>1. Resident #1 was admitted to the facility on 3/21/17, with diagnoses which included Type II diabetes mellitus, altered mental status, and substance abuse.</p> <p>An Initial Minimum Data Set assessment, dated 3/23/17, documented Resident #1 had moderate cognitive impairment and exhibited moderate-to-severe signs of depression.</p> <p>Resident #1's Behavior Care Plan, dated 3/28/17, documented she experienced frustration and became destructive towards property when she was not understood by staff. Interventions directed staff to:</p> <ul style="list-style-type: none"> * Offer and assist her to call a family member * Sit and visit one-on-one with her * Take her for a walk, weather permitting * Offer her a hug. <p>A Behavior Tracking Log documented that</p>	F 223	<p>officers who have contact with any residents will receive the same training. Abuse policy is updated to include the mandated training and responsible party. Administrator will serve as abuse coordinator; RSD or designee will be responsible for training. 100% of residents were surveyed to rule out potential abuse or psychosocial harm.</p> <p>4) To review reportable incidents and compliance with training schedule, The Social service QA audit will be used weekly times four weeks, then once a month for three months, and quarterly thereafter. Results of these audits will be acted on as appropriate and then reviewed monthly at QAPI for review and appropriate actions. RSD or designee will be responsible for completion of this monitor.</p> <p>6) Date of compliance: 5/12/17</p>		

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F 223	<p>Continued From page 6</p> <p>between 3/23/17 and 4/2/17 (11 days), Resident #1 displayed 5 episodes of "verbal assault." Resident #1's Nurse's Notes and Behavior Tracking Log, between 3/21/17 and 4/2/17, did not include documentation that she refused meals or cares, or attempted physical aggression towards staff. There was a 3/23/17 Nurse's Note which documented she threw an item at a staff member when she first arrived at the facility. Resident #1 threw something at staff when admitted and engaged in verbal assault 5 times, and no other behaviors were documented between 3/23/17 and 4/2/17.</p> <p>A 4/10/17 Incident Report documented that on 4/3/17, Resident #1 "had a verbal outburst and was brought into the DNS' office to de-escalate. A staff member, [RVPO] upon hearing of the resident's outburst, came into the office to assist. The staff member [RVPO] became loud and forceful in his attempts to help the resident; informing [Resident #1] of discharge from the facility if the resident wasn't able to calm herself. The resident did calm down, but was visibly upset by the encounter. Even though the outcome had the desired result of calming the resident, we elect to report and investigate the incident as potential abuse due to the staff member's raised voice and posturing." The Report concluded the RVPO had verbally and mentally abused Resident #1.</p> <p>Behavior Tracking Logs for 4/3/17 through 4/12/17 (10 days) documented Resident #1:</p> <ul style="list-style-type: none"> * Experienced refused meals or cares on 8 occasions after 4/3/17. * Experienced 18 episodes of depression after 	F 223			

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F 223	<p>Continued From page 7 4/3/17.</p> <ul style="list-style-type: none"> * Displayed 30 incidents of verbal assault after 4/3/17. * Attempted physical assault 10 times after 4/3/17. * Exhibited 18 incidents of socially inappropriate behavior after 4/3/17. <p>A 4/8/17 Speech Therapy Note, documented Resident #1 appeared "despondent and...depressed" and had exhibited violent behavior toward others.</p> <p>On 4/12/17 at 10:36 am, Resident #1 stated, "The man" [RVPO] told her she was out of control and that she was going to have to go to jail. She stated the RVPO "cussed" at her and "pointed his finger" in her face. Resident #1 said she was "shocked" that someone would talk to her in that manner and that the incident made her feel "at the end of my rope." Resident #1 stated she "did not feel safe" with the RVPO in the building, but was not fearful of other staff or residents in the facility. Resident #1 looked down at her folded hands and began to stammer while making these statements, and said she stammered when she was "worked up."</p> <p>On 4/12/17 at 11:05 am, the Licensed Clinical Social Worker [LCSW] stated he provided counseling to Resident #1 daily except on weekends. The LCSW stated he believed Resident #1 had sustained psychosocial harm from the 4/3/17 incident, which she continued to "cry" about when recounting details in her counseling session as it reminded her of other abuse issues from her past.</p>	F 223			

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F 223	<p>Continued From page 8</p> <p>On 4/13/17 at 11:30 pm, the Director of Nursing [DNS] stated Resident #1's behaviors occurred when she could not articulate her needs to staff. She stated the Speech Therapist working with Resident #1 suggested staff use a calm voice and sit and talk to de-escalate her behaviors.</p> <p>On 4/13/17 at 12:21 pm, the DNS stated she had witnessed the 4/3/17 interaction between Resident #1 and the RVPO. The DNS stated that at approximately 10:00 am she heard Resident #1 yelling loudly and swearing. She approached Resident #1, saw that her hands were clenched and her jaw tense, and asked the resident to come to her office to calm down. She stated LPN #1 accompanied Resident #1 into the DNS's office, where Resident #1 then began to calm down. The DNS stated Resident #1's jaw slackened, and her hands were no longer clenched, when the RVPO came into the office without knocking and stood over the DNS and Resident #1, pointed his finger, and said in a loud voice to Resident #1, "What is your f*cking problem. I'm going to ship your a** out of here!" The DNS stated the RVPO then turned to her and said in a loud, raised voice, "You get on the phone to the doctor and get her out of here; I don't care where, the hospital, away, or locked up!" The DNS stated the RVPO told her to take Resident #1 to the shower and shook Resident #1's hand before excusing her and the DNS. The DNS stated she took Resident #1 to her room and went to check whether the shower was available. The DNS said that when she re-entered the resident's room, Resident #1 was rocking back and forth and crying. The DNS stated she was "shocked that he [RVPO] was yelling and threatening a resident." She said the</p>	F 223			

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F 223	<p>Continued From page 9</p> <p>RVPO told her that "this speak in a calm, quiet voice, and get at their level, is ineffective sh*t. You need [to] get above them, shock them and get their attention, and then let them know what you want."</p> <p>On 4/13/17 at 4:45 pm, the LCSW stated the Chief Operations Officer assigned him the task of interviewing 10% of the resident population as part of the investigation into the above verbal abuse of Resident #1. The LCSW provided a copy of five interviews he conducted with residents on 4/7/17. Two of the five residents interviewed described derogatory and demeaning statements made to them by the RVPO. They included:</p> <p>* Resident #5 stated the RVPO confronted her and an Activity Aide and said the activity they were both engaged in was "stupid." When Resident #5 asked the RVPO who he was, the RVPO responded, "I'm the donut man." Resident #5 stated she was "very upset" by the RVPO's response and asked the Activity Aide why the RVPO had treated her like she was "stupid."</p> <p>* Resident #6 stated the RVPO told her she would need to leave the facility unless she showered because her smell "was offending other residents." Resident #6 stated she "felt ashamed and afraid she was going to have to leave [the facility]" as a result of the RVPO's comments.</p> <p>When the investigation into the abuse of Resident #1 identified potential abuse of Residents #5 and #6 by the RVPO, the facility did not interview, or otherwise review, all residents in</p>	F 223			

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F 223	Continued From page 10 the facility to identify, or rule out, further abuse.	F 223			
F 225 SS=F	<p>The facility failed to ensure residents were free from abuse.</p> <p>483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>483.12(a) The facility must-</p> <p>(3) Not employ or otherwise engage individuals who-</p> <p>(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;</p> <p>(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or</p> <p>(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.</p> <p>(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.</p> <p>(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment,</p>	F 225		5/12/17	

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F 225	<p>Continued From page 11 including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and review of facility policies, incidents reported to the State Agency, facility Incident Reports and related investigations, and clinical records, it was determined the facility failed to:</p> <p>a) Promptly initiate an investigation into an</p>	F 225	<p>1) Residents 1, 5 and 6 were impacted by this deficient practice. The RVPO was suspended and terminated after completion of investigation.</p>		

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F 225	<p>Continued From page 12</p> <p>allegation that the Regional Vice-President of Operations [RVPO] verbally and mentally abused Resident #1</p> <p>b) Thoroughly investigate the above allegation of abuse of Resident #1</p> <p>c) Within two hours report allegations that the RVPO verbally and/or mentally abused Residents #1, #5, and #6, to the facility Administrator and State Agency</p> <p>d) Protect all residents in the facility by immediately suspending the RVPO during the investigation of the alleged abuse of Resident #1, and not allowing the RVPO back into the facility where he had direct access to residents.</p> <p>The failure of the facility to protect residents from abuse, thoroughly investigate an allegation of abuse, and report allegations of abuse in a timely manner, directly impacted for 3 of 6 sampled residents (#1, #5, and #6) and exposed all 38 residents residing in the facility to potential verbal, mental, physical, and other forms of abuse. Findings include:</p> <p>The facility's Abuse Prohibition Policy and Procedure, dated 11/21/16, documented the following:</p> <p>* "Protection - Accused employees are immediately removed from resident contact and suspended from duty. The accused employee will not be taken off suspension until the conclusion of the investigation has been reached. The accused staff person may not be reassigned to another department in the facility or to a sister</p>	F 225	<p>2) All residents had the potential to be affected by this deficient practice. The RVPO was suspended and upon completion of investigation terminated.</p> <p>3) To ensure the facility timely investigates and reports any allegation of abuse, Corporate officers reviewed Resident Abuse Prevention policy/procedure for all employees, and was it updated to include corporate officers, contractors, and volunteers. Policy updated to include specific procedure for abuse identification, reporting and investigation, as well as training for identification of abuse and reporting requirements. Corporate HR or designee will ensure abuse training is completed during orientation and a post test will be maintained in the employee file. All appropriate corporate staff will complete training by 5/12/17. A comprehensive resident abuse prevention training was developed and implemented by the corporation..</p> <p>4)To ensure the corrective actions are effective</p>		

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F 225	<p>Continued From page 13 facility."</p> <p>* "Investigation - A thorough investigation is critical to developing effective prevention strategies...All pertinent staff, resident(s), and other witnesses must be interviewed..."</p> <p>* "Reporting - All allegations must be immediately reported to the facility's Administrator and to the [State Agency] through the Long-Term Care Reporting Portal." The policy also stated allegations "are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse..."</p> <p>a. Resident #1 was admitted to the facility on 3/21/17 with diagnoses which included Type II diabetes mellitus, altered mental status, and substance abuse.</p> <p>A facility Abuse Investigation Report, dated 4/10/17, concluded the RVPO verbally and mentally abused Resident #1. It documented the following:</p> <p>* The investigation documented the RVPO came into the Director of Nursing's [DNS] office where he verbally and mentally abused Resident #1 in the DNS's presence on 4/3/17 at approximately 10:00 am.</p> <p>* The incident was reported on 4/4/17 at 11:30 am to the Chief Operations Officer [COO], who initiated an investigation on 4/5/17.</p> <p>* The RVPO was observed in the building after the incident on 4/3/17 as well as on 4/5/17 and 4/10/17, after he was suspended on 4/5/17.</p> <p>* The facility reported to the State Agency the</p>	F 225	<p>and compliance is sustained, the COO or designee will audit employee records to ensure completion of mandated abuse training. Administrator or designee will audit all facility staff for completion of abuse training. These audits will be completed weekly x 4 weeks, monthly x 3 months, and quarterly thereafter. Resident abuse investigation process will be audited according to audit tool. Administrator will participate in the monthly QAPI meetings and COO or designee will attend at least quarterly.</p> <p>Date Certain: May 12, 2017</p>		

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F 225	<p>Continued From page 14</p> <p>allegation of abuse on the afternoon of 4/5/17. * The facility failed to interview other residents and staff members in the vicinity when the incident occurred as part of its investigation.</p> <p>A facility Abuse Investigation Summary, dated 4/3/17, documented the DNS was in the business office on 4/3/17 when at 10:00 am, she heard a resident yelling and swearing. When she approached Resident #1 and asked if she needed help, Resident #1 stated the facility had taken some of her belongings that she needed. The DNS, who noted the resident's fists and jaw were clenched, stated Resident #1 was "tense." The DNS and LPN #1 then accompanied Resident #1 into the DNS's office, where Resident #1 began to de-escalate when the RVPO entered the office without knocking, stood over the DNS and Resident #1, and began pointing his finger and yelling at the resident that she needed to calm down. The DNS stated the RVPO shouted at the resident, "I am about to send your a** to the hospital; you can't go around yelling and cussing here," before turning to the DNS and stating, "Ship her butt out of here." The RVPO then told the DNS to take Resident #1 to the shower, shook Resident #1's hand, and excused them both from the DNS's office. The DNS stated she took Resident #1 to her bedroom and then left to check whether the shower was available. When the DNS returned to the resident's room, she stated Resident #1 was rocking back and forth, crying, and repeatedly asking, "Who was that man? Who is he?" The DNS stated she told the RVPO at 11:15 am that she was "shocked" by his shouting and threatening Resident #1. The DNS stated the RVPO stated, "This speaking in a calm, quiet</p>	F 225			

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F 225	<p>Continued From page 15</p> <p>voice, and get[ting] at their level, is ineffective sh*t. You need [to] get above them, shock them and get their attention, and then let them know what you want."</p> <p>The facility's Abuse Investigation Summary documented that on 4/6/17, the RVPO stated that he was in the Administrator's office on 4/3/17 when at 10:00 am he heard loud cussing and items being thrown in the hallway in the presence of other residents. The RVPO stated "[Resident #1's] yelling and cussing continued for approximately 5 minutes. At that point because the resident could still be heard in the hallway, I went into the office. [The DNS] was talking to her but the resident did not quiet down and continued with the loud cussing and yelling. I told the resident that perhaps she needed to go to the emergency room because she [was] obviously upset and visibly shaking and whatever was being told to her was not calming her down. I also explained that her yelling was upsetting the rest of the residents...She told me that she was upset because an item was missing from her bag. I told her we would try to find her item. I also mentioned that I was told she liked to have her shower around this time of day and she agreed...At no time did I 'yell' at the resident. I was attempting (and successfully) to have the resident hear me. I have a hearing loss and my voice 'carries,' but my words were respectful and the outcome of the exchange was positive."</p> <p>An undated Abuse Investigation Summary documented LPN #1 heard loud yelling and swearing and saw Resident #1 "in hysterics" and asking about missing items. He said the DNS accepted LPN #1's offer to "witness" the</p>	F 225			

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F 225	<p>Continued From page 16</p> <p>exchange between Resident #1 and the DNS in the DNS's office. LPN #1 stated that a short time later the RVPO came into the office and in a "forceful and loud" voice told Resident #1 to stop yelling and cursing or he was going to send her "butt to the hospital." LPN #1 stated Resident #1 sat in her chair and did not say a word. After Resident #1 and the DNS exited the DNS's office, LPN #1 stated the RVPO told LPN #1 that Resident #1 had an "explosive personality" and that "you have to get above them to bring them down." LPN #1 stated the RVPO said the DNS's approach of being calm was ineffective. The Abuse Investigation Summary documented LPN #1 stated on 4/6/17 that the RVPO was standing close and directly in front of Resident #1 during the 4/3/17 incident and used foul language ["ass"] when addressing the resident. LPN #1 stated he thought Resident #1 "looked like a scared puppy" and that he "was dumb-founded that this was happening."</p> <p>The Abuse Investigation Summary, dated 4/7/17, documented Resident #1 said the RVPO "went crazy," that she "felt scared she was going to have to leave [the facility]," and she may need to "go to [the] police." The Summary documented Resident #1 was visibly anxious when the interview began and that she did not understand why the RVPO intervened when she had already begun to calm down before he entered the DNS's office.</p> <p>b. On 4/13/17 at 4:45 pm, the LCSW stated the COO assigned him the task of interviewing 10% of the resident population as part of the investigation process. The LCSW provided a copy of five interviews he conducted with</p>	F 225			

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F 225	<p>Continued From page 17</p> <p>residents on 4/7/17, none of whom were in the vicinity of the incident at the time it occurred. Two of the five residents interviewed described interactions during which the RVPO was derogatory and demeaning towards them. These include:</p> <p>* Resident #5 stated the RVPO confronted her and an Activity Aide and said the activity they were both engaged in was "stupid." When Resident #5 asked the RVPO who he was, the RVPO responded, "I'm the donut man." Resident #5 stated she was "very upset" by the RVPO's response and asked the Activity Aide why the RVPO had treated her like she was "stupid."</p> <p>* Resident #6 stated the RVPO told her she would need to leave the facility unless she showered because her smell "was offending other residents." Resident #6 stated she "felt ashamed and afraid she was going to have to leave [the facility]" as a result of the RVPO's comments.</p> <p>Subsequent to the above interviews, additional resident interviews were not completed to determine the extent of the abuse.</p> <p>c. The facility did not immediately report all allegations of abuse to the Administrator and State Agency within 2 hours:</p> <p>* Resident #1 - On 4/13/17 at 12:21 pm, the DNS said she called the COO on 4/4/17 the day after the incident occurred due to the RVPO's threatening demeanor towards other staff members and herself. She stated the RVPO told her, "If you report me for anything I do or say I'll</p>	F 225			

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F 225	<p>Continued From page 18</p> <p>deny everything and throw you under the bus." She said the RVPO also told her she had to report any and all abuse allegations to the RVPO directly and not to Administrator #1. She stated the RVPO wanted to screen and approve any reportable event report before it was submitted to the State Agency. The DNS said there were three people who were authorized to enter reportable events into the state reporting system, but she would be terminated by the RVPO if she as one of those authorized staff members entered a reportable incident into the state reporting system. The DNS said the corporate office was in charge of the abuse investigation involving the RVPO, who had been suspended on 4/5/17.</p> <p>On 4/13/17 at 1:12 pm, Administrator #1 stated the RVPO was in the building on 4/5/17, at which time he was still not aware of the allegation of abuse or the suspension. Administrator #1 stated he was informed of the abuse allegation and subsequent suspension only after the RVPO had left the building.</p> <p>* Residents #5 and #6 - As of 4/13/17 the allegations of abuse shared during interviews with the LCSW on 4/7/17, had not been reported to the State Agency.</p> <p>d. The facility allowed the RVPO to remain in the building on 4/3/17 after the incident occurred, and to enter the building where he had direct access to residents on 4/5/17 and 4/10/17.</p> <p>On 4/12/17 at 3:20 pm, the DNS stated she saw the RVPO in the parking lot on the morning of 4/10/17. The DNS said she called the Owner, who was on a cruise, and then called the</p>	F 225			

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F 225	Continued From page 19 corporate office to determine whether the RVPO was to be at the facility. She stated a corporate officer told her the RVPO was not to be at the facility. On 4/12/17 at 3:40 pm, Dietary Aide #1 said she saw the RVPO in the parking lot on 4/10/17. She stated she spoke with him and told the RVPO that he was not to be at the facility. Dietary Aide #1 said the RVPO responded to her by saying; "What are you going to do? Call the cops?" On 4/12/17 at 3:45 pm, LPN #3 stated she saw the RVPO in the facility the morning of 4/10/17. She stated he was not there very long. LPN #3 stated the RVPO entered the Administrator's office, but he was no longer on the premises by the time she finished her medication pass a short time later. On 4/13/17 at 3:30 pm, CNA #1 stated she saw the RVPO in the building on 4/10/17. On 4/13/17 at 1:12 pm, Administrator #1 stated the RVPO came into the building on 4/5/17 and spoke with him for about 30 minutes. The facility failed to fully investigated an allegation of abuse, report all allegation of abuse to the Administrator and/or the State Agency within 2 hours, and protect all 38 residents in the facility from potential abuse during its investigation.	F 225			
F 226 SS=F	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12	F 226		5/12/17	

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F 226	<p>Continued From page 20</p> <p>(b) The facility must develop and implement written policies and procedures that:</p> <p>(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>(2) Establish policies and procedures to investigate any such allegations, and</p> <p>(3) Include training as required at paragraph §483.95,</p> <p>483.95</p> <p>(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-</p> <p>(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.</p> <p>(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property</p> <p>(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and review of clinical records, abuse investigation reports, facility policy/procedures, and incidents reported to the State Agency, it was determined the facility failed to ensure implementation of its policies and procedures related to prohibiting</p>	F 226	<p>1) Residents 1, 5, and 6 were effected by this deficient practice. The RVPO was suspended and terminated upon completion of investigation.</p>		

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F 226	<p>Continued From page 21</p> <p>abuse, reporting allegations of abuse to the Administrator and State Agency within 2 hours, thoroughly investigating allegations of abuse, and protecting residents from abuse during the investigation by suspending the accused staff member. This was true for 3 of 6 sampled residents (#1, #5, and #6) and exposed all 38 residents living in the facility to potential abuse. Findings include:</p> <p>The facility's Abuse Prohibition Policy and Procedure, dated 11/21/16, documented the following:</p> <ul style="list-style-type: none"> * The policy defined verbal or mental abuse as "any use of oral, written, or gestured language that willfully included disparaging and derogatory terms to residents...examples include humiliation, threats of physical abuse or deprivation, or use of derogatory names." The policy documented the facility would not tolerate any abuse of a resident. * "Reporting - All allegations must be immediately reported to the facility's Administrator and to the [State Agency] through the Long-Term Care Reporting Portal..." The policy also stated allegations "are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse..." * "Investigation - A thorough investigation is critical to developing effective prevention strategies...All pertinent staff, resident(s), and other witnesses must be interviewed..." * "Protection - Accused employees are immediately removed from resident contact and 	F 226	<p>2) All residents had the potential to be effected by this deficient practice. The RVPO was suspended, and upon completion of the investigation was terminated.</p> <p>3)In order to ensure implementation of our abuse Policy and procedures related to prohibiting abuse, reporting allegations of abuse and protecting residents from abuse, corporate officers reviewed Resident Abuse Prevention Policy for all employees, corporate officers, contractors and volunteers. This policy was updated to include specific procedure for abuse identification, reporting and investigation, as well as training for identification of training and reporting requirements. Corporate HR or designee will ensure abuse training is completed during orientation and a post test will be maintained in the employee file. All appropriate corporate staff will complete training by 5/12/17. A comprehensive resident abuse prevention training was developed and implemented by the corporation.</p>		

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F 226	Continued From page 22 suspended from duty. The accused employee will not be taken off suspension until the conclusion of the investigation has been reached. The accused staff person may not be reassigned to another department in the facility or to a sister facility." Refer to F223 as it relates to the failure of the facility to follow its policy to ensure residents were not subjected to verbal and mental abuse. Refer to F225 as it relates to the facility's failure to follow its policy to ensure allegations of abuse were thoroughly investigated and reported to the Administrator and State Agency within 2 hours, and that residents were protected from abuse while the investigation was in process.	F 226	4) To ensure the corrective actions are effective and compliance is maintained, the COO or designee will audit employee records to ensure completion of mandated abuse training. Administrator or designee will audit all facility staff form completion of abuse training. These audits will be completed weekly x 4 weeks, monthly x three months, and quarterly thereafter. The resident abuse investigation process will be audited according to the social services QA tool. Administrator will participate in the monthly QAPI meetings and COO or designee will attend at least quarterly. Date Certain: May 12, 2017		
F 493 SS=F	483.70(d)(1)(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN (d) Governing body. (1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and (2) The governing body appoints the administrator who is-	F 493		5/12/17	

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F 493	<p>Continued From page 23</p> <p>(i) Licensed by the State, where licensing is required;</p> <p>(ii) Responsible for management of the facility; and</p> <p>(iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of facility e-mails, faxes, investigations, and reportable incidents, it was determined the facility's Governing Body failed to:</p> <ul style="list-style-type: none"> * Ensure the facility sustained substantial compliance in the implementing its policies and procedures regarding abuse and neglect; * Recognize concerns brought to their attention that the Regional Vice President of Operations (RVPO) was engaging in hostile interactions with staff in the presence of residents as an indicator that abuse may have occurred and investigated to rule out that possibility; * Recognize and address concerns brought to its attention that the appointed Administrator was not allowed by the RVPO to have responsibility for the daily management of the facility; * Ensure the protection of residents when allegations the RVPO had abused a resident were made known; and * Take measures to protect the abused resident, and all other residents in the facility, from further exposure to the RVPO from the time of the 	F 493	<p>1)No residents were identified specifically for this deficiency.</p> <p>2)All residents have the potential to be affected by the deficient practice.</p> <p>3) Systemic changes made to ensure that this deficiency does not recur: the governing body appointed a full time administrator. (Administrator job description is attached.) Resident Abuse Prevention Policy and Procedures were reviewed and revised to reflect how to handle abuse, including when the allegation of abuse is by a superior. Employees, including corporate staff, received training on the updated P&P including use of the BRP hotline and alternative methods of reporting.</p> <p>4) To ensure the corrective actions are effective and compliance is sustained, routine</p>		

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F 493	<p>Continued From page 24</p> <p>allegation until the conclusion of the investigation.</p> <p>These failures resulted in the facility's inability to ensure the organization's policies to prevent, report, and investigate instances of abuse were implemented. The failures created the potential for all 38 residents living in the facility to experience abuse and neglect. Findings include:</p> <p>1. Survey Historical Data:</p> <p>a. Past surveys:</p> <p>On 2/18/15 and 9/23/16, the facility was cited when it failed to recognize an allegation of abuse, report the allegation to the State Agency, protect residents from further abuse, investigate the allegation, and implement a corrective plan based on the conclusion to ensure ongoing protection of residents. In both cases, the staff member accused of abusing residents continued to work in the facility in a capacity which allowed direct unsupervised resident contact. The resulting citations in each of these cases identified widespread immediate jeopardy of serious harm from abuse for all residents in the facility. The report from the 2/18/15 survey also identified widespread potential for harm to all residents in the facility due to ineffective administration of the facility's resources and the lack of an effective Quality Assurance program.</p> <p>b. Current survey findings:</p> <p>Refer to F223 as it relates to the failure of the facility to ensure residents were free from abuse.</p> <p>Refer to F225 as it relates to the facility's failure</p>	F 493	<p>visits will be made by COO to the facility. Monthly administrator meeting agenda will include opportunity for administrators to provide candid feedback of corporate office performance.</p> <p>5) Date certain: May 12, 2017</p>		

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F 493	<p>Continued From page 25</p> <p>to thoroughly investigate allegations of abuse, protect residents from further exposure to the alleged abuser, and report and investigate allegations of abuse in a timely manner.</p> <p>Refer to F226 as it relates to the facility's failure to operationalize its policies and procedures regarding abuse and neglect.</p> <p>Refer to F520 as it relates to the facility's failure to ensure an effective Quality Assessment and Assurance program.</p> <p>2. Current Governing Body Practices:</p> <p>a. An anonymous fax to the facility's corporate office, time stamped 2/22/17 at 8:38 am and documented as forwarded to the facility's owner at 9:53 am, documented, "This is from the staff at [facility name]...[RVPO] yells at the staff in the hallways, is unapproachable, he does not respect the management nor any of the staff. He is constantly throwing in everyone's faces, in front of residents, about...a [survey] tag we have..." On 2/24/17 at 11:45 am, an email from the RVPO to the facility's owner, titled as a "Rebuttal," documented the RVPO denied all allegations. The facility's parent organization provided no further documented investigation of the issues, including interviews with staff or residents as to the extent to which residents may have been exposed to behaviors from the RVPO which could have been considered threatening, intimidating, or frightening.</p> <p>b. On 2/27/17, a Written Employee Disciplinary notice from the RVPO to Administrator #2 for "Ineffective Leadership" documented an</p>	F 493			

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F 493	<p>Continued From page 26</p> <p>expectation for Administrator #2 to begin, "Making deliberate management decisions regarding the disposition of your staff, to include holding them accountable...Further, eliminate staff who cannot or will not perform their assigned duties." The date the identified "improvements" were to be achieved was documented as 2/27/17. Administrator #2 documented receipt of this notice a day later, on 2/28/17.</p> <p>c. On 3/6/17, an email from Administrator #2 to the CEO documented a number of concerns with the RVPO. Among the concerns:</p> <p>* The email referred to the 3/22/17 fax, and documented, "...Anonymous staff from [facility name] have sent a fax complaint about the [RVPO's] action about yelling, cussing, and threatening floor staff around residents...I the administrator was made aware of this fax/letter due to a staff member found the fax receipt confirmation. As far as I'm aware, none of this has been investigated. Yet all this action continues..."</p> <p>* "...knowingly I have lost most of my authority [as the facility Administrator] as [of] the moment [the RVPO stepped] in the building..."</p> <p>The 3/6/17 email was attached to a Corporate Grievance form, which documented the organization's Chief Executive Officer (CEO) received it on 3/6/17 at 7:31 am, and the grievance was forwarded to "our compliance and investigation people." The "Investigation Notes" for the grievance documented the organization's Vice President of Human Resources (VPHR)</p>	F 493			

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F 493	<p>Continued From page 27</p> <p>began an investigation on 3/7/17. The VPHR signed the "Investigation Notes" as completed, with none of the allegations substantiated, on 3/21/17.</p> <p>On 3/7/17, Administrator #2 submitted a letter of resignation to the Governing Body in which he stated he "could not work for corporate officers that (sic) promoted a hostile work environment, work harassment, and who treated the employees in a demeaning way." The VPHR documented in the 3/7/17-3/21/17 "Investigation Notes" that Administrator #2's resignation was accepted and effective as of 3/8/17.</p> <p>The VPHR's 3/7/17-3/21/17 "Investigation Notes" documented:</p> <p>* "When [RVPO] was asked if he felt he had undermined [Administrator #2's] authority...[the RVPO] did not concur, as he feels...it is his responsibility to make recommendations, and if necessary, orders to [Administrator #2]...and that he is trying to help [Administrator #2]...if [the DNS] underperforms [then] they [Administrator #2 and the RVPO] will both have responsibility on their licenses for I-J tags." [IJ survey deficiencies, or tags, result from circumstances where the facility's practices have placed residents in the facility in immediate jeopardy of serious harm, impairment, or death. When an IJ deficiency is identified in Idaho, the Bureau of Occupational licenses is notified of which individual was designated by the Governing Body as the licensed Administrator of the skilled nursing facility at the time the immediacy was identified. The notification would involve only the licensed Administrator, not the RVPO.]</p>	F 493			

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F 493	Continued From page 28 * "...[VPHR] informed [Administrator #2] that we had received the fax complaint about [RVPO's] interactions with staff, but since it was anonymous, we had no one to respond to other than to forward it to [the RVPO] so that he could be aware of how his direct approach may be perceived by employees..." No further investigation into the complaint was documented in conjunction with this allegation. 3. Chain of Command a. On 4/13/17 at 12:21 pm, the DNS said she called the COO on 4/4/17 to report an allegation of abuse involving the RVPO and Resident #1. The DNS stated the incident occurred on 4/3/17 at 10:00 am. The DNS stated she delayed reporting the incident as she had been directed to avoid reporting such events to the facility's Administrator, and her employment had been previously threatened by the RVPO. The DNS stated the RVPO told her soon after he was hired that, "If you report me for anything I do or say I'll deny everything and throw you under the bus." She said the RVPO also told her she had to report any and all abuse allegations to the RVPO directly and not to Administrator #1. The DNS stated at one point, the RVPO removed the posting in the facility directing staff how to report abuse or neglect. She stated the RVPO wanted to screen and approve any reportable event before it was submitted to the State Agency. The DNS said there were three people who were authorized to enter reportable events into the state reporting system, but she would be terminated by the RVPO if she, as one of those authorized staff members, entered a reportable	F 493			

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F 493	<p>Continued From page 29</p> <p>incident into the state reporting system without the RVPO's prior approval. The DNS said the corporate office was in charge of the abuse investigation involving the RVPO, but even after the corporate office was made aware of the allegation on 4/4/17, the RVPO was not suspended, prohibited from entering the facility, or having contact with residents until 4/5/17.</p> <p>b. On 4/13/17 at 1:12 pm, Administrator #1 stated he had been the official administrator of record for approximately 17 days. Administrator #1 stated his position was part time, in that he only came to work on days when the RVPO could not be in the facility. Administrator #1 stated this meant that he may only work one or two days a week, and the RVPO was responsible for the day to day operations of the facility. Administrator #1 stated the VPHR was aware of this arrangement, as that individual was at times the one who communicated to Administrator #1 that he needed to come to work on a certain day when the RVPO could not be at the facility. Administrator #1 was asked for, but did not provide, an organizational chart or working schedule as to the chain of command within the facility or the corporate structure.</p> <p>The facility's Governing Body failed to ensure the appointed Administrator was responsible for the daily operations of the facility, failed to investigate allegations the RVPO intimidated and berated staff in the presence of residents, and delayed reporting and investigating an allegation of abuse involving the RVPO. When investigated, the allegation of abuse was substantiated but the Governing Body had not implemented measures to ensure residents were protected from contact</p>	F 493			

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F 493	Continued From page 30 with the RVPO. These combined failures resulted in the inability of the facility to operationalize their policies and procedures for prevention, investigation, reporting, and resident protection from abuse.	F 493			
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the	F 520		5/12/17	

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F 520	<p>Continued From page 31</p> <p>records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of the facility's compliance history, it was determined the facility's Quality Assessment and Assurance [QAA] committee failed to ensure corrective measures to protect residents from potential incidents of abuse were effective and sustained. This failed practice placed all 38 residents residing in the facility at risk of abuse, neglect, exploitation, and misappropriation of property. Findings include:</p> <p>For three consecutive years - 2/18/15, 9/23/16, and 4/23/17 - the facility has been cited at F225, for its failure to report alleged incidents of abuse, and F226, for its failure to implement policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents, and/or the misappropriation of of resident property.</p> <p>On 4/13/17 at 12:21 pm, the DNS stated the March 2017 QAA meeting did not address any items related to the the prevention, identification, protection from, and/or reporting of abuse, neglect, and/or misappropriation of resident property.</p> <p>On 4/13/17 at 4:21 pm, Administrator #1 stated</p>	F 520	<p>Please see IDR request form</p> <ol style="list-style-type: none"> 1) No residents were identified to have been affected by this deficient practice. 2) All residents had the potential to be affected by the same deficient practice. 3) Consistent with QAA committee requirements, each month's QAPI meeting will address any items related to the prevention, identification, protection from and/or reporting of abuse, neglect, and/or misappropriation of resident property. Please see attached March QAPI minutes that validate discussion of abuse prevention items as indicated on 2567. 4) To ensure the corrective action is effective and compliance is sustained, the COO will attend the QAPI meeting no less than quarterly to 		

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: 135084	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/13/2017
NAME OF PROVIDER OR SUPPLIER OAK CREEK REHABILITATION CENTER OF KIMBERLY			STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
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F 520	Continued From page 32 he had not attended a QAA meeting in the facility, but noted the RVPO attended the March 2017 QAA meeting.	F 520	ensure these items are being addressed and reviewed. Each months QAPI minutes will be available for the COO review. Date Certain 5/12/17		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

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July 18, 2017

Josh Smith, Administrator
Oak Creek Rehabilitation Center of Kimberly
500 Polk Street East
Kimberly, ID 83341-1618

Provider #: 135084

Dear Mr. Smith:

On **April 13, 2017**, an unannounced on-site complaint survey was conducted at Oak Creek Rehabilitation Center of Kimberly. The complaint was investigated during a Complaint Investigation Survey conducted April 12, 2017 to April 13, 2017.

Immediately after entering the facility on the first day of survey, the survey team conducted a general tour of resident's rooms and common areas. Throughout the survey, four individual residents and all residents in general were observed for quality of care, signs of distress, and quality of life issues. In addition, facility staff was observed providing care, interacting with residents, and providing residents with medications and other requests.

The clinical records of the identified residents and three other residents were reviewed for quality of life, quality of care, physician services, and medication management. Specifically, pain management, psychosocial needs, discharge planning, and physician rounding was reviewed. The facility's grievance files and Incident and Accident reports were reviewed. Staffing levels over a three-week period were also reviewed.

Interviews were conducted with multiple individual residents, including the identified resident, and the identified resident's interested party. Several direct care staff, including nurses and nursing aides, were also interviewed, as well as the Director of Nursing Services, Social Worker, and Resident Services Director. The interviews included questions about medication management, quality of life, physician rounding, and quality of care issues.

Josh Smith, Administrator
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The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007480

ALLEGATION #1:

The facility allowed an identified resident to give a fellow resident his/her medication.

FINDINGS #1:

Based on interviews with residents and interested parties, and record reviews there were concerns with residents administering medications to other residents.

Based on observation, interviews, and record review, the allegation was substantiated. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility does not have adequate staff to care for residents.

FINDINGS #2:

Throughout the survey process, interviews were conducted with multiple residents who did not identify issues with insufficient staffing. A staffing task was completed to determine whether the facility met state requirements.

Based on interviews with the identified resident, the identified resident's interested party, a Registered Nurse, and record reviews, no concerns with insufficient staffing levels were identified.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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ALLEGATION #3:

The facility told the Interested Party that an identified resident did not meet requirements to stay in the facility.

FINDINGS #3:

Based on interviews with the identified resident, the resident's interested party; a Registered Nurse, the Resident Services Director, the Director of Nursing Services, and record review there was concerns with the facility discussing potential discharge from the facility.

Based on observation, interviews, and record review the allegation was substantiated without deficient practice cited due to evidence that discharge papers were presented to the identified resident.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #4:

The Reporting Party stated an identified resident fell on March 14, 2017 and the facility failed to evaluate the identified resident for injuries to his/her hands from the fall.

FINDINGS #4:

Based on interviews with residents, residents' interested parties, Registered Nurse, the Director of Nursing Services, and record review, there were concerns with the identified resident falling on March 14, 2017.

The resident's clinical record documented his/her foot caught under a rug on March 14, 2017 resulting in his/her falling. The record documented the identified resident experienced temporary mild discomfort to his/her hands. The clinical records documented the facility continued to monitor and assess the identified resident for injury related to the fall until March 21, 2017, and the identified resident did not complain of pain in his/her hand with the exception of the initial mild temporary discomfort.

Based on observation, interviews and record review the allegation was substantiated for the resident falling on March 14, 2017, but the allegation that the identified resident was not evaluated for injury could not be substantiated. Please refer to federal 2567 report for details.

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CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #5:

The identified resident exited the building without supervision trying to speak to his/her physician.

FINDINGS #5:

Based on interviews with the identified resident, resident's interested party, a Registered Nurse, the Director of Nursing Services, and record review there were no concerns identified related to the identified resident leaving the building without supervision or attempting to speak with his/her physician.

Based on observation, interviews, and record review, the allegation could not be substantiated due to lack of sufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The facility failed to treat the identified resident's cough for three weeks following his/her first symptoms.

FINDINGS #6:

Based on interviews with the Director of Nursing Services, and record review, there were no concerns with the identified resident's cough not receiving an evaluation in a timely manner. The identified resident's clinical records documented he/she received medications for a cough and allergies since 2016. The clinical record documented the identified resident utilized breathing treatments for a cough beginning February 2017. The clinical records documented the identified resident had a history of bronchitis, as well.

Based on observation, interviews and record review the allegation could not be substantiated due to lack of sufficient evidence.

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CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Three of the allegations were substantiated, but not cited. Therefore, no response is necessary.
Thank you for the courtesies and assistance extended to us during our visit.

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