IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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3232 Elder Street
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May 12, 2017

Joan Martellucci, Administrator
Life Care Center of Coeur d'Alene
500 West Aqua Avenue
Coeur d'Alene, ID 83815-7764

Provider #: 135122

Dear Ms. Martellucci:

On **April 20, 2017**, a survey was conducted at Life Care Center of Coeur d'Alene 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.

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 22, 2017**. Failure to submit an acceptable PoC by **May 22, 2017**, may result in the imposition of penalties by **June 16, 2017**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;

- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and

- Include dates when corrective action will be completed <u>in column (X5)</u>.

  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 30, 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 19, 2017**. A change in the seriousness of the deficiencies on **June 4, 2017**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 19, 2017** includes the following:

Denial of payment for new admissions effective **July 19, 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 17, 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 19, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **May 22, 2017** If your request for informal dispute resolution is received after **May 22, 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
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135122		**04/20/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF COEUR D'ALENE	**500 WEST AQUA AVENUE** **COEUR D ALENE, ID 83815**

(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 the federal recertification and complaint survey conducted at the facility from April 17, 2017 April 20, 2017. The surveyors conducting the survey were: Teresa Kobza, RDN/LD, Team Coordinator Haley Young, LSW Marci Clare, RN Melanie Tatom, RN ABBREVIATIONS: ADL = Activities of Daily Living bid = Twice a Day BIMS = Brief Interview for Mental Status CAA = Care Area Assessment cm = Centimeter CNA = Certified Nursing Assistant Director of Maintenance = DOM DON = Director of Nursing DTI = Deep-Tissue Injury DTI PU = Deep-Tissue Injury Pressure Ulcer Dx = Diagnosis ED = Executive Director FSD = Food Service Director FTT = Failure to Thrive HTN = Hypertension LPN = Licensed Practical Nurse MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set mg = Milligram mL = milliliter p.o. = by mouth PU = Pressure Ulcer	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/22/2017

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 PVD = Peripheral Vascular Disease q = Every RCM = Resident Care Manager RD = Registered Dietitian RDCS = Regional Director of Clinical Services r/t = Related to SDTI = Suspected Deep-Tissue Injury SDTI PU = Suspected Deep-Tissue Injury Pressure Ulcer TAR = Treatment Administration Record UTI = Urinary Tract Infection x = by % = Percent	F 000		
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 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 -	F 279		5/30/17

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F 279	Continued From page 2 (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 (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). (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. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it	F 279	*Resident #2's care plan was reviewed	

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F 279	Continued From page 3 was determined the facility failed ensure a resident-specific care plan was developed for a resident with a diagnosis of depression, who received antidepressant medication, and whose MDS assessments documented mood severity scores indicating the presence of depression. This was true for 1 of 10 residents (Resident #2) sampled for care plan development. The deficient practice had the potential to cause more than minimal harm if the resident experienced continued depression or a deterioration in her mood state, because the facility did not implement a care plan for her mental health needs. Findings include: Resident #2 was admitted to the facility on 10/31/16, with multiple diagnoses which included failure to thrive, anorexia, and depression. Resident #2's 11/8/16 admission Minimum Data Set [MDS] assessment documented no cognitive impairment and signs of mild depression. Her 1/13/17 significant change MDS assessment documented no cognitive impairment and signs of mild depression. Resident #2's April 2017 physician recapitalization orders included 1/20/17 order that she receive Remeron 15 mg, by mouth, at bedtime as an appetite stimulant. Resident #2's Behavior Management Care Plan, dated 11/9/16, documented she had alterations in mood and behaviors related to a diagnosis of "appetite stimulant." The Care Plan stated Resident #2 exhibited the behavior of "poor p.o. [oral by mouth] intake."	F 279	and updated to include Depression. *DNS or designee will audit all residents with diagnosis of depression, who are taking an antidepressant to assure a care plan is in place. *Root Cause Analysis demonstrates that the resident was admitted with a diagnosis of depression and no care plan was initiated at that time. Facility will review all new residents admitted with a diagnosis will have a care plan initiated if they are on an antidepressant medication. The Health Information Manager, Director of Admissions, Case Managers, and Licensed nurses will be educated regarding the initiation of a depression care plan for residents taking an antidepressant medication. *Health Information Manager will audit all new admissions weekly for diagnosis of depression for care plan initiation for 3 months. Results will be reported to the Quality Assurance/Performance Improvement Committee for review and recommendations.	

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F 279	Continued From page 4 Resident #2's Psychotropic Medication Care Plan, dated 10/31/16, documented Resident #2 was at "risk for side effects related to the use of [an] antidepressant medication." Resident #2's clinical records did not contain a care plan for her diagnosis of depression. On 4/20/17 at 11:15 am, the House MD [Medical Doctor] stated the Remeron was initially started as an "appetite stimulant" for Resident #2. The House MD said in January 2017 he decided to increase the dose of Remeron to be used for her "diagnosis of depression." He stated Resident #2 presented her depression through "a flat affect and refusal of cares." The House MD stated he would expect staff to monitor Resident #2 for the effectiveness of the medication. On 4/20/17 at 4:29 pm, the Executive Director stated if a resident had a diagnosis of depression, the care plan should include depression, and staff should monitor for signs and symptoms of depression. Resident #2's clinical record did not contain a Care Plan to address her depression.	F 279		
F 312 SS=E	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews, it was determined	F 312	*Residents #6, #7, #10 and #14 will be assessed for signs and symptoms of	5/30/17

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F 312	Continued From page 5 the facility failed to ensure 4 of 17 sampled residents (Resident #6, #7, #10, and #14) who required staff assistance, were provided assistance with bathing and/or oral hygiene. The deficient practice created the potential for residents to experience tooth decay, skin breakdown, infection, or embarrassment when not properly groomed. Findings include: 1. Resident #7 was admitted to the facility on 2/11/17, with diagnoses which included displaced supracondylar fracture of left femur [break of the thigh bone at the knee] with subsequent encounter for closed fracture with routine healing, generalized muscle weakness, chronic obstructive pulmonary disease, depression, and type 2 diabetes. Resident #7's Care Plan-Activities of Daily Living (ADLs)-Self Care Deficit, dated 3/1/17, documented Resident #7 needed assistance with care related to impaired mobility, non-weight bearing of left lower extremity, chronic obstructive pulmonary disease with use of oxygen, pain, femur fracture with surgical repair, and chronic debilitated state. Approaches included a two person slideboard transfer for showering with two person sit-to-stand using grab bar, and exchange the resident's wheelchair to a shower chair with one person supporting the left lower extremity. An undated unsigned handwritten addition, "Refuses showers and bed baths routinely-husband to assist with washing if body odor occurs. Continue to offer showers and bed baths." Resident #7's Care Area Assessment (CAA), signed 3/2/17, documented a triggered area of	F 312	tooth decay, skin breakdown, and infection and will be interviewed for any negative effects from this deficient practice. *The facility will conduct weekly audits of records to ensure showers are documented as given or refused at least once weekly as per policy. DNS/Resident Care Managers will audit records of residents requiring total or extensive assistance with oral care and place oral care on an alternate means of documentation that will allow the option to document refusals and Licensed Nurses can ensure appropriate documentation. *Root cause analysis demonstrates that CNA's do not have the ability to document oral care refusals within the electronic health record. The electronic Health Record shows a "hole" in documentation. The Director of Staff Development and/or designee will educate all CNA's to report all refusals to the Licensed Nurse and the LN will be educated to re-approach resident who refuse and document refusals appropriately. Education will also include alternative methods of bathing to be offered if shower is declined. Ongoing refusals will be addressed in a Care Conference to determine resident preference/root cause analysis for refusals/risks and benefits, and address accordingly. * DNS or designee will audit 15 residents who require extensive or total assistance weekly for six weeks and monthly for 3 months to ensure oral care is documented or refusals are documented.	

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F 312	Continued From page 6 Activities of Daily Living (ADL) functional/rehabilitation potential, and that care planning was necessary. On 4/17/17 at 12:25 pm, Resident #7 was observed in bed. She was thin, had a wrap around her left leg, and had shoulder length hair that appeared stringy and uncombed. Resident #7 stated the aides were not careful when transferring her, had dropped her leg when attempting to transfer her for a shower, and that she did not trust the aides to bathe her. On 4/18/17 at 9:08 am, Resident #7 was observed in bed. Her hair continued to appear stringy and unwashed. On 4/18/17 at 9:10 am, CNA (Certified Nursing Assistant) #5 said she was not sure of Resident #7's scheduled shower day, but Resident #7 sometimes refused to shower. When Resident #7 refused, they were to continue to approach her and try again. In an interview on 4/18/17 at 12:00 pm, CNA #4 said she was Resident #7's usual shower aide. CNA #4 stated that usually Resident #7's husband gave her a bed bath and that when showers were offered, Resident #7 would typically say her husband would bathe her. CNA #4 said she had given Resident #7 one shower and would really like to be able to give her a shower. CNA #4 said she had told the nurses a couple weeks ago that Resident #7 really needed a bath, and the nurses said the husband would take care of it. On 4/18/17 at 12:50 pm, Resident #7 said she	F 312	DNS/Resident Care Managers will audit all showers weekly for 6 weeks and monthly for 3 months to ensure shower, refusal or bed baths are documented. Audits will be reviewed by the Quality Assurance/Performance Improvement Committee for ongoing compliance and recommendations.	

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F 312	Continued From page 7 did not trust the aides to safely get her into the shower chair. Resident #7 said she had not had a bed bath, and had no way to wash her hair. Resident #7 said she had requested a bath about a week ago but had not received one yet. Resident #7's Monthly Flow Report from the time of Resident #7's admission on 2/11/17 through 4/18/17, documented: * Showered on 2/23/17, 3/3/17, 3/14/17 * Shower refused on 3/9/17, 3/23/17, 3/30/17, and 4/6/17 * Sponge bathed on 3/9/17 * Bed bath refused on 3/23/17 The last documented Monthly Flow Sheet bathing by any means was Resident #7's shower on 3/14/17. On 4/19/17 at 9:50 am, CNA #4 said she offered Resident #7 a shower everyday she was there. On 4/19/17 at 11:40 am, an inflatable in-bed hair washing basin was observed on the bottom shelf of a supply closet in the facility beauty shop. On 4/19/17 at 12:10 pm, CNA #4 said she took Resident Care Manager (RCM) #2 with her and again offered Resident #7 a shower. CNA #4 said that Resident #7 said she had too much going on. CNA #4 said they would try again tomorrow. CNA #4 said Resident #4 had also canceled a beauty shop appointment. On 4/19/17 at 12:12 pm, the Cosmetologist was observed exiting Resident #7's room. The Cosmetologist said that Resident #7 had	F 312		

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F 312	Continued From page 8 canceled several appointments, including one today, and had just rescheduled for a haircut tomorrow. The Cosmetologist said she did have the capability to give an in-bed shampoo but had not received a request for an in-bed shampoo for Resident #7. The Cosmetologist said typically a nurse would request an in-bed shampoo for a resident. On 4/20/17 at 2:15 pm, the Director of Nursing (DON) stated that she had made the handwritten update to Resident #7's ADL care plan on 3/22/17. The DON said it was acceptable that Resident #7 be bathed every 7th day, thus computerized documentation of bathing activities might appear only every 7th day. The DON said that if Resident #7 refused a bath on a given day, Resident #7 should be offered a bath on each subsequent day after the refusal, and that the computerized documentation program would allow documentation of bathing refusals on any given day. The DON examined Resident #7's ADL flow sheets printed on 4/18/17 and concurred that the last documented attempt at bathing was a refused shower on 4/6/17. The DON said there should have been additional documented attempts to bathe Resident #7 on the twelve subsequent days. The DON said there might be additional bathing documentation regarding Resident #7 on shower sheets kept by the aides. The DON said it was Resident #7's right to refuse showers. On 4/20/17 at 3:05 pm, the DON said she had found some shower sheets for April, but was unable to access those which might have been filled out in March.	F 312		

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F 312	Continued From page 9 The untitled shower sheets provided by the DON documented the following: 3/30/17- Resident #7 "Husband does bed bath." 4/6/17- Resident #7 refused three times and a notation made that the husband would do a bed bath 4/7/17- Resident #7 refused three times 4/8/17- Resident #7 refused four times 4/11/17- Resident #7 refused three times and a notation made that the husband would do a bed bath 4/12/17- Resident #7 refused four times Resident #7 was concerned for her safety when being transferred by CNAs. Resident #7 was not offered a bath or shower daily, after she refused them. An in-bed shampoo had not been requested and offered to Resident #7 as an alternative to going to the beauty shop. 2. Resident #6 was admitted to the facility on 12/22/16, with diagnoses that included intracerebral hemorrhage, anxiety disorder, epilepsy and mixed receptive expressive language disorder. Resident #6's Minimum Data Set assessment, dated 3/18/17, documented the staff could not interview Resident #6 for the cognitive abilities section because she scored a 3 on the Glasgow Coma Scale [the most common scoring system used to describe the level of consciousness in a person following a traumatic brain injury]. The MDS assessment documented Resident #6 relied completely on the staff to perform her ADLs, including oral care.	F 312		

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	135122		**04/20/2017**

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F 312	Continued From page 10 Resident #6's care plan, dated 12/22/16, indicated she needed "total assist with oral care and brushing her teeth." Resident #6's ADL flowsheets for January 2017 through April 2017 documented Resident #6 did not receive oral care by the CNAs on 16 days. There were 7 instances where Resident #6 did not receive oral care on day shift and no oral care 9 times on the evening shift. Resident #6's nurse's notes, for January 2017 through April 2017, documented no oral care for 10 out of the 16 days. Six of the 16 days there was a nurse's note that indicated the charge nurse performed the oral care for Resident #6. An undated Oral Hygiene: Unconscious Resident policy indicated the staff was to provide dental care before breakfast and at bedtime or as needed. Under Reporting Procedures the policy documented, "the nursing assistant must report the following information to the staff/charge nurse: 1. That oral care and hygiene has been given...2. The time the procedure was given...7. If the resident refused the procedure and why." During an interview on 4/19/17 at 1:30 pm, RCM [Resident Care Manager] #1 said the floor nurses were responsible for making sure the CNAs performed all the resident's ADLs each shift. She said the floor nurses should be aware if there were blanks in the resident's ADL documentation. RCM #2 said if a CNA tells a floor nurse the resident refused oral care then the nurse should try to perform the oral care themselves and document it. RCM #2 said in the case of Resident #6 she cannot verbally refuse but if she	F 312		

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F 312	Continued From page 11 was to struggle or show signs of agitation that would be documented as a refusal. On 4/20/17 at 10:20 am, RCM #1 said if there was no documentation on the ADL flowsheet or the nurse's notes then he would have to conclude that the oral care was not provided for Resident #6 on those days. On 4/20/17 at 3:10 pm, the DON said the standard of care was for CNAs and nurses to document whenever they performed an ADL for a resident. She said she could not prove oral care was done for Resident #6 on the days in question because there was no documentation. The DON said the facility was not following its policy related to oral care documentation. 3. Resident #10 was admitted to the facility on 1/27/17 with multiple diagnoses including gout, arthritis, stroke, and hemiplegia. Resident #10's 2/3/17 admission MDS assessment documented extensive assistance of one person for hygiene and oral care. The assessment documented Resident #10 required staff assistance with all cares. Resident #10's Self Care Deficit Care Plan, dated 1/27/17, documented Resident #10 required staff assistance with self-cares related to his stroke and right sided paralysis, and required extensive assistance with personal hygiene including oral care. Resident #10's Oral Care Monthly Flow Reports documented the following number of days that oral care was not provided:	F 312		

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F 312	Continued From page 12 * February 2017 = 6 of 28 days * March 2017 = 6 of 31 days * April 2017 = 3 of 18 days On 4/19/17 at 2:30 pm, the DON stated she would expect oral care to be done twice a day as care planned. The DON said the nurses are to follow up with the aides before they leave for the day, and there should not be missing documentation. 4. Resident #14 was admitted to the facility on 12/24/13 with multiple diagnoses including pain and dementia. Resident #14's 2/3/17 annual MDS assessment documented Resident #14 required extensive assistance of one person for hygiene and oral care. The assessment documented Resident #14 required staff assistance with all cares. Resident #14's Self Care Deficit Care Plan, dated 1/3/14, documented Resident #14 had a decline in his self-cares related to debility from worsening of chronic pain and required staff assistance with self-cares, including set up at the sink for oral care morning and evening, and after lunch as Resident #14 was willing. Resident #14's Nutrition Care Plan, dated 9/11/2014, documented to encourage him to brush teeth after meals. Resident #14's Oral Care Monthly Flow Reports documented the following number of days that oral care was not provided:	F 312		

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F 312	Continued From page 13 * January 2017 = 9 of 31 days * February 2017 = 8 of 28 days * March 2017 = 8 of 31 days On 4/19/17 at 2:30 pm, the DON stated she would expect oral care to be done twice a day as care planned, the nurses are to follow up with the aides before they leave for the day, and there should not be missing documentation.	F 312		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (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 (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. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident, and interested party interview, record review, and policy review, it was determined the facility failed to ensure residents did not develop avoidable Pressure Ulcer [PU]. This was true for 1 of 4 sample residents (#2) reviewed for PU's. Resident #2 was harmed when she developed a	F 314	*Resident #2's impaired skin integrity to mid spine has resolved. Will continue plan of care which includes low air loss mattress, encouragement to allow assistance with repositioning and floating heels. Will continue with prophylactic dressing to susceptible area on spine and	5/30/17

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F 314	Continued From page 14 suspected deep-tissue injury pressure ulcer [SDTI PU] which deteriorated and worsened. Findings include: Resident #2 was admitted to the facility on 10/31/16, with multiple diagnoses including failure to thrive, anorexia, pain, tube feeding dependent, and depression. Resident #2's Physician Order, dated 10/31/16, documented staff was to complete a weekly skin assessment on Wednesdays. Resident #2's 10/31/16 Risk for Pressure Ulcers Care Plan documented she was at risk for pressure ulcers related to diagnoses of failure to thrive, peripheral vascular disease [PVD], hypertension [HTN], pain, and she required staff assistance with transfers and bed mobility. An intervention documented staff was to complete weekly skin assessments. Resident #2's 11/8/16 admission Minimum Data Set [MDS] assessment documented no cognitive impairment and she was at risk for skin breakdown. The admission MDS assessment documented interventions of using a pressure reducing device while in bed. Resident #2's Physician Order, dated 12/15/16, documented Resident #2 was to be up in a chair for 15 minutes in morning and the afternoon when her interested party was present and when she allowed. Between 12/16/16 and 1/13/17 Resident #2's Nurse's Notes documented she was turned and repositioned in bed every two hours on 13 of 84	F 314	continue to offer and encourage to get out of bed twice a day. *Interdisciplinary Skin team will review all current residents identified as high risk for skin breakdown for interventions in place to prevent skin breakdown. *Director of Staff Development or designee will conduct training to licensed nurses and cna's on identification of high risk patients and the importance of immediate intervention. *DNS or designee will audit all new admission Braden scores x 6 weeks, interventions for all high risk residents and effective implementation and documentation of interventions. DNS or designee will review completed quarterly Braden scales on a weekly basis x 3 months and ensure high risk residents have interventions to prevent pressure ulcers care planned, implemented and documented. All data will be reviewed an monthly Quality Assurance Improvement Committee meeting.	

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F 314	Continued From page 15 shifts. Repositioning or refusal to be repositioned were not documented between 1/10/17 and 1/13/17. Resident #2's Skin Team Nurse's note, dated 1/13/17 at 2:55 pm, documented the Team was called to assess an area of her mid spine/back. The note documented the area was a deep red/purple intact area [100 cm by 60 cm]. The note documented a shower aide noticed the area when Resident #2 was placed into the shower chair and she "vocalized pain." The note documented she was "resistive to repositioning techniques." The note documented the MD saw Resident #2 and confirmed the SDTI was from her back lying position. The note documented a low loss air mattress was ordered and the skin team would be following Resident #2. On 4/18/17 at 12:35 pm, LPN #3 stated the 100 cm by 60 cm measurement was a mistake in the skin team's note on 1/13/17. LPN #3 referred to the Pressure Ulcer Status Record documentation for the correct measurements. Resident #2's Physician Order, dated 1/13/17, documented Resident #2 was to have an air mattress for pressure ulcers. Resident #2's 1/13/17 significant change MDS assessment documented she had an unstageable DTI and she did not reject cares. The significant change MDS documented interventions of a pressure reducing device while in bed, a turning and repositioning program, and adequate nutrition. Resident #2's Risk for Pressure Ulcers Care Plan, updated on 1/13/17, documented, "Refuses	F 314		

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F 314	Continued From page 16 repositioning techniques...prefers to be on her back while in bed, spends most of every day, all day in bed." The interventions on the care plan did not include dates of when the interventions were added. The interventions on the care plan were undated and it was unable to be determined when they were put into place. Interventions included: * Staff was to complete weekly skin assessments. * Provide "pressure reduction mattress- low loss air mattress." * Staff were to provide a "turning and repositioning program q [every] 2-3 hours as she [Resident #2] will allow." Resident #2's Physician Progress note, dated 1/14/17, documented the facility asked the MD to look at Resident #2's back, "which shows an area that they [the skin team] think is pressure or possibly injury from lifting." The MD note documented in his assessment he was not sure where the DTI came from; he speculated it was from transferring to a shower chair or prolonged bed rest. Resident #2's Pressure Ulcer Status Record entry, dated 1/14/17, documented the deep-tissue injury pressure ulcer [DTI PU] was 5 cm x 6 cm. Resident #2's Risk for Pressure Ulcer Care Plan included an updated intervention on 1/17/17, which documented, "administer treatment to back/spine per MD." Resident #2's care plan did not include the SDTI injury to the mid spine/back except to administer the treatment on 1/17/17.	F 314		

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F 314	Continued From page 17 Resident #2's January 2017 Treatment Administration Records [TAR] documented weekly skin assessments had been completed on 1/4/17, 1/11/17, 1/18/17, and 1/25/17. Resident #2's Weekly Skin Integrity Data Collection Record, where LNs were to document the condition of Resident #2's skin at the time of each assessment, such as whether Resident #2's skin was intact, or which areas of skin were dry, red, where skin tears were found, etc., was blank on 1/18/17. Resident #2's Incident and Accident report, dated 1/19/17, documented a shower aide found Resident #2 had a purple area on her spine. The report documented the skin team assessed the area and determined it was a SDTI. The report documented Resident #2 was at high risk for pressure related injuries due to refusals to get "out of bed," failure to thrive, and need for nutritional support. The report documented actions taken included: * Resident #2 was to be placed on an alternating air mattress. * The RD [Registered Dietician] was to review Resident #2 to verify adequate nutrition was being provided through her nutrition support. * Staff was to provide a repositioning schedule as Resident #2 would allow. * Staff were to encourage her to get "out of bed" throughout the day. Resident #2's Physician Note, dated 1/19/17, documented her Interested Party asked the MD to look at Resident #2's back due to a concern about her getting an infection. The note	F 314		

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F 314	Continued From page 18 documented staff removed the dressing and it created a "mild abrasion due to the stickiness" of the dressing. The note documented new orders for the treatment of the back mid spine area and that the bed had been changed out for an air mattress to decrease any other issues with her skin. Resident #2's Physician Note, dated 1/20/17, documented the DTI PU to her back was due to "lying for prolonged periods of time in one position." The 1/24/17 Pressure Ulcer Status Record documented a small part of Resident #2's DTI PU worsened to a stage II of 1.6 cm x 2 cm by 0.2 deep. Resident #2's Braden Scale for Predicting Pressure Sore Risk, dated 1/26/17, scored her at moderate risk. Resident #2's February 2017 TAR documented weekly skin assessments had been completed on 2/1/17, 2/8/17, 2/15/17, and 2/22/17. Resident #2's Weekly Skin Integrity Data Collection Record did not document the results of the skin assessments on 2/1/17 and 2/22/17. The 2/2/17's Pressure Ulcer Status Record documented a small part of Resident #2's DTI PU measured 1.8 cm x 0.7 by 0.2 cm deep and remained a stage II pressure ulcer. The 2/10/17 Pressure Ulcer Status Record documented a small part of Resident #2's DTI PU worsened to an unstageable wound of 0.3 cm x 0.3 cm.	F 314		

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F 314	Continued From page 19 The 2/14/17 Pressure Ulcer Status Record documented Resident #2's DTI PU remained an unstageable wound. A Notifications Fax to the Physician, dated 3/2/17, documented Resident #2 had multiple diagnoses which impacted her skin integrity. The fax continued to document Resident #2 was "very self-directing" in her cares and she "chooses not to follow care planned interventions." The fax asked the MD to reference a 3/2/17 Skin Team Nurse's Note which documented the reason Resident #2's wound was unavoidable and to please write an order for an unavoidable PU. Resident #2's Skin Team Nurse's note, dated 3/2/17, documented "...Floor staff requested to strongly and consistently encourage Pt [patient] to follow medically recommended Plan of care, Due to Pts usual failure to follow recommended Plan of Care Skin Team is requesting an order for unavoidable Pressure ulcers...Recommendations for frequent Turning and Repositioning generally declined..." Resident #2's Pressure Ulcer Status Record entries on 2/21/17, 3/2/17, 3/9/17, 3/14/17, 3/21/17, 3/27/17, 4/4/17, and 4/11/17 documented progressive healing of the wound. Resident #2's March 2017 TAR documented weekly skin assessments were to be completed on 3/1/17, 3/8/17, 3/15/17, and 3/29/17. Resident #2's March 2017 TAR did not include documentation of a weekly skin assessment on 3/22/17. Resident #2's Weekly Skin Integrity Data Collection Record did not document the results of	F 314		

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F 314	Continued From page 20 a weekly skin assessment on 3/22/17. On 4/17/17 at 2:45 - 3:24 pm, Resident #2 was observed in her bed laying on her right side with a pillow behind her back. Resident #2 stated she depended on staff for most everything. She stated she got up in a chair about once a week. Resident #2's Pressure Ulcer Status Record final entry on 4/18/17, documented the DTI PU had resolved. On 4/18/17 at 9:36 - 11:30 am, Resident #2 was in her room with her Interested Party and she was observed laying on her right side throughout the observation. Resident #2's Interested Party stated a CNA had come in at about 11:00 to ask Resident #2 if she wanted to get up "out of bed" and Resident #2 had declined. On 4/18/17 at 12:35 pm, LPN #3 stated the main conclusion the Skin Team had determined the cause of Resident #2's DTI PU to her back was due to her refusal to be turned and repositioned and refusal for other cares. She stated Resident #2 managed her cares and only did what she wanted. LPN #3 was asked to provide documentation of the refusals and LPN #3 provided copies of the refusals to get "out of bed" and "weight" refusals as documentation. She stated she could not find documentation of refusals to reposition and turn prior to the discovery of the DTI PU. She stated nurses had documented in Nurse's notes, after the PU discovery that Resident #2 had been refusing to reposition and turn. On 4/18/17 at 12:40 pm, the Director of Nursing	F 314		

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F 314	Continued From page 21 [DON] stated when the SDTI PU was discovered they ordered the air mattress and the treatments did not get ordered until the SDTI PU worsened. On 4/19/17 at 9:45 am, RCM [Resident Care Manager] #1 stated when skin checks were completed nurses were to initial the TAR, and then fill out the Weekly Skin Integrity Data Collection Record which showed the RCM's that nurses had "actually looked" at residents' skin and "not just signed off" that they had completed it. RCM #1 said if nurses found no new skin issues the nurse was still to complete the Weekly Skin Integrity Data Collection Record. In addition, he said if nurses found pressure related injuries or non-pressure related injuries there was another form that staff were to fill out in addition to the Weekly Skin Integrity Data Collection Record and signing off on the TAR. RCM #1 stated the missing dates above should have contained entries on the Weekly Skin Integrity Data Collection Record. On 4/19/17 at 10:15 am, the Director of Nursing [DON] stated when skin checks were completed nurses were to initial the TAR, and then fill out the Weekly Skin Integrity Data Collection Record. She stated if the TAR was signed off as completed, then a skin check was completed, and the dates above, with the exception of 3/22/17, was just missing documentation. On 4/19/17 at 3:40 pm, the DON stated Resident #2 got the SDTI PU related to Resident #2's refusal to get up out of bed, failure to thrive, and her lack of subcutaneous tissue [innermost layer of skin made up of fat] on her back.	F 314		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 22 On 4/20/17 at 11:15 am, the House MD stated it was a "mystery" how Resident #2 got the area on her back. He stated the nursing staff told him it was due to her refusals to be turned or repositioned. He stated he knew she required staff assistance with repositioning. The MD said he would expect nurses to be monitoring her for refusals to reposition before making that determination. The MD stated he personally did not monitor Resident #2 for refusals but expected nursing staff to monitor for it. b. The facility's resistance to cares monitoring included: * Resident #2's January - February 2017 Treatment Administration Record [TAR] documented staff monitored when Resident #2 was up in a chair for 15 minutes in morning and the afternoon, and staff were to document refusals. Resident #2 did not get out of bed 81 times out of 118 opportunities throughout January and February 2017. The TAR did not include Resident #2's acceptance or refusal of turning and/or repositioning. * Resident #2's 3/1/17 - 4/17/17 TAR documented staff was monitored when Resident #2 was up in a chair for 15 minutes in morning and the afternoon, and were to document refusals. Resident #2 did not get "out of bed" 81 times out of 94 opportunities throughout time frame. The TAR documented an intervention of the staff re-approaching Resident #2 on 4/15/17, which was 1 out of 81 opportunities. On 4/20/17 at 8:59 am, Resident #2 stated she did not mind being turned in bed. She stated she	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135122		**04/20/2017**

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F 314	Continued From page 23 depended on staff to transfer and reposition her in bed. Resident #2's clinical record, prior to the discovery of the DTI PU, did not document a pattern of Resident #2 refusing to be turned or repositioned. The facility determined Resident #2's pressure ulcer was unavoidable due to her refusals to be turned or repositioned. Resident #2's clinical record did not include documentation of such refusals. The facility failed to ensure Resident #2, who was at high risk for PUs, did not develop a PU, and did not modify interventions to increase Resident #2's compliance with her care planned interventions.	F 314		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329		5/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135122		04/20/2017

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F 329	Continued From page 24 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (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; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents' psychoactive medications had adequate indications for use and specific target behaviors were identified and monitored. This was true for 1 of 7 (#2) sampled residents reviewed for depression. These failures created the potential for harm if residents received excessive doses or unnecessary medications. Findings include: Resident #2 was admitted to the facility on 10/31/16, with multiple diagnoses which included failure to thrive, anorexia, and depression. The manufacturer's recommendations for the antidepressant, Remeron, documented the medication was indicated for the treatment of major depressive disorder.	F 329	*Resident #2's medication was reviewed by physician and determined to have adequate indications for use. Targeted behaviors have been identified and behavior monitoring put into place. * All other residents utilizing psychoactive medications were audited to ensure adequate indications for use, specific targeted behaviors identified, and behavior monitoring in place. *Director of Staff Development/and/or designee will instruct Interdisciplinary Team members of the policy requiring identification of targeted behaviors and behavior monitoring for psychoactive medications with focus on assuring adequate monitoring to prevent the use of un-necessary medications. *Health Information Manager will conduct	

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	135122		04/20/2017

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F 329	Continued From page 25 Resident #2's 11/8/16 admission Minimum Data Set [MDS] assessment documented no cognitive impairment and signs of mild depression. Her 1/13/17 significant change MDS assessment documented no cognitive impairment and signs of mild depression and that she was dependent on a feeding tube for her nutritional needs. Resident #2's Admission October 2016 physician recapitulation orders documented she received Remeron 7.5 mg, by mouth, at bedtime as an appetite stimulant, ordered 10/31/16 and discontinued 1/20/17. Resident #2's April 2017 recapitulation orders documented a new order for Remeron at 15 mg daily for an appetite stimulant. The April recapitulation orders also documented Resident #2 had her nutritional needs met through a feeding tube since 12/12/16, and had oral food intake only when she chose, for pleasure. Resident #2's Nutrition Care Plan, revised 1/10/16, documented staff were to administer feeding tube nutrients per Medical Doctor's [MD] orders. The care plan documented Resident #2, "eats meals for pleasure only." Resident #2's Nutrition Support Care Plan, dated 11/15/16, documented Resident #2 ate "pureed foods as tolerated for pleasure." Resident #2's Behavior Management Care Plan, dated 11/9/16, documented she had "alterations in mood and behaviors [related to a diagnosis] of appetite stimulant. Resident exhibits the following behavior: poor [oral by mouth] intake." Resident #2's Psychotropic Medication Care	F 329	an audit of all new psychoactive medications to assure adequate indications for use, behaviors identified, and behavior monitoring is in place, on a monthly basis and report finding to the Quality Assurance/Performance Improvement Committee for ongoing oversight/compliance.	

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	135122		04/20/2017

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F 329	Continued From page 26 Plan, dated 10/31/16, documented Resident #2 was at "risk for side effects related to the use of [an] antidepressant medication." Resident #2's clinical records did not contain a care plan for her diagnosis of depression. Resident #2's Physician Progress note, dated 1/20/17, documented the physician's plan was to increase Resident #2's Remeron dose to 15 mg at bedtime. The note did not document a clinical justification for the increased dosage and/or include a diagnosis for the continued use of the medication. Resident #2's Social Services Psych Med Note, dated 2/1/17, documented she was currently prescribed Remeron 7.5 mg daily at bedtime as an appetite stimulant. The note documented "Resident continues to consume average 25% each meal daily and IDT [Interdisciplinary Team] recommends she remain on this antidepressant...Dietary and nursing state oral intake [is] for pleasure eating only... Monitor in place to document [percent of] pleasure meals consumption daily..." Resident #2's 1/1/17 through 4/19/17 Behavior Intervention Monthly Flow Record documented she was receiving the medication as an appetite stimulant and staff monitored the percentages of meals Resident #2 was consuming. On 4/20/17 at 8:59 am, Resident #2 stated she was happy in the facility, however, it would be nice to be able to go home someday. On 4/20/17 at 11:15 am, Resident #2's physician	F 329		

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F 329	Continued From page 27 stated the Remeron was initially started as an "appetite stimulant" for Resident #2. He stated Resident #2 had a history of refusing to eat and weighed as little as 68 pounds when she was admitted to the facility. He stated a tube feeding was initiated in November 2016, but she remained on the medication. The physician said in January 2017 he decided to increase the dose of Remeron to be used for her "diagnosis of depression." He stated Resident #2 presented her depression through "a flat affect and refusal of cares." The MD stated he would expect staff to be monitoring Resident #2 for the effectiveness of the medication. Resident #2's clinical records did not did not identify or document targeted behaviors related to depression.	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 371		5/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 28 (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure measures were in place to prevent possible cross-contamination, a) of dirty to clean areas in the kitchen and b) during food preparation and service. This was true for 14 of 17 (#1-#10 and #14-#17) sampled residents and 65 of 69 other residents who ate food prepared by the kitchen. This had the potential for harm if residents contracted foodborne illnesses or contagious diseases. Findings include: Residents #1-#10 and #14-#17 ate food prepared in the facility's kitchen. The facility's Cross-Contamination Policy, dated 12/6/07, documented staff are to keep clean dishes, pots and pans away from soiled ones. The facility's Dietary Services Policy: A guide to Infection Control, dated 4/1/15, documented hand washing was to be performed at these times: * After handling food. * Between working with raw foods to cooked foods. * After contacting any soiled utensils.	F 371	*All residents in facility have the potential to be affected by the deficient practice. *Food Service Director will conduct training with dietary staff focusing on prevention of cross contamination, glove exchange during meal service and hand washing. *Facility purchased 3 additional food processing containers to assure one is available for each food product in a meal to prevent cross contamination and updated dishwashing process to include use of an apron between dirty and clean steps to prevent cross contamination. *Food Service Director and or Registered Dietician will conduct observations of dietary staff during puree meal preparation and dishwashing, two times per week for 4 weeks then weekly for 4 weeks, then monthly for 3 months to assure ongoing compliance. Food Service Director will report to the Quality Assurance/Performance Improvement Committee for review and recommendations.	

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	135122		04/20/2017

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F 371	Continued From page 29 * After engaging in activities that contaminated the hands such as touching hair, mouth and other activities. 1. Food Preparation and Service: On 4/19/17 at 10:29 am, the kitchen staff was preparing the puree lunch meal. The following was observed: i. Cook #1 was preparing the pureed shrimp Creole. After Cook #1 finished she placed the (now soiled) scoop that she had used to measure out the Shrimp Creole into the puree rice she was going to prepare next. Cook #1 took the dirty food processor bowl over to the sink and rinsed it out with water. She then submerged the bowl quickly in the three compartment sink for approximately 1-2 seconds in each compartment. Cook #1 did not clean or rinse the lid to the food processor. She returned the wet food processor to its base and continued with preparing the rice dish. ii. Cook #1 used the soiled scoop to measure out the rice into the food processor. She stated "Oh I forgot to clean this." She did not stop to clean the scoop, but continued to prepare the pureed rice. Cook #1 stated the facility had multiple residents with different food allergies. She stated allergies she could remember were fish, pineapple, eggs, and milk. After Cook #1 finished pureeing the rice she took the food processor bowl and rinsed it out with water, but did not otherwise clean it. Cook #1 took the wet bowl back over to the base and began to prepare the pureed Harvard Beets without changing gloves or performing hand hygiene. Cook #1 had not washed or rinsed the	F 371		

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F 371	Continued From page 30 lid to the food processor. iii. Cook #1 finished pureeing the Harvard Beets. The food processor lid now had Shrimp Creole, Rice and Harvard Beets on it. Cook #1 rinsed the food processor bowl out with water and returned it to the base to begin the Turkey Tetrazzini; she was continuing to wear the same gloves. She did not wash or rinse the food processor lid. iv. Cook #1 finished preparing the Tetrazzini and placed the food processor and the lid into the dish machine, while the food processor was running through its cycle; she scratched her face and scratched her side. The food processor finished its cycle in the dishwasher and Cook #1 retrieved it without washing hands or changing her gloves and began the next dish. Cook #1 stated her normal process was to rinse out the food processor with water between different dishes. Throughout the observation above Cook #1 was observed using three different methods to clean and sanitize utensils. Hand hygiene was not observed three times during the observation after touching her body or coming into contact with dirty dishes. 2. Dishware washing: On 4/19/17 at 1:01 pm, Dietary Aide #1 was observed collecting soiled dishes from the dining room and placing the soiled dishes into the dishwashers. She had no barrier between her shirt and the soiled dishware. The front of Dietary Aide #1's shirt was visibly soiled with liquid. After Dietary Aide #1 finished running a load of soiled	F 371		

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F 371	Continued From page 31 dishes she retrieved a handful of clean silverware to place on trays. As she was placing them on the different trays, she touched the handful of silverware repeatedly against the side of her (now soiled) shirt to get one in her hand. The clean silverware was touching her visibly soiled shirt. On 4/19/17 at 1:20 pm, the Food Service Director [FSD] stated he had not thought about the front of someone's outfit contaminating clean utensils, he stated staff are not to touch dishes with their clothes. He stated he would correct this. The FSD stated when cooks were sanitizing equipment between different pureed dishes he expected them to run it through the dishwasher to prevent cross contamination.	F 371		
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident;	F 514		5/30/17

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	135122		04/20/2017

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F 514	Continued From page 32 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure clinical records were complete and accurate for 3 of 17 residents (#7, #15, and #17) reviewed for accuracy of records. The clinical records of Residents #7 and #15 did not include complete documentation of weekly skin assessments and Resident #17's clinical record did not include a consent for a psychiatric medication. This deficient practice placed residents at risk of medical complications due incomplete medical records. Findings include: 1. Resident #15's undated face sheet, printed 4/20/17, documented he had diagnoses including a pressure ulcer of sacral region-stage 4 (admit diagnosis), encounter for surgical aftercare following surgery on the circulatory system, cardiomyopathy, muscle weakness, other symbolic dysfunctions, difficulty in walking, and heart failure.	F 514	*Residents #7 and #15 records have been audited and weekly skin checks have been completed as identified. resident #17's consent for Ambien was reviewed with resident and responsible party and consent provided for use of medication. *All residents with psychoactive medications were audited to assure consent forms are accurate and complete. All treatment records for the previous two weeks have been audited to ensure weekly integrity forms are complete and skin assessments are complete and documented. *Root cause analysis demonstrates that nurses did not consistently document on the treatment Administration Record and weekly skin integrity flow sheet that the assessment was completed and the	

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F 514	Continued From page 33 Resident #15's Physicians Orders March 2017, documented an order for weekly skin assessments. Resident #15's Care Plan-Pressure Ulcer, dated 3/11/17, documented he was at risk for further pressure ulcers. Approaches included "complete weekly skin check" by a licensed nurse. The 200 Hall Treatment Binder was reviewed and included the following: * Resident #15's April 2017 treatment administration record (TAR) indicated skin assessments were completed on 4/1/17, 4/8/17, and 4/15/17. The 4/15/17 assessment was initialed by LPN #3. The corresponding undated Weekly Skin Integrity Data Collection form, where LNs were to document the condition of Resident #15's skin at the time of each assessment, such as which areas his skin were dry, red, where skin tears were found, etc., was blank. Resident #15's Non-Pressure Skin Integrity Data Collection form documented one entry, dated 4/8/17. The entry documented a scab and bruise on Resident #15's left forearm and a scab on his right forearm. The results of Resident #15's skin assessments documented as completed on 4/1/17 and 4/15/17, were not found in the Treatment Binder. During an interview on 4/19/17 at 2:20 pm, LPN #3 examined Resident #15's April 2017 TAR and confirmed it was her initial on 4/15/17. LPN #3 was asked to show where her 4/15/17 weekly skin assessment of Resident #15 was documented. LPN #3 said the entire Weekly Skin	F 514	psychotropic consent from had been completely filled out. The Director of Nursing Services and/or designee will provide education with all Licensed Nurses to certain to complete all documentation as required. *DNS or designee will audit 15 residents weekly for six weeks and then monthly for 3 months for complete documentation on psychoactive consent forms and completed weekly skin assessments. Director of Nursing or designee will submit report to the Quality Assurance/Performance Committee for ongoing review and recommendations.	

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	135122		**04/20/2017**

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F 514	Continued From page 34 Integrity Data Collection sheet was gone. LPN #3 said she might have pulled the form because she sometimes reviewed them for new skin insults. LPN #3 said a new blank form was added at the beginning of each month. LPN #3 went to the Team Training Room and looked through an orange book she identified as the "skin book" and looked through a black binder. LPN #3 did not produce a completed April 2017 Weekly Skin Integrity Data Collection for Resident #15. LPN #3 stated the form might be in someone else's office. Resident #15's Progress Notes from 4/1/17 through 4/18/17, did not include documentation of skin assessments other than those related to Individual #15's sacral pressure ulcers. The 200 Hall Treatment Binder was again reviewed on 4/20/17 at 10:20 am, and did not contain additional information related to Resident #15's weekly skin assessments. 2. Resident #7's undated Face Sheet, printed 4/20/17, included diagnoses of displaced supracondylar fracture of left femur [fracture of the thigh bone at the knee] with subsequent encounter for closed fracture with routine healing, generalized muscle weakness, chronic obstructive pulmonary disease, depression, and type 2 diabetes. Resident #7's Minimum Data Set (MDS) assessment, dated 3/3/17, documented she was at risk for pressure ulcers. Resident #7's Care Plan-Risk for Pressure Ulcer, dated 3/1/17, documented she was at risk for	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135122		04/20/2017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 35 developing pressure ulcers. Approaches included "complete weekly skin assessment" by the licensed nurse. The facility's policy, Nursing Documentation, revised 03/7/17, outlined basic nursing documentation and specified that reassessment occurs in conjunction with the interdisciplinary care plan's schedule. Resident #7's March 2017 TAR documented weekly skin assessments were to be completed every Tuesday. There was not documentation on the TAR that a skin assessment was completed on Tuesday, 3/7/17. Resident #7's undated Weekly Skin Integrity Data Collection form was filed immediately behind the March 2017 TAR. The form did not include documentation of a 3/7/17 skin assessment. Resident #7's Progress Notes, dated 03/7/17, did not include documentation of a 3/7/17 skin assessment. A progress note, dated 03/8/17, which was a late entry for 3/7/17, did not include a skin assessment except to note that the dressing on Resident #7's outer left thigh was clean, dry, and intact. On 4/19/17 at 9:45 am, RCM #1 stated when skin checks were completed nurses were to initial the TAR, and then fill out the Weekly Skin Integrity Data Collection Record, which showed the RCM's that nurses had "actually looked" at residents' skin and "not just signed off" that they had completed it. 4. Resident #17's April 2017 Physician Orders, documented the facility admitted Resident #17 on	F 514		

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	135122		04/20/2017

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F 514	Continued From page 36 3/24/17, with diagnoses that included insomnia. Resident #17's Minimum Data Set (MDS-a comprehensive physical and psychosocial assessment), dated 3/27/17, documented Resident #17 was cognitively intact. Resident #17's psychoactive medication informed consent for Zolpidem (a sedative used to treat insomnia) was signed and dated but did indicate whether the resident refused or consented to the medication. During an interview on 4/19/17 at 11:15 am, Social Worker #1 said the admitting nurse normally filled out the consent forms with the residents. She said she reviewed them at care plan meetings and quarterly. She said Resident #17's medication consent form should be filled out completely.	F 514		
F 518 SS=F	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview and policy review, it was determined the facility failed to ensure that all staff were knowledgeable and able to implement emergency procedures. Nine of 10 staff members interviewed (CNAs #1, #2, & #3; Resident Care Managers #1 & #2, Director of Maintenance, Executive Director, Activity Director, and LPN #1) were unable to accurately	F 518	* All residents have the potential to be affected by this deficient practice. *Plant Operations Supervisor and/or designee will conduct training with all staff members on the evacuation policy with emphasis on order of evacuation. *The evacuation policy, with emphasis on the order of evacuation will be reviewed	5/30/17

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F 518	Continued From page 37 list the order of evacuation for residents in the case of an emergency. The deficient practice had the potential to increase the danger to all 83 residents in the facility during an emergency situation, due to a lack of staff knowledge and an organized evacuation process. Findings include: The facility's undated "Department Supervisor Responsibilities" policy indicated the order of evacuation in the case of an emergency was "Residents will be turned over to transportation groups as follows: a) Ambulatory residents with no assist: Evacuate using designated stairwell or exit door. b) Ambulatory residents with assist: Use same process as above, however must be assisted by Transportation staff. c) Non-ambulatory: Carry or move by elevator. Unit staff will accompany these residents as necessary." Facility staff were not familiar with the above policy as follows: * During an interview on 4/19/17 at 9:05 am, CNA #1 said the order of evacuation was residents with dementia who were bed-bound would be evacuated first and then all other residents. * During an interview on 4/19/17 at 9:15 am, CNA #2 said the order of evacuation was most severe residents to the least severe. * During an interview on 4/19/2017 at 10:45 am, the Director of Maintenance stated he believed	F 518	with each new employee in orientation and annually with disaster training and as necessary as identified with audit results. *The safety Committee will complete interviews with staff members to determine ongoing compliance, monthly for three months then quarterly for 9 months. The Safety Committee will report to the Performance Improvement Committee on a monthly basis with results and any recommendations for ongoing compliance.	

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F 518	Continued From page 38 the order of evacuation was to evacuate the non-ambulatory residents first because the ambulatory residents could take care of themselves to some extent. * During an interview on 4/20/17 at 8:55 am, LPN #1 said the order of evacuation was bed-bound residents first, then residents who used wheelchairs, and ambulatory residents last. * During an interview on 4/20/17 at 9:05 am, the Activity Director said the order of evacuation was residents who were the most frail or bedridden first, and then residents who had equipment. * During an interview on 4/20/17 at 9:10 am, Resident Care Managers #1 and #2 said the order of evacuation was bed-bound residents first, then residents in wheelchairs and ambulatory residents. * During an interview on 4/20/17 at 9:16 am, the Executive Director said the order of evacuation was residents who need the most assistance first, then residents who used wheelchairs and ambulatory residents last. She said she and the Director of Maintenance provide the training to the staff on emergency preparedness. * During an interview on 4/20/17 at 10:00 am, CNA #3 said she did not know the order of evacuation and would refer to a nurse. During an interview of 4/20/17 at 11:05 am, the Executive Director provided the facility's policy on the order of evacuation. She said if it was a planned evacuation the residents would be evacuated according to the policy (ambulatory,	F 518		

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F 518	Continued From page 39 wheelchair, bed-bound) but if it was unplanned then they would remove the residents in any order.	F 518		