



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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May 12, 2017

Josh Bowman, Administrator
Madison Carriage Cove Short Stay Rehabilitation
410 West 1st North
Rexburg, ID 83440-1406

Provider #: 135140

Dear Mr. Bowman:

On **April 21, 2017**, a survey was conducted at Madison Carriage Cove Short Stay Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 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 in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **May 31, 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 20, 2017**. A change in the seriousness of the deficiencies on **June 5, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **July 20, 2017** includes the following:

Denial of payment for new admissions effective **July 20, 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 18, 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 20, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **May 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,

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

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/21/2017
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NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH REXBURG, ID 83440
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint investigation survey conducted at the facility from April 17, 2017 to April 21, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Presie Billington, RN Lesley Davis, RN</p> <p>Abbreviations:</p> <p>ADL = Activities of Daily Living ADON = Assistant Director of Nursing AIT = Administrator in Training BG = Blood Glucose (sugar) BID =Two times a day CMS = Center for Medicare Medicaid and Services CNA = Certified Nursing Assistant C/O = Complaint of COPD = Chronic obstructive pulmonary disease COC = Change of Condition DON = Director of Nursing DVT =Deep Vein Thrombosis INR = International Normalcy Ratio LN = Licensed Nurse LPN = Licensed Practical Nurse LTC = Long Term Care MAR = Medication Administration Record mcg = microgram(s) MDS = Minimum Data Set mg = milligram(s) MWF = Monday, Wednesday, Friday NPO = Nothing by Mouth OT = Occupational Therapist</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/22/2017
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 PCC = Point Click Care PN(s) = Progress Note(s) PRN = As Needed Pt = Patient QAA = Quality Assessment and Assurance RN = Registered Nurse ROM = Range of motion Sats = Saturations S/S = Signs and Symptoms TID = Three times a day UA = Urinalysis	F 000			
F 156 SS=F	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;	F 156		5/31/17	

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F 156	<p>Continued From page 2</p> <p>(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.</p> <p>(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and</p> <p>(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.</p> <p>(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental</p>	F 156			

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F 156	<p>Continued From page 3</p> <p>Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.</p> <p>(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:</p> <p>(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State</p>	F 156			

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F 156	<p>Continued From page 4</p> <p>agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and</p> <p>(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.</p> <p>(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.</p> <p>(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.</p>	F 156			

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F 156	Continued From page 5 (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.	F 156			

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F 156	<p>Continued From page 6</p> <p>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.</p> <p>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Admission Agreement and staff interview, it was determined the facility failed to ensure its Admission Packet informed residents of all their rights while in the facility. This deficient practice affected all residents in the facility and created the potential</p>	F 156	<p>Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies</p>		

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F 156	<p>Continued From page 7 for harm should residents fail to realize and/or exercise those rights. Findings include:</p> <p>The following revised federal regulations issued in November 2016 were not included in the facility's Admission Packet provided to residents and/or their interested parties:</p> <p>a. The resident's representative will be notified...when there is "an accident involving the resident ... a significant change...a need to alter treatment significantly..."</p> <p>b. "The facility must have reports with respect to any surveys, certifications, and complaints investigations made during the 3 preceding years...and post notice of the availability of such reports..."</p> <p>c. The facility's Admission Agreement documented the resident had the right to privacy in written communication, including the right to receive mail unopened and the right to use a telephone in private, but did not include, "The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for Internet research."</p> <p>d. The facility's Admission Agreement notified residents they had the right "to be free from neglect, financial exploitation, verbal, mental, physical or sexual abuse," but did not include notification of their right to be free from corporal punishment and involuntary seclusion.</p> <p>e. The facility's Admission Agreement notified residents they have the right "to have access to</p>	F 156	<p>by the State Licensing Authority. Accordingly, the facility has drafted this Plan of Correction in accordance with Federal and State Laws which mandate the submission of a Plan of Correction as a condition for participating in the Medicare and Medicaid program. This Plan of Correction shall constitute this facility's credible allegation compliance with this section.</p> <p>F 156 SS=F 483.10 (d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility does ensure that it's Admission packet informs residents of all their rights while in the facility.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>All Admission Agreements have been revised to include all Resident Rights including the most recent revised Federal regulations issued in November 2016. To include the following rights:</p> <p>A) The resident's representative will be notified when there is an accident involving the significant change or the need to alter treatment significantly. B) The facility must have reports with respect to any surveys within the preceding three years and that these reports are available and posted in the</p>		

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F 156	Continued From page 8 and participate in social activities", but did not inform residents they had "a right to choose activities, schedules (including sleeping and waking times)..." On 4/21/17 at 9:10 am, the Administrator in Training (AIT) said he was not aware federal regulations were revised in November 2016.	F 156	building C) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. D) The right to be free from corporal punishment and involuntary seclusion E) The right to choose activities, schedules (sleeping and waking times). In addition all of the affected resident admission agreements will be updated and resigned by resident and/or responsible party. Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following: All residents have the potential to be affected by this deficient practice. All current and future residents will receive and sign our revised admission agreement that includes the November 2016 updates mentioned above. Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur, The Administrator/designee will review CMS and state publications periodically to		

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F 156	Continued From page 9	F 156	<p>ensure that the facility is aware of and publishing the most current rights within the resident admission agreement.</p> <p>Admission coordinator will be educated on revisions to the admission agreement to ensure that each resident has been properly notified of resident rights. In addition Admission agreements from current guests will be revised and resigned.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through:</p> <p>The Administrator/designee will review 3 random admission agreements to ensure that residents are being informed of all rights upon admission.</p> <p>Monitoring will start on 5/31/17. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3 The Administrator or Designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p> <p>5/31/2017</p>		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	F 164		5/31/17	

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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 164	<p>Continued From page 10</p> <p>483.10</p> <p>(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>(h)(3)The resident has a right to secure and confidential personal and medical records.</p> <p>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.</p> <p>§483.70</p> <p>(i) Medical records.</p> <p>(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to</p>	F 164			

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F 164	<p>Continued From page 11</p> <p>coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure electronically stored personal medical information was protected for 1 random resident (#24). The failure created the potential for unauthorized individuals to access Resident #24's protected health information, share it with others, and place Resident #24 at risk of embarrassment and/or diminished sense of self-worth. Findings include:</p> <p>On 4/18/17 from 11:48 am to 11:58 am, Resident #24's personal medical information was observed on the computer screen on the North Wing medication cart. The exposed information included the resident's date of birth, room number, vital signs at 7:01 am and oxygen saturation at 8:42 am that morning, allergies, code status, pain monitor instructions, medication instructions for prn Norco, Soma and Zofran, and what to do if the resident did not have a BM in 2, 3 or 4 days. The medication cart was stationed near the nurses' station and a male resident in a wheelchair was 6 feet from the medication cart throughout the observation.</p> <p>On 4/18/17 at 11:51 am, CNA #3, a male resident, and female visitor, exited the room directly across from the medication cart and talked for several minutes before the resident and visitor left the vicinity, and the CNA went to the nurses' station.</p>	F 164	<p>F 164 SS=D 483.10 (h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The facility does ensure electronically stored personal medical information is protected for residents.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>Resident #24 has since been discharged from the facility. All staff will receive in service on or before 5/31/17 regarding resident privacy and protected health information. New Policies and Guidelines will be included in every general orientation.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All resident s have the potential to be affected by the deficient practice. ALL staff currently employed will be in-serviced regarding HIPAA policy and procedure on or before 5/31/2017. All</p>		

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F 164	Continued From page 12 On 4/18/17 at 11:58 am, RN #6 arrived at the North Wing medication cart and said Resident #24's information should not have been visible. The RN closed and locked the computer screen.	F 164	<p>new hires will receive orientation/training to these policies and guidelines.</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur,</p> <p>Facility policy and procedure regarding HIPAA, resident privacy and protected health information (PHI) has been revised and updated accordingly to ensure protection of resident privacy and healthcare information. All staff will be in serviced on Privacy of PHI and HIPAA policy and procedure on or before 5/31/17.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through:</p> <p>Administrator/designee will review 2 random employee files to ensure that employees are being informed of our HIPPA policies and procedures.</p> <p>Monitoring will start on 5/31/17. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3 The Administrator or Designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken</p>		

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F 164	Continued From page 13	F 164	Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		
F 167 SS=C	<p>483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>(g)(10) The resident has the right to-</p> <p>(i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and</p> <p>(g)(11) The facility must--</p> <p>(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.</p> <p>(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and</p> <p>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.</p> <p>(iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by:</p>	F 167	5/31/2017	5/31/17	

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F 167	<p>Continued From page 14</p> <p>Based on observation, and resident and staff interview, it was determined the facility failed to ensure results of the most recent survey of the facility was accessible and notice was posted that the three preceding years' survey results were available for review. This deficient practice effected all residents in the facility, their representatives, and any visitor who may have wanted to review the facility's survey history. Findings include:</p> <p>On 4/17/17 at 5:52 pm, a binder at the corner of the main dining room, containing the facility's 2/26/15 initial certification survey report, was reviewed for completeness. The binder did not contain the facility's 10/5/16 recertification survey results and plan of correction, and there was no notice posted that survey results, certifications, and complaint investigation during the preceding 3 years were available for review.</p> <p>On 4/18/17 at 7:45 am, the survey results binder was observed on a table in the facility's lobby area. The binder contained the results of one survey, the results of the 2/26/15 initial certification survey.</p> <p>On 4/18/17 at 2:00 pm, 6 of 6 residents in a group interview said they did not know where survey results were located in the facility.</p> <p>On 4/18/17 at 3:30 pm, the Administrator in Training (AIT) said the facility opened in 2015 and would only have 2 recertification surveys completed. The AIT also said he was not aware federal regulations were revised in November 2016, and added he would update the facility's survey binder to include the 10/5/16</p>	F 167	<p>F 167 SS=C 483.10 (g)(10)(i)(11) RIGHTS TO SURVEY RESULTS-READILY ACCESSIBLE</p> <p>The facility does ensure results of the most recent survey of the facility is accessible and notice is posted of the three preceding years <input type="checkbox"/> survey results available for review.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>All residents were affected by this deficient practice.</p> <p>The Survey Results Binder was updated to include the previous three years of survey results and was placed in a prominent location within the facility.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All residents have the potential to be affected by this deficient practice</p> <p>The Survey Results Binder was updated to include the previous three years of survey results and was placed in a prominent location within the facility. Posting of Survey results has also been added to the admission agreement in the resident rights section.</p>		

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F 167	Continued From page 15 recertification survey report and the facility's corresponding plan of correction.	F 167	<p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur,</p> <p>Administrator has been educated regarding requirements for posting the 3 most recent survey results and associated plan of corrections. In addition it will be made known that these results are available upon request and that these results must be posted in a prominent location within the facility.</p> <p>All current guests will receive the amended resident rights to reflect their right to notification of survey results.</p> <p>Most current survey results will be added to the binder when they are received following each annual/complaint survey.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through:</p> <p>Administrator/Designee will perform monthly audits to verify that most recent survey results are on display in a prominent location.</p> <p>Monitoring will start on 5/31/17. This will be done monthly x 6</p>		

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F 167	Continued From page 16	F 167	Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		
F 176 SS=D	<p>483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure it was safe and clinically appropriate for residents to self-administer medications. This was true for 1 of 10 residents (#23) observed during medication passes. The failure created the potential for incorrect administration of medications, which could compromise residents' health. Findings include:</p> <p>On 4/18/17 at 10:00 am, RN #4 was observed setting-up Resident #23's nebulizer treatment with Brovana and budesonide medications. In the resident's room, the RN poured the two medications into the nebulizer's medication reservoir, handed the nebulizer pipe to Resident #23, turned on the nebulizer machine, then left the room and closed the door.</p> <p>On 4/18/17 at 10:15 am, RN #4, who was at the nurses' station, said Resident #23's nebulizer treatment took "12 to 13 minutes" and the resident was "good about turning it off." The RN said Resident #23 had COPD (Chronic</p>	F 176	<p>5/31/17</p> <p>F 176 SS=D 483.10 (c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>The facility does ensure it is safe and clinically appropriate for residents to self-administer medications.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>Resident #23 discharged from facility on 4/21/2017. Every Admission will be screened using the Medication <input type="checkbox"/> Self Assessment to ensure they are safe to give medications to themselves and the Self- Medication Agreement will be reviewed with the new admit. Nursing will monitor and document the medications are self-administered according to the provider orders.</p>	5/31/17	

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F 176	<p>Continued From page 17</p> <p>Obstructive Pulmonary Disease) and had for a long time. At 10:25 am, the RN opened Resident #23's door, asked if the nebulizer treatment was finished, and then closed the door when the resident said, "Yes."</p> <p>Immediately afterward, RN #4 said she did not know whether the Interdisciplinary Team had determined Resident #23 could appropriately self-administer the nebulizer medications. Resident #23's Medication Self-Administration Assessment was requested at that time.</p> <p>Resident #23's clinical record contained a 2/13/17 order for the Brovana and budesonide medications via nebulizer. An order for self-administration of the medications was not found in the resident's clinical record.</p> <p>Resident #23's MAR also documented the 2 medications were administered twice daily from 4/1/17 through 4/20/17, but did not specify the medications could be self-administered.</p> <p>On 4/21/17, a Self-Medication Agreement, signed by Resident #23 on 2/8/17, was found in the clinical record. The agreement documented, "If I decide that I would like to have a medication in my room, I understand that there is a procedure that needs to be followed, including: ...If the Nurse and Interdisciplinary Team determines that I am safe to self-administer the medication the Nurse will contact my physician and obtain an order to allow me to self-administer...that SPECIFIC medication..." In addition, a Medication Self-Administration Assessment, dated 2/8/17, was in the clinical record. However, the assessment was blank except for the</p>	F 176	<p>At any time there is a deviation or assessment of confusion by the Licensed Nurse on duty. The DON or designee will be notified and the Medication Self Assessment will be reassessed and after this assessment a disposition to continue if safety is not in question.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All residents have the potential to be affected by the deficient practice. A facility wide audit of all current resident self medication assessments has been conducted to ensure that they are safe to self administer medications.</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur, All licensed nurses will be in-serviced on or before 5/31/2017 and as needed. All newly hired licensed nurses will be in serviced upon hire during new hire orientation.</p> <p>Every Admission will be screened using the Medication Self-Assessment to ensure they are safe to give medications to themselves and the Self-Medication Agreement will be reviewed with the new admit. Nursing will monitor and document</p>		

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F 176	Continued From page 18 resident's name, date, and a nurse's signature and date.	F 176	<p>if the medications are self-administered according to the provider orders.</p> <p>At any time there is a deviation or assessment of confusion by the Licensed Nurse on duty, The DON or designee will be notified and the Medication Self <input type="checkbox"/> Assessment will be reassessed and after this assessment a disposition to continue if safety is not in question.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through:</p> <p>DON/designee will conduct random audits of self-medication assessments.</p> <p>Monitoring will start on 5/31/17. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3 The Administrator or Designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meetings.</p> <p>5/31/17</p>		
F 226 SS=E	<p>483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>483.12 (b) The facility must develop and implement</p>	F 226		5/31/17	

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F 226	<p>Continued From page 19 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 facility policy, staff interview and review of employee hiring records, it was determined the facility failed to ensure that potential employees were thoroughly screened by attempting to complete reference checks with their previous and/or current employers, to if the person has a work history of abuse, neglect,</p>	F 226	<p>F 226 SS=E 483.12 (b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility does ensure that potential employees are thoroughly screened by</p>		

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F 226	<p>Continued From page 20</p> <p>exploitation, or misappropriation of property. This was true for 2 of 5 staff (Staff A & B) whose files were reviewed. Staff A was a CNA and Staff B was a housekeeper. This failed practice created the potential for residents who come in contact with newly hired staff, to be exploited, abused, neglected, and/or have their property misappropriated. Findings include:</p> <p>The facility's Abuse Prevention Policy and Procedure documented, "All potential staff members are screened prior to or by the time of hire for a history of abuse, neglect or mistreating residents, through prior reference checks and criminal background checks per regulatory requirements. Potential staff members unfit for hiring will not be hired."</p> <p>On 4/18/17 at 3:20 pm, two of five employees' records reviewed did not include evidence that previous employers had been contacted for professional references prior to the employees' beginning work in the facility. Those records documented:</p> <p>*Staff A, a CNA, was hired on 1/17/17. The facility failed to check with any of the previous employers Staff #A provided in his/her work history from September 2013 and January 2017.</p> <p>*Staff B, a Housekeeper, was hired on 3/22/17. The facility failed to check with any of the previous employers Staff #B provided in his/her work history from June 2013 through December 2016.</p> <p>On 4/21/17 at 8:30 am, the Administrator in Training said the staff member responsible for</p>	F 226	<p>attempting to complete reference checks with their previous and/ or current employers. These reference checks will aid in determining if a person has a work history of abuse, neglect, exploitation, or misappropriation of property.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>All employee files have been audited to ensure professional reference(s) have been obtained.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All current and future guests have the potential to be affected by this deficient practice.</p> <p>Reference checks have been obtained for all current employees.</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur,</p> <p>All hiring managers will be educated on the requirement to obtain references before each new employee's first worked shift.</p>		

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F 226	Continued From page 21 checking references had left the facility and he could not find additional documentation related to reference checks for Staff A or Staff B other than what he had already provided.	F 226	HR representative/designee will verify that references have been obtained in the newly hired employee's file prior to the first worked shift. How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through: HR representative/designee will randomly audit employee files to ensure compliance with obtaining reference checks. Monitoring will start on 5/31/17. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3 The Administrator or Designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was	F 253	5/31/17 F 253 SS=E	5/31/17	

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F 253	<p>Continued From page 22</p> <p>determined the facility failed to ensure an ice machine, microwave oven, and popcorn machine, equipment frequently used by residents and visitors, were kept clean and sanitary. This deficient practice created the potential for harm should residents consume food or ice contaminated by pathogenic organisms. Findings include:</p> <p>On 4/17/17 at 4:35 pm, 4/18/17 at 11:20 am, and 4/19/17 at 9:55 am, the South Wing ice dispenser was observed with a considerable amount of white and gray built-up residue on the machine's tray and inside spout.</p> <p>On 4/17/17 at 5:47 pm, 4/18/17 at 11:20 am, and 4/19/17 at 4:30 pm, the Activity Room microwave oven was observed with red and orange stains on the inside walls and under the rotating plate.</p> <p>On 4/17/17 at 4:35 pm, 4/18/17 at 11:20 am, and 4/19/17 at 4:30 pm, the Activity Room popcorn machine was observed with oil residues on each "wall" surface, as well as popcorn husks on the bottom and inside sides of the machine.</p> <p>On 4/20/17 at 4:30 pm, the Maintenance Supervisor said the ice dispenser tray and spout needed cleaning, and the microwave oven and popcorn machine in the Activity room should be cleaned after each use.</p> <p>On 4/20/17 at 6:15 pm, the Administrator in Training said there was no Housekeeping Supervisor as the previous supervisor left the facility about two weeks prior to survey.</p>	F 253	<p>483.10 (i)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility does ensure that the ice machine, microwave oven, popcorn machine and equipment frequently used by residents and visitors, are kept clean and sanitary</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>The ice machine, popcorn machine and microwave were cleaned.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All current and future guest have the potential to be affected by this deficient practice.</p> <p>The above mentioned appliances/items have been added to the housekeeping daily cleaning checklists.</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur,</p> <p>Housekeeping Supervisor and</p>		

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F 253	Continued From page 23	F 253	<p>Housekeeping staff have been educated on the need to clean and maintain cleanliness on the above mentioned appliances.</p> <p>The housekeeping daily cleaning checklist has been revised to include the above mentioned items.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through:</p> <p>Housekeeping Supervisor/Designee will perform random audits to ensure proper cleaning of above mentioned appliances has taken place.</p> <p>Monitoring will start on 5/31/17.</p> <p>This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3 The Administrator or Designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p> <p>5/31/17</p>		
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans	F 281		5/31/17	

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F 281	<p>Continued From page 24</p> <p>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of a Fall Scene Investigation Report, Incident and Accident Reports [I&As], and resident records, it was determined the facility failed to:</p> <p>a) Ensure medications were administered consistent with physician orders. This was true for 2 of 26 sampled residents (#17 and #20) reviewed for accuracy of medication administration. This failed practice placed Resident #20 at risk of blood clots when anticoagulant [blood thinner] medication was not continued as ordered by the physician, upon her admission to the facility following knee joint surgery. The deficient practice also created the potential for Resident #17 to experience excessive bleeding when an anticoagulant medication was not discontinued 2 days prior to permanent placement of an indwelling dialysis port, as ordered by the physician.</p> <p>b) Ensure used needles were covered/secured following medications injections. This was true following the insulin injection of 1 of 2 residents (#7) observed receiving insulin injections and impacted 1 of 2 hallways (North Wing). This created the potential for needle sticks, which could lead to infections and/or disease.</p> <p>c) Ensure residents rinsed their mouths and spit after administration of an inhaled corticosteroid</p>	F 281	<p>F 281 SS=E 483.21 (b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The facility does ensure that services provided to residents meet professional standards.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>A) Resident #17 discharged on 11/10/16. Resident # 20 was discharged on 12/31/16. B) A sharps container was installed in all resident rooms, including resident #7. All LN□s were in serviced 5/8/17 regarding proper use and disposal of sharps. C) Resident #23 was discharged from the facility on 4/21/17. D) #4 neuro assessment was initiated after the fall before she was admitted to the hospital on the same day the fall took place. #7 a cognitive assessment was conducted on 2/8/17, showing no decline in cognitive function. #8 did receive a neurological evaluation on the day of her fall. #22 has discharged from the facility. E) Resident #22 discharged from facility</p>		

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F 281	<p>Continued From page 25</p> <p>medication. This was true for 1 random resident (#23) observed during medication pass. The failure created the potential for the resident to develop oral candidiasis, commonly known as thrush, a fungal infection of the mouth.</p> <p>d) Ensure the neurological status of residents was consistently assessed after falls with the potential for head injury. This was true for for 4 of 6 residents (#4, #7, #8, & #22) reviewed for falls. This deficient practices created the potential for residents' neurological changes to go undetected and untreated.</p> <p>e) Ensure treatment was not delayed after a resident's fall which caused pain in her clavicle that had been fractured in the recent past. This was true for for 1 of 6 residents (#22) reviewed for falls. This deficient practice placed Resident #22 at risk of further injury to her clavicle before treatment was provided.</p> <p>Findings include:</p> <p>1. Resident #20 was admitted to the facility on 12/16/16, with multiple diagnoses including rehabilitation after knee joint surgery.</p> <p>Resident #20's 12/14/16 Hospital Medication Reconciliation Report documented Eliquis [blood thinner] 2.5 mg was to be continued twice daily related to the potential for DVT [deep vein thrombosis - blood clotting].</p> <p>A 12/27/16 Medication Review Report and Order Summary Report documented, "Eliquis Tablet 2.5 mg (Apixaban) Give 2.5 mg by mouth every morning and at bedtime..." The Report</p>	F 281	<p>2/9/17.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>A) All residents on anticoagulant therapy have the potential to be affected by the same deficient practice. DON/designee will conduct an audit on all current residents on anticoagulant medications. Identified residents will be added to the anticoagulant tracking log for review and follow up Monday <input type="checkbox"/> Friday.</p> <p>B) All residents have the potential to be affected by the same deficient practice. Sharps containers were installed in all resident rooms. LN□s were educated 5/8/17 on proper use and disposal of sharps.</p> <p>C) All residents with orders for corticosteroid medication have the potential to be affected by the deficient practice. All residents with orders for corticosteroid medication now have a routine standing order to swish and spit after each administration.</p> <p>D) All residents have the potential to be affected by the deficient practice. All LN□s have been educated on the policy and procedure regarding the initiation and completion of a neurological assessment upon a resident fall.</p> <p>E) All residents have potential to be affected by the deficient practice. Policy and procedure regarding accidents and incidents to define clear steps for the</p>		

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F 281	<p>Continued From page 26</p> <p>documented the physician's order was initiated on 12/22/16 with a 12/23/16 start date.</p> <p>Resident #20's MAR documented Eliquis 2.5 mg was started on 12/23/16, and not continued upon the resident's admission to the facility as directed on the 12/14/16 Hospital Medication Reconciliation Report. There was no physician's order found in Resident #20's clinical record to discontinue the Eliquis when she was admitted to the facility on 12/16/16.</p> <p>On 4/20/17 at 1:50 pm, the DON said the facility utilizes one of its CNAs to transcribe orders to the computer, where it is then "triple checked" by the DON, ADON, or MDS nurse. The DON stated a night shift nurse then completes a last review of the order. The DON stated she could not locate a physician's order discontinuing the medication prior to, or following, Resident #20's admission to the facility.</p> <p>Resident #20 did not receive Eliquis between 12/17/16 and 12/22/16, placing her at risk of developing blood clots.</p> <p>2. Resident #17 was admitted to the facility on 11/2/16, with multiple diagnoses including chronic kidney disease and obesity.</p> <p>Resident #17's Hospital Discharge Medication Reconciliation Report, dated 11/2/16, documented staff was to administer Warfarin [blood thinner] 5 mg every Tuesday.</p> <p>An 11/2/16 Admitting Progress Note documented Resident #17 was admitted for permanent placement of an indwelling dialysis port in the</p>	F 281	<p>nurse on the floor. LN□s will be inserviced on the policy and procedure.</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur,</p> <p>A) Created a new policy and procedure to address the use of anticoagulant medications in the facility. A daily anticoagulant tracking tool was created to allow continual monitoring of residents on anticoagulants. All licensed nurses will be educated on the policy and procedure as well as the tracking log.</p> <p>B) Sharps containers were installed in all resident rooms. LN□s were educated 5/8/17 on proper use and disposal of sharps.</p> <p>C) All residents with orders for corticosteroid medication Now have a routine standing order to swish and spit after each administration. All LN□s were in serviced on 5/8/2017 regarding the new standing routine order to swish and spit after the administration of corticosteroid medications.</p> <p>D) All LN□s have been educated on the policy and procedure regarding the initiation and completion of a neurological assessment upon a resident fall. All newly hired LN□s will be educated upon hire.</p> <p>E) All resident have potential to be affected by the deficient practice. Policy and procedure regarding accidents and</p>		

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F 281	<p>Continued From page 27 right upper chest.</p> <p>Resident #17's physician's orders documented the following:</p> <ul style="list-style-type: none"> * 11/3/16: Coumadin 5 mg (Warfarin Sodium) every Tuesday and Coumadin 4 mg PO (orally) all other days * 11/5/16 - 4:59 pm: Coumadin 5 mg one time daily * 11/5/16 - 10:24 pm: Coumadin 5 mg was discontinued <p>A Progress Note, dated 11/7/16 at 11:56 pm, documented, "NPO [nothing by mouth] after midnight 11/9/16 for Fluoroscopy Placement of New Dialysis Catheter...Hold Coumadin 11/6/2016 and 11/7/2016..." The progress note stated Resident #17's Coumadin was to be held for two days after the medication was discontinued.</p> <p>Resident #17's Medication Administration Record documented Coumadin 5 mg was administered on 11/6/16 and 11/7/16 at 5:00 pm.</p> <p>On 4/20/17 at 1:30 pm, the Director of Nursing (DON) was asked about the Progress Note and the Coumadin being given on 11/6/16 and 11/7/17, when the physician had ordered the medication be discontinued on 11/5/16. The DON reviewed Resident #17's clinical record and confirmed Coumadin was given on 11/6/17 and 11/7/17. The DON stated she would call the dialysis provider about the orders and share that information with the surveyor. Additional</p>	F 281	<p>incidents to define clear steps for the nurse on the floor. LN□s will be in serviced on or before 5/31/2017 on the policy and procedure for accidents and incidents.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through:</p> <ul style="list-style-type: none"> A) DON/designee will conduct random audits on tracking tool for all anticoagulant therapy residents to ensure proper management of anticoagulant therapy medications with the providers for therapeutic interchange. B) DON/designee will conduct random audits to verify LN□s are properly disposing of used needles/sharps. C) DON/designee will conduct random audits of the EMAR to ensure compliance with the new order. D) DON/designee will conduct random audits to verify LN□s are conducting neurological assessments upon each resident fall. E) DON/designee will conduct random audits to verify Incident and accident policy and procedures are being followed. F) Monitoring will start on 5/31/17. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3 The Administrator or Designee will present to at least quarterly QA&A Committee meeting any findings and/or corrective actions taken 	

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F 281	<p>Continued From page 28</p> <p>information related to the progress note was not provided.</p> <p>3. Resident #22 was admitted to the facility 12/24/16, after a fall at home resulting in fractures to left hip and left clavicle. Her admission diagnoses included fracture of the left femur, fracture of the left clavicle [collarbone], and pain. Resident #22's plan of care, dated 12/24/16, documented Resident #22 required the assistance of 1 person for all activities of daily living and transfers to her wheelchair.</p> <p>A facility Incident/Occurrence report, dated 1/20/17, documented Resident #22 was found by a certified nursing assistant (CNA) sitting on floor next to her bed. The report documented Resident #22 stated sheets on the bed were too loose and she slipped off the bed. The report stated Resident #22 was complaining of pain to her left shoulder. Documentation recorded Resident #22's range of motion was intact and no skin issues noted at time of assessment. The facility neurological evaluation for recording neurological checks was not complete. Documentation for two 15 minute checks after the initial evaluation were blank; the four-hour check for 1/21/17 was blank; and the 12-hour check for 1/23/17 was incomplete. The section of the report to document "steps put in place to prevent recurrence" documented a bed alarm was placed under Resident #22's bed sheets because she takes "chair alarm off herself." There was no documentation on the Incident/Occurrence Report or Resident #22's medical record that she was sent out for evaluation after the fall and complaints of shoulder pain.</p>	F 281	<p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p> <p>5/31/2017</p>		

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F 281	<p>Continued From page 29</p> <p>Resident #22's hospital discharge instructions, dated 1/23/17 at 12:08, documented Resident #22 was sent for emergency evaluation of her left shoulder. An X-ray report, dated 1/23/17, documented a non-displaced fracture through the distal aspect of the left clavicle. This was the same clavicle identified as fractured when Resident #22 was admitted to the facility on 12/24/16.</p> <p>During an interview 4/21/17 at 8:50 am, the DON said Resident #22 was not sent out to a hospital emergency room immediately as "it was the weekend" and she did not complain of pain. Progress notes documented Resident #22 requested medication to relieve pain in her left shoulder on 1/22/17 at 3:20 pm and 1/22/17 at 7:18 pm.</p> <p>4. Resident #7 was admitted to the facility on 10/31/16, with multiple diagnoses, including obesity and diabetes mellitus.</p> <p>a. Resident #7's Fall Risk care plan, dated 11/11/16, identified the risk for falls related to "impaired balance and pain." Interventions included instructing or reminding the resident to wait for assistance.</p> <p>A Fall Scene Investigation Report documented Resident #7 had a "witnessed" fall in his room at 8:15 am on 11/15/16, which resulted in bruising and abrasion.</p> <p>A witness statement by an OT [Occupational Therapist] was attached to the 11/15/16 fall report that documented Resident #7 was ambulating in his room with supervision and, "...he was</p>	F 281			

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F 281	<p>Continued From page 30</p> <p>gathering items from the closet. I stepped into the bathroom for a moment to prepare shower & client stated, 'I dropped something on the floor.' I next heard a thump and [Resident #7] was laying on his back..." The OT documented a nurse assessed Resident #7 after which the resident still wanted to shower and the shower was completed without incident. The OT noted bruises to Resident #7's lateral left knee, left inner elbow, and the right "back of head." After showering and dressing, Resident #7 lost his balance once while moving to the recliner.</p> <p>The "Fall Huddle" and "Summary of Meeting" for the 11/15/16 Fall Scene Investigation Report both documented "neuro [neurological]" checks were completed. However, no neurological assessments were attached to the fall report and none were found in Resident #7's electronic or paper clinical record.</p> <p>On 4/20/17 at 5:30 pm, the DNS was asked to provide the neurological assessments related to Resident #7's fall on 11/15/16.</p> <p>On 4/21/17 at 8:15 am, the DNS said there were no neurological checks related to the fall.</p> <p>b. Resident #7's care plan for diabetes, initiated 11/1/7, included an intervention for insulin administration as ordered.</p> <p>Resident #7's Order Summary Report of active orders included Aspart insulin injections per sliding scale as of 11/1/16.</p> <p>On 4/19/17 at 11:45 am, RN #2 was observed as she drew up Resident #7's Novolog (Aspart)</p>	F 281			

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F 281	<p>Continued From page 31</p> <p>insulin into an insulin syringe, recapped the needle using 2 hands, and walked to his room, where she administered the insulin to him by subcutaneous injection. After the medication administration, RN #2 carried the used insulin syringe, with the uncapped and unprotected needle exposed, into the hallway. While RN #2 was in the hallway with the unprotected used needle in hand, an alarm sounded. RN #2 crossed the hall, opened the door to another resident's room and asked if the resident was alright. Upon learning the resident was alright, RN #2 closed the resident's door and reset the alarm on the handrail outside the resident's room. The RN continued down the hall with the unprotected used needle/syringe in hand, passing 5 resident rooms, toward the nurses' station, where she dropped the used needle/syringe into the sharps container on the medication cart.</p> <p>Immediately afterward, RN #2 said there were no sharps containers in resident rooms. She said the facility had insulin syringes with protective covers but she picked up another type of insulin syringe instead.</p> <p>5. Resident #4 was admitted to the facility on 2/5/17, and readmitted on 4/5/17, with multiple diagnoses, including sciatica and rehabilitation after surgical repair of a fractured hip.</p> <p>Resident #4's admission Minimum Data Set (MDS) assessment, dated 2/10/17, documented Resident #4's cognition was moderately impaired, she had a Foley catheter, experienced a fall-related fracture prior to admission and had a history of falls, and required extensive</p>	F 281			

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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 281	<p>Continued From page 32 assistance from staff with transfers and mobility.</p> <p>Resident #4's Fall Risk Care Plan, initiated 2/22/17, documented she was on a fall prevention program.</p> <p>An Incident and Accident (I&A) report documented Resident #4 fell on:</p> <p>* 3/13/17 at 11:45 pm: Resident #4's bed alarm sounded and she was found on the floor of her room. She had requested Ambien [sleep medication] 5 mg and was observed sleeping 10-15 minutes before the fall. Vital signs and neurological checks were completed and determined to be within normal limits immediately following the fall. The I&A did not include ongoing documentation of Resident #4's vital signs or neurological checks.</p> <p>On 4/20/17 at 5:00 pm, the Director of Nursing (DON) said neurological checks should be completed for all unwitnessed falls.</p> <p>6. Resident #8 was admitted to the facility 2/6/17 with diagnoses that included a displaced fracture of the right femur, hypertension, hypothyroidism, and atrial fibrillation [irregular heartbeat].</p> <p>A 4/5/17 MDS assessment documented Resident #8 was alert and responsive, required stand-by assistance of one staff for activities of daily living and transfers, and used a wheeled walker with a seat for mobility.</p> <p>A 2/6/17 care plan documented Resident #8 was on a "fall program."</p>	F 281			

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F 281	<p>Continued From page 33</p> <p>An Incident and Accident Report documented Resident #8 experienced an unwitnessed fall on 2/24/17, when according to Resident #8, she attempted to transfer from bed to an unlocked wheelchair. Resident #8 stated she did not call for help as she was embarrassed. The Report documented Resident #8 was not injured as a result of the fall and the space allocated for neuro checks was blank.</p> <p>On 4/2/17 at 11:10 am, the DON stated the Incident and Accident Report did not contain the information (neuro checks) required for an unwitnessed fall.</p> <p>7. On 4/18/17 at 10:00 am, RN #4 was observed setting-up Resident #23's nebulizer with Brovana (bronchodilator) and budesonide (corticosteroid) medications. RN #4 gave the nebulizer mouth piece to the resident, turned on the nebulizer machine, then left the room and closed the door.</p> <p>On 4/18/17 at 10:15 am, RN #4, who was at the nurses' station, said Resident #23's nebulizer treatment took "12 to 13 minutes" and the resident was "good about turning it off." At 10:25 am, the RN opened Resident #23's door, asked if the nebulizer treatment was finished, then closed the door when the resident said, "Yes."</p> <p>Immediately afterward, RN #4 said she did not ask, encourage or assist Resident #23 to rinse his mouth and spit after the corticosteroid nebulizer treatment.</p> <p>Resident #23's clinical record included a 2/13/17 physician order that documented Brovana and budesonide were to be given twice daily via</p>	F 281			

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F 281	Continued From page 34 nebulizer and the MAR documented the 2 medications were administered 2 times a day from 4/1/17 through 4/20/17.	F 281			
F 283 SS=D	Regarding administration of budesonide, the Nursing 2017 Drug Handbook documents the following in Patient Teaching, "Rinse your mouth with water and then spit out the water after each dose to decrease the risk of developing oral candidiasis." 483.21(c)(2)(i)-(iii) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS (c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is not met as evidenced by: Based on staff interview and review of residents'	F 283		5/31/17	
			F 283 SS=D		

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F 283	<p>Continued From page 35</p> <p>records, facility policy, Concern Forms, and fall investigations, it was determined the facility failed to ensure discharge summaries were developed when residents were discharged from the facility. This was true for 2 of 13 residents (Residents #10 and #11) whose discharge records were reviewed. This deficient practice created the potential for harm should residents require continuing care after discharge and relevant health information was not available to subsequent healthcare providers. Findings include:</p> <p>1. Resident #10 was admitted to the facility on 10/23/16 with diagnoses that included cerebral vascular accident with right hemiparesis (stroke with partial paralysis), generalized anxiety disorder, and major depressive disorder.</p> <p>Progress Notes, dated 11/3/16 at 10:09 pm, documented Resident #10 was "yelling," confused, and found on the floor of his room with multiple abrasions and skin tears to the right forearm and right elbow.</p> <p>A fall investigation report, dated 11/3/16, documented Resident #10's injuries were cleansed with normal saline and "geri sleeves" were applied and were to remain on at all times. No further injuries were noted. The physician was notified of the incident and Zyprexa Solution (antipsychotic medication) 10 mg (milligram) IM (intramuscular injection) was ordered and administered.</p> <p>Resident #10 was discharged home with family on 11/11/16. Resident #10 record did not contain a discharge summary that included recapitulation</p>	F 283	<p>483.21 (c)(2)(i)-(iii) ANTICIPATE DISCHARGE RECAP STAY/FINAL STATUS</p> <p>The facility does ensure discharge summaries are developed when residents are discharged from the facility.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>Residents # 10 and #11 have been discharged.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All current and future residents have the potential to be affected by this deficient practice.</p> <p>All discharged residents will have a discharge summary completed upon discharge.</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur,</p> <p>Social Service Representative/Designee will be educated on the requirement to complete a current discharge summary</p>		

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F 283	<p>Continued From page 36</p> <p>of his stay in the facility and a complete summary of his status at the time of discharge, to ensure Resident #10's post-discharge needs were met.</p> <p>On 4/21/17 at 10:30 am, the Director of Nursing (DON) stated the clinical record for Resident #10 did not contain a recapitulation of his stay in the facility and summary of his status at the time of discharge.</p> <p>2. Resident #11 was admitted to the facility on 1/19/17, with diagnoses that included spine fusion, peripheral vascular disease (PVD), ulcer to the right lower leg, and anxiety.</p> <p>A "Concern Form," dated 2/28/17, documented Resident #11 was assisted in the bathroom, where she became weak and required additional male assistance to sit on the commode. The form documented that afterward, the resident complained of back pain/discomfort. The form further documented Resident #11 and her Interested Party stated the incident was a "fall," rather than an assist to sit, and the issue was not resolved to the Interested Party's satisfaction.</p> <p>A Progress Note, dated 3/1/17 at 11:52 am, documented Resident #11 was discharged to another nursing facility. Resident #11's record did not contain a discharge summary, including a recapitulation of her stay in the facility or a complete summary of her status at time of discharge, to ensure continuity of care at the receiving nursing facility.</p> <p>The facility's April 2014 Discharge Planning Policy and Procedure documented the Social Worker or designee was responsible for</p>	F 283	<p>for each resident prior to, or upon discharge. Discharge policy and procedure was reviewed and approved as being appropriate.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through:</p> <p>Our Administrator/Designee will conduct random audits to ensure that discharge summaries are being completed for residents prior to discharge.</p> <p>Monitoring will start on 5/31/17. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3 The Administrator or Designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p> <p>5/31/2017</p>		

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F 283	Continued From page 37 completing the Discharge Summary and Recapitulation of stay. On 4/20/17 at 12:10 pm, the Administer-In-Training stated the Assistant Director of Nursing had been the acting Social Worker designee for approximately "three weeks." On 4/21/17 at 10:30 am, the DON stated the clinical record for Resident #11 did not contain a recapitulation of her stay in the facility or a complete summary of her status at time of discharge.	F 283			
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:	F 309		5/31/17	

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F 309	<p>Continued From page 38</p> <p>(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to clarify insulin orders and monitor a diabetic resident's blood glucose levels. This was true for 1 of 1 resident (#12) reviewed for diabetic management and created the potential for more than minimal harm if the resident received excessive or insufficient dosages of insulin for various blood glucose levels. Findings included:</p> <p>1. Resident #12 was readmitted to the facility on 11/22/16 with diagnoses that included diabetes mellitus.</p> <p>Resident #12's Interim Care Plan, dated 11/21/16 but signed on 11/22/16 by an LN, documented diabetes as a medical condition and the use of insulin.</p> <p>Hospital discharge orders, dated 11/22/16, documented Resident #12 was to receive insulin lispro (Humalog), 1-7 Units 4 times daily with</p>	F 309	<p>F 309 SS=D 483.24, 483.25 (k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>The facility does ensure insulin orders are clarified and that diabetic resident's blood glucose levels are monitored.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>Resident #12 was discharged from facility on 12/6/16.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All insulin dependent diabetic residents</p>		

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F 309	<p>Continued From page 39</p> <p>meals and at night. Next to the order was a handwritten note that documented, "Sliding scale with meals & before bed." The handwritten notation was not dated or initialed.</p> <p>Resident #12's Progress Notes, dated 11/22/16 at 5:41 pm through 11/23/16 at 10:24 am, did not document an attempt to clarify the vague order for insulin per sliding scale. A Progress Note, dated 11/23/16 at 12:58 pm, documented, "[Physician] has been notified of the need for sliding scale clarification r/t [related to] the Humalog orders that arrived with [Resident #12] 11/22/16. He was contacted 11/22/16. Contacted again today for orders. Order that arrived form [sic] the [referring hospital] read Humalog 1-7 units four times daily before meals and at bedtime. No sliding scale came with order. [Physician] is having his nurse send over sliding scale." An 11/23/16, 2:45 pm, Progress Note documented, "Received Sliding Scale clarification for Insulin [sic] Lispro [sic] and Blood Glucose checks from [physician]..."</p> <p>An 11/23/16 physician order documented insulin lispro per sliding scale 3 times a day before meals as follows:</p> <ul style="list-style-type: none"> * 1 unit if blood glucose (BG) greater than 150 * 2 units if BG greater than 200 * 3 units if BG greater than 250 * 4 units if BG greater than 300 <p>A nurse noted the order on 11/23/16 at 2:47 pm.</p> <p>Resident #12's November 2016 Medication Administration Record (MAR) documented the first time the insulin lispro per sliding scale order</p>	F 309	<p>have been identified as having potential to be affected by the deficient practice. All current diabetic patients will be screened for completeness of diabetic insulin regimens including sliding scale.</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur,</p> <p>All current diabetic residents and new residents will be reviewed for completeness of insulin and sliding scale orders upon admission. All current residents have been screened. Diabetic care policy and procedure has been updated to ensure completeness of insulin orders and regimen with sliding scale parameters in place upon admission. All LN□s were educated on the updated diabetic policy and procedure. All newly hired LN□s to be in-serviced on new policy and procedure.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through: DON/designee will conduct weekly nutrition at risk audits for diabetic residents to evaluate blood glucose levels and communicate with physician if any changes are needed to their regimen.</p> <p>Monitoring will start on 5/31/17.</p>		

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F 309	Continued From page 40 was administered was on 11/23/16 at 5:30 pm. Resident #12's clinical record did not include documentation that his BG level was monitored during the time the physician's order was being clarified. On 4/20/17 at 3:00 pm, the Director of Nursing (DNS) said Resident #12 was admitted in the evening on 11/22/16. The DNS said that prior to admission, the Interdisciplinary Team (IDT) met to determine if the facility could meet the resident's needs. The DNS said the admission orders were available when the IDT met. The DNS did not reply when asked to explain the delay requesting a clarification to the admission order for insulin lispro per sliding scale Resident #12 experienced a delay in care when the facility failed to request timely clarification of a vague admission order for insulin lispro per sliding scale and his BG level was not monitored for almost 24 hours, from 11/22/16 at 5:41 pm through 11/23/16 at 5:30 pm.	F 309	This will be done weekly The Administrator or Designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting. 5/31/17		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side	F 323		5/31/17	

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F 323	<p>Continued From page 41</p> <p>or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and review of residents' records, it was determined the facility failed to ensure bed canes [small version of a side rail] were assessed as safe for 2 of 9 sample residents (#4 and #7). These deficient practices created the potential for neurological changes to go undetected and untreated; and created the potential for residents to become entrapped in bed canes, which could lead to injury or death. Findings include:</p> <p>1. Resident #7 was admitted to the facility on 10/31/16, with multiple diagnoses, including obesity and diabetes mellitus.</p> <p>Resident #7's ADL care plan, dated 11/1/16, identified the risk for self care deficit. Interventions included, "Positioning Devices used daily and PRN," initiated 10/31/16.</p> <p>Resident #7's bed canes were observed in the raised position on 4/19/17 at 11:45 am and</p>	F 323	<p>F 323 SS=E 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility does ensure bed canes are assessed as safe.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>#4 had a device use assessment and signed consent form for the bed canes dated 2/5/17 and 4/5/17. Resident has since been discharged from facility. Resident #7 did have an assessment completed upon admission dated 10/31/16 as well as a consent form dated 10/31/16.</p> <p>Identification of other residents having the</p>		

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F 323	<p>Continued From page 42</p> <p>4/20/17 at 4:30 pm. Resident #7 was seated in a recliner in his room during both observations. During the 4/20/17 observation, Resident #7 said the bed canes stay "up" when he is not in bed and that he uses them "sometimes" when in bed.</p> <p>Resident #7's electronic and paper clinical records did not contain documented evidence the bed canes had been assessed and determined to be safe for the resident to use.</p> <p>On 4/21/17 at 9:00 am, the DNS was asked to provide all assessments related to the use of Resident #7's bed canes. At 10:45 am, a "Physical Restraint/Enabler Consent for Bed Canes and/or Trapeze" for Resident #7 was provided.</p> <p>The restraint/enabler consent, signed by Resident #7 on 10/31/16, documented the bed canes were to assist with bed mobility, transfers in and out of bed, improve independence in bed mobility and transfers, decrease risk of injury from falls and for positioning with ADLs. The consent did not include whether Resident #7 had been assessed and determined to be safe with the use of the bed canes.</p> <p>On 4/21/17 at 11:00 am, the DNS said there were no other bed cane assessments for Resident #7.</p> <p>2. Resident #4 was admitted to the facility on 2/5/17, and readmitted on 4/5/17, with multiple diagnoses, including sciatica and rehabilitation after surgical repair of a fractured hip.</p> <p>Resident #4's admission Minimum Data Set (MDS) assessment, dated 2/10/17, documented</p>	F 323	<p>same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All residents have the potential to be affected by the deficient practice. A facility wide audit has been conducted to verify all residents have the appropriate assessments and consents for the bed canes.</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur,</p> <p>A policy and procedure will be developed to ensure that all devices considered a physical restraint/enabler i.e., Bed rail and trapeze are individually assessed for safety of the resident, and that consent is provided. All staff members will be educated regarding the policy and procedure on or before 5/31/17.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through:</p> <p>DON/designee to conduct random audits on the licensed nurse check in sheet to ensure that each newly admitted resident has been assessed and consent provided for a physical restraint/enabler device.</p>		

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F 323	Continued From page 43 Resident #4's cognition was moderately impaired, she had a Foley catheter, experienced a fall-related fracture prior to admission and had a history of falls, and required extensive assistance from staff with transfers and mobility. Resident #4's Fall Risk Care Plan, initiated 2/22/17, documented she was on a fall prevention program. On 4/17/17 at 4:10 pm, Resident #4 was observed in bed with bilateral bed canes in an upraised position. Resident #4 was observed in her room sitting in her wheelchair on 4/18/17 at 8:15 am, 9:00 am, 9:22 am, and 11:05 am. Resident #4's bed canes were observed attached to her bed and in the upraised position during each observation. Resident #4's "Physical Restraint/Enabler Consent for Bed Canes and/or Trapeze" documented the potential benefits and potential risks for restraint/enabler use. There were no safety assessments found in Resident #4's clinical record related to the use of bed canes. On 4/20/17 at 5:00 pm, the DON said there were no other assessments completed for Resident #4 regarding the use of bed canes.	F 323	Monitoring will start on 5/31/17. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3 The Administrator or Designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting. 5/31/17		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance	F 328		5/31/17	

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F 328	<p>Continued From page 44 with professional standards of practice, including to prevent complications from the resident's medical condition(s) and</p> <p>(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments</p> <p>(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.</p> <p>(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.</p> <p>(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.</p> <p>(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the</p>	F 328			

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F 328	<p>Continued From page 45 residents' goals and preferences, and 483.65 of this subpart.</p> <p>(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure oxygen therapy was administered per physician orders. This was true for 1 of 4 residents (#4) reviewed for the use of oxygen and created the potential for harm if the resident received unnecessary, excessive, or insufficient oxygen to maintain stability. Findings included:</p> <p>Resident #4 was admitted to the facility on 2/5/17, and readmitted on 4/5/17, with multiple diagnoses including asthma and aftercare rehabilitation for a surgically-repaired fractured hip.</p> <p>Minimum Data Set (MDS) Assessments, dated 2/10/17 and 4/12/17, documented Resident #4 experienced moderately impaired cognition with short and long-term memory impairment and received oxygen therapy.</p> <p>Resident #4's current care plan did not include a Respiratory Care plan or Oxygen care plan.</p> <p>The April 2017 Medication Administration Record (MAR) documented "Change out oxygen (O2)</p>	F 328	<p>F 328 SS=D 483.25 (b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility does ensure oxygen therapy is administered per physician orders.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>Resident number 4 has been discharged 5/19/2017 from the facility.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All residents have the potential to be affected by the deficient practice. A facility wide audit will be conducted to ensure that all resident's oxygen orders match the current oxygen usage/administration.</p>		

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F 328	<p>Continued From page 46</p> <p>tubing every Sunday night, Change humidifier bottles if water level is low...Check O2 sats every shift to maintain sats [blood saturations] [greater than] 90%..." The MAR did not indicate how much oxygen Resident #4 was to receive.</p> <p>Resident #4 was observed in her room receiving oxygen via nasal cannula at 2 liters per minute (LPM) on 4/18/17 at 8:15 am, 9:00 am, and 11:05 am, and on 4/19/ at 9:45 am and 11:00 am.</p> <p>On 4/20/17 at 5:00 pm, the Director of Nursing (DON) said Resident #4 received oxygen at 2 LPM via nasal cannula, which was also documented on the Certified Nursing Assistant (CNA) task sheet. The DON provided a copy of the CNA task sheet, which documented Resident #4 received oxygen at 2 LPM. When asked for a physician's order for oxygen, the DON said it was on Resident #4's 2/10/17 Admission Orders, but not on the current recapitulated physician's orders.</p> <p>The following records of Resident #4 did not include a physician's order for oxygen.</p> <ul style="list-style-type: none"> * 2/5/17 Hospital Discharge Medication Reconciliation * 4/5/17 Hospital Discharge Medication Reconciliation * 1/1/17 to 4/30/17 Order Summary Report containing active, completed, and discontinued order 	F 328	<p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur,</p> <p>A policy and procedure for Routine standing orders to include O2 at 2 liters PRN in order to maintain saturations greater than 90% during routine vital signs checked each shift, unless otherwise specified in admission orders. All LN□s to be educated on the policy and procedure.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through: DON/designee to conduct random audits to verify that actual oxygen usage matches physician orders.</p> <p>Monitoring will start on 5/31/17. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3 The Administrator or Designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p> <p>5/31/17</p>		
F 425	483.45(a)(b)(1) PHARMACEUTICAL SVC -	F 425		5/31/17	

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F 425 SS=D	Continued From page 47 ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on review of clinical records and controlled medication count sheets, staff interview, and policy review, it was determined the facility failed to ensure there was collaboration with a licensed pharmacist to coordinate pharmaceutical services within the facility, to guide development and evaluation of the implementation of pharmaceutical services procedures, and to help identify, evaluate, and address/resolve pharmaceutical concerns and issues affecting residents' care. This was true 2 of 7 sample residents (#5 & #12) and 1 random resident (#26) reviewed for narcotic (controlled) medication use. The failure to account for the disposition of controlled medications, including used fentanyl patches, and to develop and implement procedures for missing controlled medications created the potential for misuse or diversion of controlled medications. Findings include: 1. Resident #5's Controlled Substance	F 425	F 425 SS=D 483.45 (a)(b)(1) PHARMACEUTICAL SVC-ACCURATE PROCEDURES, RPH? The facility does ensure there is collaboration with a licensed pharmacist to coordinate pharmaceutical services within the facility, to guide development and evaluation of the implementation of pharmaceutical services procedures, and to help identify, evaluate, and address/resolve pharmaceutical concerns and issues affecting residents care. Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice Policy and procedure developed to require two LN signatures on the removal and disposal of each fentanyl patch. Two		

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F 425	<p>Continued From page 48</p> <p>Administration Record for fentanyl patches documented that 5 of 16 times (31%) a second nurse did not witness the disposal of the used fentanyl patches.</p> <p>2. The Disposition of Remaining Doses forms for oxycodone (controlled) medication documented 83 oxycodone tablets remained when Resident #12 was "Released" on 12/6/16. A "Release of Responsibility and Receipt of Medication Upon Discharge" form documented Resident #12 "Refused" the 83 oxycodone tablets when discharged on 12/6/16. Only one nurse signed these forms on 12/6/16 and the nurse did not document the disposition of the controlled medications.</p> <p>3. Resident #26's Disposition of Remaining Doses for Norco (controlled) medication documented 1 Norco was "missing" in the morning on 2/13/17.</p> <p>On 4/20/17 at 12:45 am, the DNS provided the facility's Narcotics Policy and Procedure upon request. The P&P did not include what to do regarding missing narcotic medications. Also, the DNS did not provide evidence that the pharmacy was involved when the disposal of used fentanyl patches was not witnessed by 2 nurses, when the disposition of 83 oxycodone was unaccounted for, or when a Norco tablet was missing and unaccounted for.</p> <p>On 4/21/17 at 9:18 am, the facility's pharmacy was contacted by telephone. A pharmacy technician said the Pharmacist in Charge (PIC) and the owner were not available and a "fill-in" pharmacist was on duty. The pharmacy</p>	F 425	<p>licensed nurses signatures for the disposal of unused narcotic medications.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All residents have the potential to be affected by the deficient practice. Policy and procedure developed to require two LN signatures on the removal of each fentanyl patch. Two licensed nurses signatures for the disposal of unused narcotic medications.</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur,</p> <p>Policy and procedure have been developed to require two LN signatures on the removal of each fentanyl patch on the EMAR. Two licensed nurses signatures for the disposal of unused narcotic medications is required. All LN□s have been educated on the policy 5/4/2017 and 5/8/2017.</p> <p>A policy and procedure for the event of unaccounted for or missing narcotics has been developed to include the following steps: Immediate notification of DON, Administrator, and pharmacist; nurse on shift with narcotic keys will be drug tested immediately and suspended pending the</p>		

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F 425	Continued From page 49 technician was given a telephone number and a request for the owner or PIC to call back. The technician said he would "text" the owner and the PIC with the message and one of them would call back after 1:00 pm on 4/21/17 or on 4/24/17. By the end of business on 4/21/17 and 4/24/17, no calls or messages were received from the pharmacy owner or the PIC. The P&P did not include licensed pharmacist consultation on all aspects of the provision of pharmacy services in the facility or that a pharmacist would determine that drug records were in order and account for all controlled drugs. 4. Refer to F431 as it relates to the failure of the facility to to ensure accurate reconciliation and accounting of all controlled medications.	F 425	results of the investigation of the missing narcotics. How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through: EMAR will be audited randomly by the DON/designee to ensure proper removal/destruction of each fentanyl patch. Monitoring will start on 5/31/17. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3 The Administrator or Designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 431		5/31/17	

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F 431	<p>Continued From page 50 biologicals) to meet the needs of each resident.</p> <p>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--</p> <p>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>(g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>(h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 431			

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F 431	<p>Continued From page 51</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility's controlled substance medication logs and resident records, staff interview, and policy review, it was determined the facility failed to ensure accurate reconciliation and accounting of all controlled medications for 2 of 7 sample residents (#5 & #12) and 1 random resident (#26) reviewed for narcotic medication use. The deficient practice created the potential for diversion of narcotic medications and for residents to experience uncontrolled pain. Findings include:</p> <p>According to Potter, Perry & Ostendorf (2014), Clinical Nursing Skills & Techniques, 8th ed. Elsevier: St. Louis, Guidelines for Safe Narcotic Administration and Control include: "An inventory record is used each time a narcotic is dispensed...and provide an accurate ongoing account of the narcotics used, wasted, and remaining...A second nurse witnesses disposal of the unused portion, and the record is signed by both nurses..."</p> <p>The facility's April 2014 Narcotics Policy and Procedure [P&P] documented, "...PROCEDURE 1...a. Scheduled I, II, and III drugs are counted with each key pass...b...both parties (one holding keys and the one receiving the keys) look at both medication card and narcotic book while counting. c. All Schedule I, II, III medications are counted. 2...a. Each cart has a...narcotic key b. Second key set is acceptable if stored in a double lock location. c. The Director of Nursing or designee will only have access to this location...4...a. Destroyed narcotics must contain two licensed nurse signatures. b. Documentation</p>	F 431	<p>F 431 SS=D 483.45 (b) (2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility does ensure accurate reconciliation and accounting of all controlled medications.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>A) Resident #5. Policy and procedure developed to require two LN signatures on the removal and disposal of each fentanyl patch. B) Resident #12 was discharged from the facility on 12/6/16.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>A) All residents have the potential to be affected by the deficient practice. Policy and procedure developed to require two LN signatures on the removal of each fentanyl patch. B) All residents have the potential to be affected by the deficient practice. Policy and procedure has been updated to require two LN's to witness for all transactions of narcotic mediations upon receipt, release and disposal of narcotic</p>		

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F 431	<p>Continued From page 52 of destruction...per standards and includes: What was destroyed, the date, the time, two signatures on narcotic page and must have disposal record. c. Disposal record matches page in book d. The Director of Nursing or designee maintains the disposal record...6. When a Narcotic is Discontinued or Resident Discharged a. A list of what was sent with resident and what was destroyed is kept - two signatures (see 4 above)..."</p> <p>The P&P did not address what to do if or when discrepancies were identified.</p> <p>1. Resident #12 was readmitted to the facility on 11/22/16, with several diagnoses, including presence of a prosthetic heart valve and idiopathic gout. The resident was discharged on 12/6/16.</p> <p>Resident #12's Interim Care Plan, dated "11/21/16" signed as 11/22/16 by the LN, and an 11/29/16 Interim Care Plan both documented pain medication use.</p> <p>Resident #12's Order Summary Report of active orders for 11/1/16 to 12/31/16 included oxycodone 5 mg 1 tablet every 6 hours as needed for pain. The controlled pain medication was ordered on 11/22/16 and reordered on 11/29/16.</p> <p>Two "Disposition of Remaining Doses" forms documented the facility received 25 oxycodone 5 mg tablets on 11/22/16 and 60 oxycodone 5 mg tablets on 11/29/16 for Resident #12. The 11/22/16 form documented 1 oxycodone tablet was administered on 11/22/16 and 1 tablet on</p>	F 431	<p>medications.</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur,</p> <p>A) Policy and procedure have been developed to require two LN signatures on the removal of each fentanyl patch on the EMAR. All LN's have been educated on the policy.</p> <p>B) Policy and procedure has been updated to require two LN's to witness for all transactions of narcotic medications upon receipt, release and disposal of narcotic medications and at shift change. A policy and procedure for missing or unaccounted for narcotics has been developed to include the following: charge nurse will immediately notify the DON, administrator and pharmacist; the off going nurse will be directed to fall river urgent care for immediate drug testing and will be suspended pending an immediate investigation into the missing/unaccounted for narcotic medications. All LN's will be educated on the updated policy and procedure regarding narcotic medications on or before 5/31/2017</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through:</p>		

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F 431	<p>Continued From page 53 11/23/16, with 23 tablets remaining. Both of the forms also documented, "Patient released 12/6" signed by 1 LN.</p> <p>A "Release of Responsibility and Receipt of Medication Upon Discharge" form, dated 12/6/16, documented Resident #12 "Refused" the remaining 23 and 60 (83) oxycodone tablets.</p> <p>On 4/21/17 at 10:00 am, the Assistant Director of Nursing (ADON) said Resident #12 refused 83 oxycodone 5 mg tablets when discharged from the facility on 12/6/16. The ADON said it was not evident what happened to the 83 oxycodone tablets and that a second nurse should have signed if the medications were wasted.</p> <p>2. Resident #5 was admitted to the facility on 2/24/17 with multiple diagnoses, including hip fracture, dementia and anxiety disorder.</p> <p>Resident #5's admission Minimum Data Set (MDS) assessment, dated 3/3/17, documented short and long-term memory problems, severely impaired cognition, and non-verbal sounds and facial expressions of pain observed for 3-4 days.</p> <p>Resident #5's Order Summary Report documented 1 fentanyl 12 microgram (mcg) patch transdermally every 72 hours (3 days) on 3/1/17. His March 2017 and April 2017 Medication Administration Record (MAR) documented a fentanyl 25 mcg patch was administered every 3 days from 3/1/17 through 4/18/17.</p> <p>Resident #5's "Controlled Substance Administration Record" for fentanyl patches</p>	F 431	<p>A) EMAR will be audited randomly by the DON/designee to ensure proper removal/destruction of each fentanyl patch.</p> <p>B) DON/designee will conduct random audits to ensure two LN's witness each narcotic transaction as well as at shift change.</p> <p>Monitoring will start on 5/31/17. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3 The Administrator or Designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>		

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F 431	<p>Continued From page 54</p> <p>included spaces for a witness to sign the witnessing of the disposal of used patches. Five of 16 spaces (31%) for "Witnessed disposal of" were blank.</p> <p>On 4/20/17 at 12:45 pm, the Director of Nursing Services (DNS) said 2 nurses did not consistently witness the wasting, or disposal, of Resident #5's used fentanyl patches. The DNS said she recently started requiring 2 nurses to witness the disposal of used fentanyl patches but did not yet have a policy to that effect.</p> <p>Regarding disposal of used fentanyl patches, the Nursing 2017 Drug Handbook documented, "Alert: Transdermal patches must be stored, used, and disposed of properly to prevent poisonings or other harm...A patch that has been worn for 3 days may still contain enough fentanyl to cause harm..."</p> <p>3. The facility's controlled medications logs included a "Disposition of Remaining Doses" form for Resident #26's controlled pain medication, Norco. The form documented "missing" 1 Norco tablet on 2/13/17 and signed by 2 nurses.</p> <p>On 4/20/17 at 3:15 pm, the DNS said the night nurse was sent for a drug test immediately when Resident #26's missing Norco was discovered in the morning on 2/13/17. The DNS said there is one key for the medication cart, the nurse on duty has the key, and a count of the controlled medications is done at shift change in the morning and the evening. The DNS said other controlled medication cards and records were reviewed at the time and no other problems were</p>	F 431			

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F 431	Continued From page 55 identified. The DNS said she did not conduct a "formal" investigation because the nurse's drug screen was negative and no other problems were identified.	F 431			
F 441 SS=E	<p>483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>(a) Infection prevention and control program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);</p> <p>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of</p>	F 441		5/31/17	

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F 441	<p>Continued From page 56 infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure laundry personnel demonstrated proper handling of dirty linen and cleaned resident-use equipment</p>	F 441	<p>F 441 SS=E 483.80 (a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS</p>		

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F 441	<p>Continued From page 57</p> <p>consistent with current standards of practice. This deficient practice directly impacted 1 of 1 sampled residents (#25) observed having her blood glucose levels tested, and had the potential to place all residents at risk for infections due to cross-contamination. Findings include:</p> <p>1. On 4/18/17 at 4:15 pm, at the entry of the dirty area of the laundry room, two white disposable gowns were observed hanging on the wall on the right side of the room. The gowns were wrinkled and one had many lint balls on it. There was also a commercial washing machine and a small white washing machine. On the front of the small white washing machine was posted a laminated 8.5 in x 11 white paper stating, "WASH MACHINE Please do the following when washing laundry...Put on gloves and gown prior to sorting dirty clothes..." When asked, Laundry Personnel #1 said he always did the laundry after he finished cleaning residents' room and offices in the facility. Laundry Personnel #1 said that to do the laundry he wore a pair of gloves, weighed the soiled clothes and linen while they were still in the clear plastic bags to make up one load, and then put the load in the commercial washing machine. When asked if he wore a protective gown or apron while sorting the soiled linen, he said "No, I only wear a gown if I am sorting the biohazard [clothes and linen] which is in the red bags."</p> <p>On 4/19/17 at 1:00 pm, Laundry Personnel #2 was observed in 200 Hall. She said she would deep clean the resident's room that was just vacated that day. When asked how would she clean the resident's room, Laundry Personnel #2 said she would do high and low dustings of all</p>	F 441	<p>The facility does ensure laundry personnel demonstrate proper handling of dirty linen and clean resident-use equipment consistent with current standards of practice.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>A) Laundry: Although no residents were found to be affected by the deficient practice all residents have the potential to be affected by this deficient practice.</p> <p>B) Glucometer: All nurses responsible for the care and treatment of the identified resident have been inserviced on the proper infection control protocols and procedures in regards to handling of nursing equipment.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>A) All residents have the potential to be affected by this deficient practice. Laundry staff will be educated on the proper protocols related to the handling of laundry and linen, in order to prevent cross-contamination on or by 5/31/17.</p> <p>B) All residents have potential to be affected by the deficient practice. All nurses responsible for the care and</p>		

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F 441	<p>Continued From page 58</p> <p>the furniture in the room, empty the trash cans, clean the toilet, mop the bathroom, vacuum the carpet and change all the linen and make the bed. Laundry Personnel #2 said she would do the laundry after she cleaned the rooms.</p> <p>On 4/19/17 at 4:00 pm, Laundry Personnel #2 was observed in the laundry room. The two disposable white gowns observed the previous day, were still hanging on the wall. Laundry Personnel #2 was observed to don a pair of gloves, go to the clean area of the laundry room, and empty the dryer. Laundry Personnel #2 started to fold the clean towels and linen. As she was doing so, the clean towels and linen were observed to come in contact with her clothes, which were the same clothes she was wearing when she cleaned the residents' room.</p> <p>On 4/19/17 at 4:07 pm, Laundry Personnel #3 was observed to enter the laundry room through the clean area and went to the dirty area after she had just finished cleaning the residents' rooms. Then wearing a pair of gloves, Laundry Personnel #3 put the clear plastic bags containing the soiled linen into the laundry basket to weigh. Laundry Personnel #3 then emptied the clear plastic bags of soiled linen and loaded them into the commercial washing machine. Laundry Personnel #3 was not wearing a protective gown or apron while emptying the clear plastic bags containing the soiled linen into the commercial washing machine. Laundry Personnel #2, also present, and Laundry Personnel #3, said they only wear a gown when sorting linen which was in a red bag. Laundry Personnel #2 said that during her training she was not told to wear a gown while sorting the soiled linen which was in</p>	F 441	<p>treatment of the identified resident have been inserviced on the proper infection control protocols and procedures in regards to handling of nursing equipment on or by 5/31/17.</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur,</p> <p>A) Laundry staff will be educated on the proper protocols related to the handling of laundry and linen, in order to prevent cross-contamination.</p> <p>All existing and new housekeeping/laundry staff shall complete a skills checklist verifying that their understanding of the process is complete</p> <p>Housekeeping supervisor shall post step by step process on proper laundry protocols</p> <p>B) Facility will create a Policy for Multi-resident glucometer use and cleaning</p> <p>Director of Nursing/Designee will train all licensed nurses on the newly created Policy and Procedure on or before 5/31/17.</p> <p>How the corrective actions will be monitored to ensure the deficient practice</p>		

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F 441	Continued From page 59 clear plastic bags. Laundry Personnel #3 also said she was not told to wear a gown while sorting the soiled linen in clear plastic bags. 2. On 4/19/17 at 11:55 am, RN #5 was observed as she prepared to check Resident #25's blood glucose level. The RN removed a glucometer from a medication cart drawer and placed it on the top of the cart. She did not utilize a barrier under the glucometer. RN #5 gathered supplies then put the glucometer into a cup and took it and the supplies to Resident #25's room. In Resident #25's room, the RN took the glucometer out of the cup and placed it on the resident's over bed table. The over bed table was cluttered and had debris and shiny areas, like moisture, on it. RN #5 did not cleanse the over bed table or utilize a barrier under the glucometer. After the BG check, RN #5 wiped the glucometer with a bleach wipe then placed it on the over bed table while she collected the used supplies. Again, RN #5 did not cleanse the over bed table or utilize a barrier under the glucometer. On 4/19/17 at 1:10 pm, RN #5 said a glucometer was on each medication cart and they were used for multiple residents. RN #5 said she did not remember placing the glucometer on top of the medication cart or on Resident #25's over bed table without a barrier. The RN said she would be more attentive. On 4/20/17 at 9:15 am, the Director of Nursing Services and Assistant Director of Nursing Services said the facility did not have a policy and procedure for multi-resident glucometer use or cleaning.	F 441	will not recur: Monitoring will be done through: A) Housekeeping Supervisor will perform random audits to ensure corrective actions are effective and sustained. B) Director of Nursing/Designee will perform random audits to ensure Licensed nurses are adhering to our multi-resident use glucometer policy Monitoring will start on 5/31/17. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3 The Administrator or Designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting. 5/31/17		
F 490	483.70 EFFECTIVE	F 490		5/31/17	

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F 490 SS=F	Continued From page 60 ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record and policy and procedure review, it was determined the facility's administration failed to ensure the facility was administered in a manner to effectively use its resources to attain or maintain the highest practicable well being of each resident. The facility failed to ensure compliance with several regulatory requirements, which had the potential to adversely affect the health and safety of 9 of 9 sample residents (#1-#9), as well as, the other 16 residents receiving services and treatment at the facility. Findings include: 1. Deficiencies related to ineffective administration: Refer to F226 as it relates to the facility's failure to ensure an on-going abuse prevention program. Refer to F253 as it relates to the facility's lack of housekeeping services for appliances frequently used by residents and visitors. Refer to F323 as it relates to the facility's lack of adequate supervision for residents based on their individualized care plans and assessed needs.	F 490	F 490 SS=F 483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING The facility does ensure it is administered in a manner that effectively uses its resources to attain or maintain the highest practical well being of each resident. The facility does ensure compliance with regulatory requirements. Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice All residents have been found to be affected by the deficient practice and a Licensed Administrator has since been appointed by the governing body. Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following: All residents have the potential to be		

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F 490	Continued From page 61 Refer to F425 as it relates to the facility's lack of coordination of pharmaceutical services within the facility. Refer to F441 as it relates to the facility's failure to implement infection control measures in the laundry and for glucometers used for multiple residents. Refer to F493 as it relates to the failure of the facility's governing body to appoint a licensed administrator to manage the facility. Refer to F520 as it relates to the facility's failure to maintain a quality assessment and assurance program. 2. On 4/17/17 at 3:31 pm, the Administrator in Training (AIT) said the Interim Administrator was not in that day but would be in the next day. At 3:40 pm, the AIT said he would call the Interim Administrator as soon as possible. At 5:50 pm, the AIT said the Interim Administrator left his position with the facility on 4/5/17. The AIT said he was the "Acting Administrator" but he did not have a license to be a nursing home administrator. The AIT said another administrator would be in the facility on 4/24/17.	F 490	affected by the deficient practice. A licensed administrator has been appointed by the governing body Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur, The governing body will be educated on the applicable LNHA requirements. How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through: Governing body/designee will ensure that the facility has a licensed administrator of record and that the administrator has an active license and is in good standing. Random NHA license verification audits will be conducted. Monitoring will start on 5/31/17. This will be done monthly The Governing Body/Designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		
F 493 SS=F	483.70(d)(1)(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN	F 493		5/31/17	

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F 493	Continued From page 62 (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- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Based on staff interview, it was determined the facility failed to ensure an Administrator was appointed by the facility's Governing Body. The failure had the potential to affect all 25 residents in the facility, including 9 of 9 sample residents (#1-#9) and the 16 other residents residing in the facility. This deficient practice created the potential that residents would not receive the care and services to meet their needs. Findings include: 1. On 4/17/17 at 3:40 pm, the Administrator in Training (AIT) said the previous administrator had moved to Texas several weeks ago and that the Interim Administrator was not available.	F 493	F 493 SS=F 483.70 (d)(1)(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMIN The facility does ensure an Administrator is appointed by the Governing Body Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice All residents have been found to be affected by the deficient practice and a Licensed Administrator has since been appointed by the governing body.		

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NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH REXBURG, ID 83440		
(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 493	<p>Continued From page 63</p> <p>On 4/17/17 at 5:50 pm, the AIT said the Interim Administrator left the facility on 4/5/17 and that he, the AIT, was the "Acting Administrator." The AIT said he was not licensed as a nursing home administrator. The AIT said he thought the facility had "30 days" to find a new administrator but said he did not have documentation to support that belief.</p> <p>On 4/21/17 at 12:30 pm, the Director of Nursing (DNS) said the facility's governing body consisted of the Chief Financial Officer (CFO) for the local hospital, the owner of the building, the previous administrator, and the AIT.</p> <p>The facility's Governing Body failed to appoint a licensed Administrator to administer the daily operations of the facility.</p> <p>2. Refer to F490 as it relates to the failure to ensure a licensed Administrator was responsible for the administration of the facility.</p>	F 493	<p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All residents have the potential to be affected by the deficient practice. A licensed administrator has been appointed by the governing body</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur,</p> <p>The governing body will be educated on the applicable regulations pertaining to the LNHA position.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through:</p> <p>Governing body/designee will ensure that the facility has a licensed administrator of record and that the administrator has an active license and is in good standing. Random NHA license verification audits will be conducted.</p> <p>Monitoring will start on 5/31/17. This will be done quarterly The Governing Body/designee will present to the quarterly QA&A Committee</p>		

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F 493	Continued From page 64	F 493	meeting any findings and/or corrective actions taken		
F 520 SS=F	<p>483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>(g) Quality assessment and assurance.</p> <p>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:</p> <p>(i) The director of nursing services;</p> <p>(ii) The Medical Director or his/her designee;</p> <p>(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</p> <p>(g)(2) The quality assessment and assurance committee must :</p> <p>(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</p> <p>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;</p>	F 520	<p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p> <p>5/31/2017</p>	5/31/17	

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F 520	Continued From page 65 (h) Disclosure of information. A State or the Secretary may not require disclosure of the 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. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of clinical records and policies and procedures, it was determined the facility's Quality Assessment and Assurance (QAA) committee failed to take actions to identify and resolve systemic problems for 9 of 9 sample residents (#1-#9) and the 16 other residents residing in the facility, as well as 13 of 13 residents whose closed records were reviewed (#10-#22). The deficient practice resulted in insufficient direction and control necessary to ensure residents' rights were maintained and quality of life and quality of care needs were met. The failure had the potential to harm residents due to inadequate care and services. Findings include: 1. The QAA committee failed to provide sufficient monitoring and oversight to sustain regulatory compliance as evidenced by the following citations: Refer to F156 as it relates to the facility's failure to ensure its Admission information incorporated	F 520	F 520 SS=F 483.75 (g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS The facility does ensure residents rights are maintained and quality of life and quality of care needs are met. Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice The facility will designate specific time at the QAA meeting to address previous state survey deficiencies and what has been accomplished towards correcting these deficiencies. Action plans will be implemented and followed up on at each QAA meeting to ensure that deficient items are brought back into compliance. Identification of other residents having the same potential to be affected by the same		

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F 520	<p>Continued From page 66</p> <p>all related regulatory requirements. The facility was cited at F156 on its 2/26/15 initial certification survey and 10/5/16 recertification survey.</p> <p>Refer to F226 as it relates to the facility's failure to ensure a licensed Administrator was in place to implement and oversee the facility's abuse prevention program and allegations of abuse; and, that potential employees were screened prior to or upon hire</p> <p>Refer to F253 as it relates to the facility's failure to ensure housekeeping services were provided for equipment/appliances used by residents and visitors.</p> <p>Refer to F281 as it relates to the facility's failure to ensure nursing staff followed nursing standards of practice.</p> <p>Refer to F309 as it relates to the facility's failure to follow physicians' orders for anticoagulant medications and to request clarification of vague admission orders for sliding scale insulin in a timely manner.</p> <p>Refer to F323 as it relates to the facility's failure to ensure bed canes [small version of a bed rail] were assessed as safe for the residents who used them.</p> <p>Refer to F425 as it relates to the facility's failure to ensure collaboration with a licensed pharmacist to coordinate pharmaceutical services within the facility, to guide development and evaluation of the implementation of pharmaceutical services procedures, and to help</p>	F 520	<p>practice and what corrective actions taken includes the following:</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>The facility will designate specific time at the QAA meeting to address previous deficiencies and what has been accomplished towards correcting these deficiencies. Action plans will be implemented and followed up on at each QAA meeting to ensure that deficient items are brought back into compliance.</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur,</p> <p>Minutes, follow up items, assignments with completion dates shall be compiled for each QAA meeting. All committee members will be educated regarding the design, process and system that will govern the functions of the QAA committee.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through:</p> <p>A member of the governing body will monitor the QAA process of the facility to ensure that the QAA program is</p>		

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F 520	<p>Continued From page 67</p> <p>identify, evaluate, and address/resolve pharmaceutical concerns and issues affecting residents' care.</p> <p>Refer to F431 as it relates to the facility's failure to ensure accurate reconciliation and accounting of all controlled medications.</p> <p>Refer to F441 as it relates to the facility's failure to ensure implementation of infection control measures in the laundry area and regarding glucometers used for multiple residents.</p> <p>2. On 4/21/17 at 9:30 am, the Administrator in Training said he attended "a majority" of the facility's QAA committee meetings during 9 months of training as an AIT. The AIT said he knew in a "general sense" some of the things the committee worked on "but no specifics." The AIT said the previous Administrator took notes and created action plans for identified areas of concern but, "I don't know where those notes are. I'm unaware."</p>	F 520	<p>functioning as intended. They will randomly review/audit the committee minutes and action plans.</p> <p>Monitoring will start on 5/31/17. This will be done monthly x 6</p> <p>The Administrator or Designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p> <p>5/31/17</p>		

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State licensure and complaint investigation survey conducted at the facility from April 17, 2017 to April 21, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Presie Billington, RN Lesley Davis, RN</p> <p>Abbreviations:</p> <p>ADON = Assistant Director of Nursing AIT = Administrator in Training ICC = Infection Control Committee QAA = Quality Assessment and Assurance</p>	C 000		
C 105	<p>02.100,02 ADMINISTRATOR</p> <p>02. Administrator. The governing body, owner or partnership shall appoint a licensed nursing home administrator for each facility who shall be responsible and accountable for carrying out the policies determined by the governing body. In combined hospital and nursing home facilities, the administrator may serve both the hospital and nursing home provided he is currently licensed as a nursing home administrator. This Rule is not met as evidenced by: Based on observation, staff interview, clinical record review, and policy and procedure review, it was determined the facility failed to ensure an Administrator was appointed to the facility responsible for facilitating the effective use of</p>	C 105	<p>C 105 02.100,02 ADMINISTRATOR</p> <p>The facility does ensure that an</p>	5/31/17

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/22/17
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C 105	<p>Continued From page 1</p> <p>resources in a manner. This deficient practice created the potential for 9 of 9 sample residents (#1 - #9) and 16 other residents receiving services and treatment at the facility not to receive the care and services necessary to meet their needs. Findings include:</p> <p>1. On 4/17/17 at 3:40 pm, the Administrator in Training (AIT) said the previous administrator had moved to Texas several weeks prior and that the Interim Administrator was not available.</p> <p>On 4/17/17 at 5:50 pm, the AIT said the Interim Administrator left the facility on 4/5/17 and that he, the AIT, was the "Acting Administrator." The AIT said he was not licensed as a nursing home administrator. The AIT said he thought the facility had "30 days" to find a new administrator, but could not provide documentation to support that belief.</p> <p>On 4/21/17 at 12:30 pm, the Director of Nursing (DNS) said the facility's governing body consisted of the Chief Financial Officer (CFO) for the local hospital, the owner of the building, the previous administrator, and the AIT.</p> <p>On 4/17/17 at 3:31 pm, the AIT said the Interim Administrator was not in that day, but would be in the next day. At 3:40 pm, the AIT said he would call the Interim Administrator as soon as possible. At 5:50 pm, the AIT said the Interim Administrator left his position with the facility on 4/5/17. The AIT said he was the "Acting Administrator" but he did not have a license to be a nursing home administrator, nor had he received direct oversight from a licensed administrator since 4/5/17. The AIT said another administrator would be in the facility on 4/24/17.</p>	C 105	<p>Administrator is appointed to the facility to be responsible for facilitating the effective use of resources.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>All residents have been found to be affected by the deficient practice and a Licensed Administrator has since been hired by the governing body.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All residents have the potential to be affected by the deficient practice. A licensed administrator has been hired by the governing body</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur, The governing body will be educated on the applicable LNHA requirements.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through:</p> <p>Governing body member/designee will ensure that the facility has an appointed</p>	

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C 105	<p>Continued From page 2</p> <p>2. Deficiencies related to the facility's failure to appoint licensed, full-time administrator:</p> <p>Please refer to F490 as it relates to the failure to ensure a licensed Administrator was responsible for the administration of the facility.</p> <p>Please refer to F226 as it relates to the facility's failure to ensure an on-going abuse prevention program.</p> <p>Please refer to F253 as it relates to the facility's lack of housekeeping services for appliances frequently used by residents and visitors.</p> <p>Please refer to F323 as it relates to the facility's lack of adequate supervision for residents based on their individualized care plans and assessed needs.</p> <p>Please refer to F425 as it relates to the facility's lack of coordination of pharmaceutical services within the facility.</p> <p>Please refer to F441 as it relates to the facility's failure to implement infection control measures in the laundry and for glucometers used for multiple residents.</p> <p>Please refer to F493 as it relates to the failure of the facility's governing body to appoint a licensed administrator to manage the facility.</p> <p>Please refer to F520 as it relates to the facility's failure to maintain a quality assessment and assurance program.</p>	C 105	<p>licensed administrator of record and that the administrator has an active license and is in good standing. Random NHA license verification audits will be conducted monthly</p> <p>Monitoring will start on 5/31/17.</p>	

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C 664	Continued From page 3	C 664		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on review of ICC (Infection Control Committee) attendance records and staff interview, it was determined the facility failed to ensure a representative from the maintenance department and housekeeping department participated in ICC meetings at least quarterly. The failure created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings include:</p> <p>On 4/20/16, the Assistant Director of Nursing (ADON) said the facility's ICC met monthly during Quality Assessment and Assurance (QAA) meetings and that attendance records for the ICC meetings and the QAA meetings were one in the same.</p> <p>QAA/ICC attendance records for January through March 2017 documented representatives from the maintenance and housekeeping departments did not participate in the ICC meetings during the first quarter of 2017.</p>	C 664	<p>C664 02.150, 02 REQUIRED MEMBERS OF COMMITTEE</p> <p>The facility does ensure representatives from maintenance and housekeeping departments, including maintenance and housekeeping participate in ICC meetings.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>All residents were identified as being potentially affected by this deficient practice</p> <p>The housekeeping and maintenance supervisors have been in serviced on the need to attend the ICC meetings at least quarterly.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All current and future residents have the</p>	5/31/17

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C 664	Continued From page 4	C 664	<p>potential to be affected by this deficient practice</p> <p>The housekeeping and maintenance supervisors have been in serviced on the need to attend the ICC meetings at least quarterly.</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur,</p> <p>The housekeeping and maintenance supervisors have been in serviced on the need to attend the ICC meetings at least quarterly.</p> <p>A specific sign in sheet shall be created that will indicate required members with a designated signature slot to ensure that all required members are present before ICC meeting can take place.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through:</p> <p>The Administrator/designee will conduct random audits to verify all required members of the ICC have signed the sign in form.</p> <p>Monitoring will start on 5/31/17. This will be done monthly The Administrator or Designee will</p>	

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C 664	Continued From page 5	C 664	present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting. 5/31/17	
C 880	<p>02.203,01 Responsible Staff</p> <p>01. Responsible Staff. The administrator shall designate a staff member the responsibility for the accurate maintenance of medical records. If this person is not a Registered Records Administrator (RRA) or an Accredited Records Technician (ART), consultation from such a qualified individual shall be provided periodically to the designated staff person.</p> <p>This Rule is not met as evidenced by: Based on interview, it was determined facility failed to ensure the staff member responsible for the accurate maintenance of medical records periodically received consultation from a qualified individual. The failure affected 9 of 9 (#s 1-9) sample residents, all other residents in the facility, and residents discharged after November 2016. Findings include:</p> <p>On 4/17/17, the Administrator in Training (AIT) was asked for a list of Key Facility Personnel which included the facility's medical records consultant.</p>	C 880	<p>C880 02.203,01 RESPONSIBLE STAFF</p> <p>The facility does ensure that our medical records designee receives periodic consultation from a qualified individual.</p> <p>Corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice</p> <p>All residents were affected by this deficient practice</p>	5/31/17

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C 880	Continued From page 6 On 4/21/17 at 9:30 am, the AIT said a medical records consultant had not been available since "last November [2016]."	C 880	<p>Consultation from a qualified individual has been obtained to provide periodic Medical Records oversight in order to comply with the regulation</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective actions taken includes the following:</p> <p>All current and future guests have the potential to be affected by this deficient practice. A qualified Medical Records consultant for the facility has been obtained</p> <p>Consultation from a qualified individual has been obtained to provide Medical Records oversight in order to comply with the regulation.</p> <p>Measures that will be put into place or systematic changes you will make to ensure that the deficient practice does not recur includes the following: To ensure the deficient practice does not recur,</p> <p>The facility shall implement a regular schedule of when the consultant will provide services to the facility and the facility shall obtain a consultation note to verify that the service was provided.</p> <p>The facility shall create a consultation binder for any consultation services rendered to the facility</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001445	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/21/2017
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NAME OF PROVIDER OR SUPPLIER MADISON CARRIAGE COVE SHORT STAY RE-	STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST 1ST NORTH REXBURG, ID 83440
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 880	Continued From page 7	C 880	<p>How the corrective actions will be monitored to ensure the deficient practice will not recur: Monitoring will be done through:</p> <p>Administrator/Designee shall audit the consultation binder to ensure that consultation services are being performed.</p> <p>Monitoring will start on 5/31/17. This will be done monthly x6</p> <p>The Administrator or Designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p> <p>5/31/17</p>	