



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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P.O. Box 83720  
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June 7, 2017

Julie Johansen, Administrator  
Good Samaritan Society-- Silver Wood Village  
PO Box 358  
Silverton, ID 83867-0358

Provider #: 135058

Dear Ms. Johansen:

On **May 22, 2017**, a survey was conducted at Good Samaritan Society - Silver Wood Village 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 in your facility to be **WIDESPREAD PATTERN** and to constitute immediate jeopardy to residents' health and safety. You were informed of the immediate jeopardy situation(s) in writing on May 18, 2017.

On May 19, 2017, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the residents had been removed. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction. The most serious deficiency now constitutes actual harm that is not immediate jeopardy and that is isolated in scope, as evidenced by the Form CMS-2567, whereby significant corrections are required.

On **May 22, 2017**, a survey was conducted at Good Samaritan Society - Silver Wood Village by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes immediate jeopardy to resident health or safety, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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 **June 19, 2017**. Failure to submit an acceptable PoC by , may result in the imposition of additional civil monetary penalties by **July 10, 2017**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- 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*.

Based on the immediate jeopardy cited during this survey:

- **F0309 -- S/S: K -- 483.24, 483.25(k)(l) -- Provide Care/services For Highest Well Being**

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

- A civil money penalty

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 22, 2017**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

Your facility's noncompliance with the following:

- **F0309 -- S/S: K -- 483.24, 483.25(k)(l) -- Provide Care/services For Highest Well Being**

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

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

Residents #2, #5 as identified on the Resident Identifier List, and Random Residents #13 through #22 as identified on the Resident Identifier List.

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

If you believe the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888,

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with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **June 19, 2017**. If your request for informal dispute resolution is received after **June 19, 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,



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

DS/lj  
Enclosures

c: Chairman, Board of Examiners - Nursing Home Administrators

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

PRINTED: 06/26/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/22/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>		
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>A Federal Recertification survey was conducted at the facility on May 15, 2017 to May 22, 2017. Immediate Jeopardy was identified at:</p> <p>*42 CFR 483.25 [F309]</p> <p>Immediate Jeopardy at F309 was removed prior to the exit conference.</p> <p>The surveyors conducting the survey were:</p> <p>Teresa Kobza, RDN, LD, Team Coordinator Linda Kelly, RN</p> <p>Definitions Include:</p> <p>ADL - Activities of Daily Living ATW - All Terrain Walker BG - Blood Glucose [sugar] cc - cubic centimeter CNA - Certified Nursing Assistant C/O - Complaint of DKA - Diabetic Ketoacidosis DM - Diabetes Mellitus FSBS = Finger stick blood sugar FSHW = Fall Scene Huddle Worksheet FWW = Front wheel walker g - Gram H &amp; P - History and Physical HS - At Hour of Sleep IDNS - Interim Director of Nursing Services LN - Licensed Nurse LPN - Licensed Practical Nurse LSW - Licensed Social Worker MAR - Medication Administration Record MD - Physician MDS - Minimum Data Set</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

06/13/2017

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

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F 000	Continued From page 1 mg - Milligram mg/dl - Milligram/deciliter min - minute mL - MiliLiter(s) OT - Occupational Therapy oz - ounce PAINAD - Pain Assessment in Advanced Dementia PA - Posteroanterior PRN - As needed PT - Physical Therapy P & P - Policy and Procedure RN - Registered Nurse RNA - Restorative Nursing Aide SDC - Staff Development Coordinator SSD - Social Service Director s/s - Signs and symptoms TAR - Treatment Administration Record TID - Three Times a day Q - Every QAA- Quality Assessment and Assurance QID - Four times a day U/A - Urine Analysis UTI - Urinary Tract Infection W/C - Wheelchair < - Less than > - Greater than	F 000			
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  (g)(14) Notification of Changes.  (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-  (A) An accident involving the resident which	F 157		7/18/17	

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F 157	<p>Continued From page 2</p> <p>results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, review of Incident and Accident Reports, and review of residents' records, it was determined the facility failed to ensure residents' physicians were notified of significant changes in their conditions and/or a need to alter treatment. This was true for 2 of 13 sampled residents (#2 and #11) and had the potential for harm if physicians were not provided with information necessary to make decisions to initiate and/or alter interventions to meet residents' changing needs. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 4/14/17, with diagnoses which included Type II diabetes mellitus [DM].</p> <p>The initial Minimum Data Set (MDS) assessment, dated 4/25/17, documented Resident #2 was cognitively intact.</p> <p>The Hyperglycemia Care Plan, revised 5/4/17, directed staff to monitor, document, and report to the physician, as needed, when Resident #2 experienced signs and symptoms (s/s) of hyperglycemia. The care plan did not document how often staff was to monitor Resident #2's BG (blood glucose) levels, when staff was to notify the physician if BG levels were outside of physician-established parameters, when to administer insulin, or when to follow hyper/hypo glycemc protocols.</p> <p>Resident #2's May 2017 Physician's Orders documented:</p> <p>* HumaLOG (Insulin Lispro) solution before</p>	F 157	<p>F157 (1)Corrective actions for those residents identified: Resident #2; 05/18/17 Physician was notified of abnormal blood sugars that were out of range. Medication adjustment was made per physician order. The physician has been notified of blood glucose levels outside of the parameters. Orders were obtained specifying how to manage hyper/hypo glycemc episodes and blood glucose parameters for notification of physician. Care plan was updated. Staff education on 5/18/17 (and on-going) on the management of hyper/hypo glycemc episodes and when to notify the physician/family. The resident had a change of condition on 5/24/17 related to increased edema. Hospice called to consult on edema issues, picking of the skin and continued unstable blood glucose levels and possible need for transfer to inpatient hospice. Orders were obtained specifying how to manage hyper/hypo glycemc</p>		

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F 157	<p>Continued From page 4</p> <p>meals and at bedtime (HS) per the following sliding scale for BGs (all measurements in milligrams/deciliter) of:</p> <p>70 - 130 = 0 units; 131 - 180 = 4 units; 181 - 240 = 8 units; 241 - 300 = 10 units; 301 - 350 = 12 units; 351 - 400 = 16 units; 401 - 499 = 20 units, and call physician for BG levels greater than 400 mg/dl, ordered 4/20/17.</p> <p>* 28 units of Tresiba (Insulin Degludec) solution in the morning for DM, ordered 5/1/17.</p> <p>* BG assessments before meals and at bedtime related to Type II DM. For BG level greater than 400 mg/dl the physician was to be called. If Resident #2 had a BG level less than 70 and was able to swallow, staff were to give the resident a rapidly absorbing carbohydrate such as 4 ounces juice. Resident #2's BG level was to be checked in 15 minutes and repeat if carbohydrate was necessary. This was initiated on 4/19/17.</p> <p>A Nurse's Note, dated 4/18/17 at 6:01 pm, documented Resident #2 had a BG level of 514 mg/dl.</p> <p>Resident #2's MAR from 4/19/17 through 4/30/17 documented:</p> <p>* BG levels ranged from 209 - 509 mg/dl.</p> <p>* 13 BG levels were greater than 400 mg/dl, including 1 BG greater than 500 mg/dl.</p>	F 157	<p>episodes and blood glucose parameters for notification of physician.</p> <p>Resident #11: Resident was discharged 4/25/2017 to in patient hospice.</p> <p>(2) Address how you will identify other residents who have the potential to be affected and how it will be corrected; All residents have the potential for incidents requiring physician/family notification. All incidents will be reviewed daily Monday <input type="checkbox"/> Friday to ensure that physician and family have been notified. All residents requiring blood glucose monitoring have the potential to be affected. All diabetic residents have new orders to follow facility guidelines for diabetic management. Care plans and MARs reflect the change in diabetic management orders; completed 05/18/2017. All residents requiring pain management have the potential to be affected. Residents on narcotic pain medications will have the MAR and Narcotic book checked</p>	

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F 157	<p>Continued From page 5</p> <p>* The resident's record documented the physician was notified of 4 of the 13 hyperglycemic assessments, those on 4/18/17, 4/20/17, 4/21/17, and 4/27/17.</p> <p>Resident #2's MAR from 5/1/17 to 5/16/17 documented:</p> <p>* BG levels ranging from 119 - 586 mg/dl.</p> <p>* 13 BG levels greater than 400 mg/dl, 6 of which were greater than 500 mg/dl.</p> <p>* Resident #2's record documented the physician was notified of 1 of the 13 hyperglycemic assessments, that on 5/14/17.</p> <p>On 5/18/17 at 8:42 am, the Interim Director of Nursing Services (IDNS) stated facility staff were to notify the physician as soon as possible when BG levels exceeded parameters specified by the physician.</p> <p>On 5/18/17 at 11:15 am, Licensed Practical Nurse (LPN) #1 stated she would notify a physician when BG levels were outside established parameters and document that she called the physician in a Nurse's Note.</p> <p>On 5/18/17 at 3:15 pm, Resident #2's physician stated he was aware of Resident #2's elevated BG levels and was not "all that upset" that he was not notified on "every" occasion, but that he expected nurses to follow his orders "all the time." He stated the facility would usually send a fax notifying him of elevated BG levels.</p> <p>2. Resident #11 was readmitted to the facility on</p>	F 157	<p>daily to ensure nurses are following physician orders.</p> <p>(3) What measures will be put in place and what systematic changes will be made: Orders were obtained for diabetic residents specifying how to manage hyper/hypo glyceimic episodes and including blood glucose parameters for physician notification. Care plans were updated. Staff education on 5/18/17 (and on-going) on the management of hyper/hypo glyceimic episodes and when to notify the physician/family. Physician/family will be notified of all incidents as they occur.</p> <p>(4) indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and do not recur; All diabetics with orders for blood glucose monitoring have been audited daily X two weeks; weekly X two weeks; every two weeks x two months by the DNS and/or designee. QAPI will evaluate if monthly audits are indicated. All incidents will be monitored the DNS and/or designee</p>		

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F 157	<p>Continued From page 6</p> <p>1/28/16 with diagnoses which included malignant neoplasm of the lung [lung cancer], dementia and mood disorder.</p> <p>The quarterly MDS assessment, dated 2/22/17, documented Resident #11 was cognitively intact, required supervision with transfers and ambulation, experienced 1 non-injury fall prior to the assessment, and rejected cares 1-3 days during the look back period.</p> <p>Resident #11 experienced 5 falls between 4/1/17 and 4/25/17.</p> <p>* Fall on 4/1/17 at 3:15 am: A Fall Scene Huddle Worksheet [FSHW] documented Resident #11 was found on 4/1/17 on her hands and knees crawling out of the bathroom. The worksheet documented the resident seemed "forgetful, "confused, [and] had just been out to [the] nurses station looking for her husband stating she had seen him outside her window."</p> <p>A Social Services Note, dated 4/1/17 and attached to an Incident &amp; Accident Report documented, "[Resident #11] had a large bruise to her left thorax. [Resident #11] stated she fell and her ribs hurt..." The note documented Resident #11's Interested Party was contacted in regards to what "appears" to be a "non-injury" incident from a fall.</p> <p>Resident #11's clinical record did not contain the Social Services Note from the Incident Report or documentation that the facility reported her complaint of rib pain to the physician following the 4/1/17 fall.</p>	F 157	<p>daily X two weeks; weekly X two weeks; every two weeks X two months; Monthly X three months;</p> <p>QAPI will evaluate if monthly audits continue to be indicated.</p> <p>(5) Include dates when corrective action will be completed; July 18, 2017</p>		

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F 157	Continued From page 7 On 5/22/17 at 10:05 am, the Social Service Director [SSD] stated the notes she wrote on the Incident Report was not in the clinical record and were a "reminder" to herself.  * Fall 4/3/17 at 4:00 pm: An FSHW, dated 4/3/17 at 4:00 pm, documented Resident #11 was found on the floor in her room attempting to ambulate. The worksheet documented the resident seemed "agitated," but had otherwise sustained no injuries.  Resident #11's clinical record did not contain documentation that the facility reported Resident #11's 4:00 pm fall on 4/3/17 to the physician.  On 5/22/17 at 11:10 am, Resident #11's physician stated he expected nursing staff to notify him when residents complained of increased pain or potential injury following a fall.	F 157			
F 224 SS=D	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN  §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms.  483.12(b) The facility must develop and implement written policies and procedures that:  (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 224		7/18/17	

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F 224	<p>Continued From page 8</p> <p>(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>(b)(3) Include training as required at paragraph §483.95. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of facility policies, investigations, and grievances, it was determined the facility failed to ensure 1 of 13 (#11) residents reviewed for abuse prevention, was protected from verbal/mental abuse by staff. Resident #11 was exposed to the potential for psychosocial harm when Registered Nurse [RN] #2 demeaned her for refusing to shower. Findings include:</p> <p>Resident #11 was readmitted to the facility on 1/28/16, with diagnoses which included malignant neoplasm of the lung [lung cancer], dementia and mood disorder.</p> <p>A quarterly Minimum Data Set [MDS] assessment, dated 2/22/17, documented Resident #11 was cognitively intact, required supervision with transfers and ambulation, experienced a non-injury fall prior to the assessment, and rejected cares 1-3 days during the look back period.</p> <p>Progress Notes from 4/3/17 through 4/6/17 included 21 entries that Resident #11's pain had increased prior to the alleged abuse from RN #2.</p> <p>A Nurse's Note, dated 4/6/17 at 7:24 pm, documented Resident #11 did not want to bathe, but eventually consented to a bath. The Note documented Resident #11 indicated she was</p>	F 224	<p>F224 (1)Address what corrective action(s) will be accomplished for those residents found to be affected; Resident #11 discharged to inpatient hospice on 04/25/2017.</p> <p>RN #2 was terminated.</p> <p>(2)How will you identify other residents who have the potential to be affected and what corrective actions will be taken: All residents have the potential to be affected. The Administrator will ensure staff involved in allegations of potential abuse will be suspended immediately pending investigation and disciplined in accordance with the findings of the investigation.</p> <p>(3)What measures will be put in place and what systematic changes will be made to ensure there is no reoccurrence; Staff will be educated and re-educated</p>		

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F 224	<p>Continued From page 9 hurting "too bad" for a bath.</p> <p>A undated Witness Statement documented Certified Nursing Assistant [CNA] #1 offered a bath to Resident #11, who declined. After an unsuccessful second offer to the resident, CNA #1 asked RN #2 to ask Resident #11 to shower. CNA #1 stated Resident #11 declined again and she heard shouting between Resident #11 and RN #2. CNA #1 stated she heard RN #2 tell Resident #11 that she smelled like a "dirty crotch" at least three times. CNA #1 removed RN #2 from the room and RN #2 told two staff members of the incident.</p> <p>A 4/6/17 Witness Statement documented CNA #2 was at the nurses station on 4/6/17 at 6:45 pm, when she heard RN #2 respond to Resident #11 about her refusal to bathe. CNA #2 stated RN #2 told Resident #11 she could not refuse her bath because she "smelled like a dirty crotch." CNA #2 stated she offered to re-approach Resident #11 with an offer to bathe.</p> <p>A 4/7/17 Witness Statement documented Licensed Practical Nurse [LPN] #3 observed Resident #11 come out of her room on 4/6/17 at 6:30 pm and state she did not want to take a shower. LPN #3 stated she saw Resident #11's agitation level was "escalating" when RN #2 approached her. LPN #3 stated RN #2 and CNA #1 entered Resident #11's room and closed the door. After a few minutes, LPN #3 said, RN #2 and CNA #1 emerged from the resident's room and RN #2 informed LPN #3 that she "told" Resident #11 that she "smelled like a dirty crotch" and could not refuse a bath.</p>	F 224	<p>on abuse, How to report the abuse; what are the indications of abuse; How to intervene and protect the resident. All new staff receives abuse training in general orientation and 8 hours of training with Hand-in-Hand training with in their first 30 days of employment, yearly through required in-services and as needed; one to one interviews with staff to ensure understanding of abuse and the process of S-A-F-E. Allegations of abuse</p> <p>(4) Indicate how the facility plans to monitor performance to ensure the corrective action(s) are affective and compliance is sustained;</p> <p>When allegations of abuse occur, the Administrator will ensure; alleged staff involved is suspended, and notification of Health &amp; Welfare , local authorities, physician and family has occurred as indicated.</p> <p>The DNS or designee will audit all allegations of abuse as reported to ensure alleged staff involved is suspended, and notification of Health &amp; Welfare, local authorities, physician and family has occurred as indicated.</p> <p>Audits will be completed weekly X 4; bi-monthly X2; monthly X3; quarterly X3.</p>		

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F 224	<p>Continued From page 10</p> <p>The Abuse Investigation included documentation of weekly meetings between RN #2 and the Administrator, who spoke with RN #2 and reviewed different types of abuse on 4/7/17.</p> <p>Resident #11 filed a grievance on 4/7/17, which documented she did not want a bath and was upset because of two falls she had experienced earlier in the week. She stated RN #2 told her she "smelled like dirty crotch." A facility investigation validated the allegation and RN #2 was given a written warning and required to take elderly care and sensitivity training within the next 10 days.</p> <p>The Abuse Investigation documented a 4/10/17 phone conversation took place between LPN #4 and the Administrator regarding LPN #4's monitoring of RN #2. The dates that RN #2 was monitored by LPN #4 were not included in the document, which noted LPN #4 monitored RN #2 while both staff members were working in the building for two days.</p> <p>The Abuse Investigation documented a 4/17/17 phone conversation occurred between LPN #4 and the Administrator. The dates that RN #2 was monitored by LPN #4 were not included in the document, which noted RN #2 was monitored by LPN #4 while RN #2 was working in the building. The document noted "... there were [no] episodes of concerns. If she wasn't in hearing distance of [RN #2], she tried to ensure that there was a care giver within hearing distance of [RN #2]."</p> <p>The Abuse Investigation documented a weekly meeting between RN #2 and the Administrator, who spoke with RN #2 and reviewed types of</p>	F 224	<p>All audits will be reported to QAPI for additional monitoring/modification.</p> <p>Administrator will ensure compliance</p> <p>(5)Dates when corrective action will be completed; July 18, 2017.</p>		

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F 224	Continued From page 11 abuse, took place on 4/17/17.  Resident #11's clinical record documented RN #2 came into contact with Resident #11 when she provided pain medication to the resident on 4/8/17, 4/14/17, 4/15/17, 4/19/17, 4/20/17, 4/21/17, and 4/22/17.  The Abuse Investigation did not include documentation of a phone conversation between a staff monitor for RN #2 and the Administrator for 4/19/17 and 4/20/17 or whether RN #2 was monitored on those two days.  The Abuse Investigation included documentation of a 4/24/17 phone conversation between LPN #4 and the Administrator and that RN #2 was monitored by LPN #4 on 4/21/17 and 4/22/17. The document stated if LPN #4 wasn't within hearing distance of [RN #2] there were care givers in the area.  On 5/19/17 at 4:14 pm, the Administrator stated she had a monitor or other staff working with RN #2 and that these staff members could hear "everything" RN #2 said to residents. The Administrator stated a CNA was with RN #2 if the monitor was busy elsewhere and that she met with RN #2 weekly to discuss abuse prevention and review different types of abuse. The Administrator stated she met weekly with RN #2, and some residents RN #2 came into contact with, to assess for signs of abuse. The Administrator stated there were no signs of abuse.	F 224			
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280			7/18/17

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F 280	Continued From page 12 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:  (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.  (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.  (iv) The right to receive the services and/or items included in the plan of care.  (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.  (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--  (i) Facilitate the inclusion of the resident and/or resident representative.  (ii) Include an assessment of the resident's strengths and needs.  (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.	F 280			

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F 280	Continued From page 13 483.21 (b) Comprehensive Care Plans  (2) A comprehensive care plan must be-  (i) Developed within 7 days after completion of the comprehensive assessment.  (ii) Prepared by an interdisciplinary team, that includes but is not limited to--  (A) The attending physician.  (B) A registered nurse with responsibility for the resident.  (C) A nurse aide with responsibility for the resident.  (D) A member of food and nutrition services staff.  (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.  (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.  (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 280			

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F 280	<p>Continued From page 14</p> <p>by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents' care plans were revised to reflect their current behavioral status, level of assistance required for activities of daily living [ADLs], and diabetic management. This was true for 1 of 13 residents (#2) sampled for care plan revision and had the potential to cause harm if residents did not receive appropriate care and interventions due to outdated and/or incomplete care plan information. Findings include:</p> <p>Resident #2 was admitted to the facility on 4/14/17 with diagnoses which included Type II diabetes mellitus.</p> <p>The initial Minimum Data Set [MDS] assessment, dated 4/25/17, documented Resident #2 was cognitively intact and required limited assistance of 1 staff member with transfers.</p> <p>a. The Hyperglycemia Care Plan, revised 5/4/17, directed staff to monitor, document, and report to the physician as needed when Resident #2 experienced signs and symptoms (s/s) of hyperglycemia. The care plan did not document how often staff was to monitor Resident #2's BG levels, when to notify the physician if BG levels were outside of physician-established parameters, when to administer insulin, or when to follow hyper/hypo glyceemic protocols.</p> <p>On 5/18/17 at 4:43 pm, the Interim Director of Nursing Services [IDNS] stated the care plan should include when to notify the physician and what to do if residents experienced hyper/hypo glyceemic events.</p>	F 280	<p>F280 (1)Corrective actions for those residents identified: Resident #2; regarding updating of care plan related to behaviors and (ADLs) Activities of Daily Living; the resident was discharged to inpatient hospice on 05/24/2017. 05/18/17 Physician was notified of abnormal blood sugars that were out of range. Medication adjustment was made per physician order. The physician has been notified of blood glucose levels outside of the parameters. Orders were obtained specifying how to manage hyper/hypo glyceemic episodes and blood glucose parameters for notification of physician. Care plan was updated. Staff education on 5/18/17 (and on-going) on the management of hyper/hypo glyceemic episodes and when to notify the physician/family. The resident had a change of condition on 5/24/17 related to increased edema. Hospice called to consult on edema issues, picking of the skin and continued unstable blood glucose levels</p>		

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F 280	<p>Continued From page 15</p> <p>b. The ADL Care Plan, revised 5/4/17, documented Resident #2 required supervised "stand by assistance" of 1 staff member, with a mobility bar for transfers.</p> <p>On 5/16/17 at 8:34 am, Resident #2 was observed wheeling herself into her room and transferring into her recliner chair without staff assistance or supervision.</p> <p>On 5/17/17 at 10:15 am, Resident #2 was observed transferring herself into her recliner chair from her wheelchair without staff assistance or supervision.</p> <p>On 5/18/17 at 4:43 pm, the IDNS stated Resident #2 was independent with transfers and that the care plan needed to be updated.</p> <p>c. The Anti-anxiety Care Plan, revised 5/4/17, documented Resident #2 received an anti-anxiety medication for anxiety disorder. The care plan did not identify resident-specific behaviors staff was to monitor.</p> <p>On 5/18/17 at 4:43 pm, the IDNS stated Resident #2's behaviors present as picking at her skin and making herself bleed. The IDNS stated the resident's care plan needed to be updated to reflect these behaviors.</p>	F 280	<p>and possible need for transfer to inpatient hospice. Orders were obtained specifying how to manage hyper/hypo glycemic episodes and blood glucose parameters for notification of physician. (2)Address how you will identify other residents who have the potential to be affected and what corrective action will be taken; All residents with behaviors have the potential to be affected. Identified resident specific behaviors will be documented on the care plan and MAR. All residents requiring ADL assistance have the potential to be affected. RNA and Therapy are going to evaluate all residents requiring assistance with ADLs to establish their base line. Care plans will be updated to reflect current level of ADL assistance. RNA and MDSC will meet weekly to see if residents have had a change in base line. Therapy will report to MDSC changes as they occur. All residents requiring blood glucose monitoring have the potential to be affected. All diabetic residents have new orders to follow facility guidelines for diabetic management. Care plans and MARs reflect the change in diabetic</p>		

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F 280	Continued From page 16	F 280	<p>management orders; completed 05/18/2017.</p> <p>(3)What measures will be put in place and what systematic changes will be made: SSD will review all behavior care plans for resident specific behaviors that staff are to monitor.</p> <p>MDSC will review all residents <input type="checkbox"/> ADL care plans for level of assistance required.</p> <p>The DNS and/or designee will obtain orders for hyper/hypo glycemic protocols, when to administer insulin, and when to notify physician if BG levels are outside of the physician-established parameters.</p> <p>(4)indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and do not recur;</p> <p>All diabetics with orders for blood glucose monitoring have been audited daily X two weeks; weekly X two weeks; every two weeks x two months by the DNS and/or designee. QAPI will evaluate if monthly audits are indicated. Administrator/DNS and/or designee will audit all care plans for specific behaviors for staff monitoring; ADL assistance. Audits will be completed weekly X 4; bi-monthly X2; monthly X3;</p>		

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F 280	Continued From page 17	F 280	quarterly X3. All audits will be reported to QAPI for additional monitoring/modification.		
F 281 SS=E	<p>483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>(b)(3) Comprehensive Care Plans</p> <p>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident and staff interview, review of clinical records, Fall Scene Huddle Worksheets (FSHW), and facility policy, it was determined the facility failed to ensure the neurological status of residents was consistently assessed after falls with the potential for head injury. This was true for 5 of 7 residents (#3, #4, #6, #7 &amp; #11) reviewed for falls and created the potential for more than minimal harm if changes in a resident's neurological status went undetected and untreated.</p> <p>The facility also failed to ensure 5 of 13 (#1, #2, #5, #7, and #11) residents reviewed for pain control received PRN [as needed] pain medications and medications for the treatment of Parkinson's Disease as physician ordered, and fluid restrictions specified in physician orders were followed. This deficient practice placed residents at risk of harm as follows:</p>	F 281	<p>Include dates when corrective action will be completed; July 18, 2017</p> <p>F281</p> <p>(1)Corrective actions for those residents identified:</p> <p>Resident #3; Resident has not experienced any further falls.</p> <p>Resident #4; Resident has experienced any further falls. Resident was discharged to inpatient hospice 06/06/2017.</p> <p>Resident #6; has not experienced any further falls.</p> <p>Resident #7; has not experience any further falls. She expired on hospice 06/07/2017.</p>	7/18/17	

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F 281	<p>Continued From page 18</p> <p>* Residents #2, #7, and #11 were administered PRN Schedule II medications in frequency and dosages inconsistent with physician orders. * Resident #5's medications prescribed for a diagnosis of Parkinson's Disease were not administered per physician orders * Resident #1's physician-ordered fluid restriction was not implemented by staff.</p> <p>Findings include:</p> <p>The facility's Fall Prevention and Management policy and procedure documented, "If a fall was not witnessed, neurological checks are required and must be documented in the medical record. The Neuro Check UDA [User Defined Assessment] is recommended." The Neuro Check - V 3 (UDA) documented the purpose was to record observations after a fall resulting in a known or possible head injury or any other condition requiring neuro-check. It also documented that after the completion of the initial neuro-check evaluation with vital signs, neuro-check evaluations are to continue every 30 minutes times 4, then every 8 hours for 3 days or as directed by the provider. This policy was not followed. Examples include:</p> <p>1. Resident #3 was admitted to the facility in May 2016 with multiple diagnoses, including dementia with behavioral disturbance, restlessness, and agitation. The resident was readmitted on 2/20/17 for orthopedic aftercare following surgical intervention of a right hip fracture related to a fall in the facility.</p> <p>Fall Scene Huddle Worksheets (FSHW)</p>	F 281	<p>Resident #11; Resident transferred to inpatient hospice 04/25/2017.</p> <p>Administration records for PRN narcotic pain medications on residents #2, 7 and 11 have been reviewed to ensure accuracy of administration of schedule II drugs as ordered by the physician.</p> <p>Resident #5 medication orders were clarified on 05/17/2017. Resident had no adverse reaction as a result of this discrepancy.</p> <p>Resident #1 fluid restriction was discontinued 06/08/2017.</p> <p>(2)Address how you will identify other residents who have the potential to be affected, what corrective action will be taken;</p> <p>All residents have the potential for unwitnessed falls or falls with identified head injuries that necessitate neurological assessment. Licensed nurses began receiving in-servicing on the process of completing the neurological check UDA on 05/26/2017.</p> <p>All residents receiving physician orders have the potential to be affected. The DNS and/or designee are reviewing new</p>		

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F 281	<p>Continued From page 19</p> <p>documented Resident #3 experienced unwitnessed falls on 1/22/17 at 5:25 pm, 2/13/17 at 9:30 am and 11:10 pm, and on 2/15/17 at 12:30 pm.</p> <p>Resident #3's clinical record and FSHW records did not contain documentation of neurological evaluations for the above three unwitnessed falls.</p> <p>On 5/18/17 at 8:35 am, the Interim Director of Nursing Services (IDNS) said neurological evaluations should be performed for 3 days after unwitnessed falls and she did not find neuro-checks related to Resident #3's unwitnessed falls on 1/22/17, 2/13/17, or 2/15/17.</p> <p>2. Resident #4 was admitted to the facility on 9/2/16 with multiple diagnoses, including anorexia, altered mental status, anxiety, major depressive disorders, and dementia.</p> <p>FSHW records documented Resident #4 experienced unwitnessed falls on 2/15/16 at 11:45 am, 3/15/17 at 5:25 am, 3/22/17 at 9:30 pm, 4/5/17 at 12:10 pm and 4/7/17 at 6:20 pm.</p> <p>The FSHW for the fall on 4/5/17 documented Resident #4 sustained a "Laceration back of head."</p> <p>Resident #4's Progress Notes documented the following:</p> <p>* 4/5/17 at 1:09 pm - "...fall with injury to head...refusing to go out...or see a doctor..."</p> <p>* 4/5/17 at 4:57 pm - "...agreed to see [physician]...needed to have 4 stitches...did begin to dry heave...stated she had a head ache..."</p>	F 281	<p>orders daily Monday <input type="checkbox"/> Friday beginning 06/08/2017. All admission orders will be checked by two nurses beginning 06/05/2017.</p> <p>All residents with fluid restrictions orders have the potential to be affected. DNS and/or designee have reviewed orders of all residents with fluid restrictions. DNS met with RD 06/08/2017 regarding fluid restriction orders. Physicians will be contacted as needed.</p> <p>All residents receiving narcotic pain medications have the potential to be affected. Residents on narcotic pain medications will have the MAR and Narcotic book checked daily to ensure nurses are following physician orders.</p> <p>(3)What measures will be put in place and what systematic changes will be made: The QAPI process has identified the root cause of the deficiency as failure to follow physician orders, and assessing the resident for neurological</p>		

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F 281	<p>Continued From page 20</p> <p>* 4/5/17 at 8:49 pm - "...neuro checks prior to going to [doctor]...Upon return...[d]id one more neuro before she fell asleep..."</p> <p>* 4/6/17 at 9:01 am - "...has a headache this morning..."</p> <p>* No documentation was found that Resident #3's neurological status was checked or monitored after 4/5/17.</p> <p>On 5/18/17 at 8:35 am, the IDNS said neurological evaluations should be performed for 3 days after unwitnessed falls and that she found "some" neuro-check documentation for Resident #3. She provided Neuro Check - V 3 forms which documented Resident #4's neurological status was monitored on 4/5/17 at 12:10 pm, 12:25 pm, 3:10 pm, 3:40 pm and 4:10 pm.</p> <p>On 5/19/17 at 2:00 pm, the Medical Records Director said no other neuro-check documentation was found for the fall on 4/5/17, and that no documentation of neurological checks was found for the other falls on 2/15/17, 3/15/17, 3/22/17 and 4/7/17.</p> <p>3. Resident #6 was admitted to the facility on 12/30/16, with diagnoses which included dementia and depression.</p> <p>FSHW records documented Resident #6 experienced unwitnessed falls on 2/6/17 at 8:25 pm, 2/11/17 at 8:10 pm, 3/5/17 at 1:00 pm, and on 3/25/17 at 7:05 pm.</p> <p>Resident #3's clinical record and FSHW records did not contain documentation of neurological evaluations for the above noted unwitnessed</p>	F 281	<p>injuries after unwitnessed falls or witnessed falls with head injuries. Audits will be completed on completion of neurological UDA, narcotic pain medication documentation, staff compliance with fluid restrictions and transcriptions of new physician orders.</p> <p>(4)Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and do not recur; Licensed staff will be in-serviced on following MD orders and neuro-checks 06/23/2018.</p> <p>DNS and/or Designee will audit to ensure resident have neurological UDA completed, pain medications are administered as ordered, and fluid restrictions orders are followed. Documentation of new admission orders are checked by two nurses to ensure correct transcription. Audits will be completed two times weekly X 4; weekly X 2; bi-monthly X2; monthly X3. Results will be reported to QAPI for additional monitoring/modification.</p> <p>(5)Include dates when corrective action will be completed; July 18, 2017</p>		

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F 281	<p>Continued From page 21 falls.</p> <p>On 5/18/17 at 8:35 am, the IDNS said neurological evaluations should be performed for 3 days after unwitnessed falls. The IDNS noted neuro-checks related to Resident #6's unwitnessed falls on 2/6/17, 2/11/17, 3/5/17, and 3/25/17 could not be found in the clinical record.</p> <p>4a. Resident #7 was admitted to the facility on 3/9/17, with diagnoses which included depression, insomnia, and Pseudobulbar Affect (involuntary, uncontrollable, and sudden crying and/or laughing).</p> <p>FSHW records documented Resident #7 experienced unwitnessed falls on 3/10/17 at 8:15 pm and on 3/23/17 at 12:45 pm.</p> <p>Resident #7's clinical record contained one Neuro Check - V 3 form, which documented Resident #7's neurological status was monitored on 3/23/17 at 3:06 pm.</p> <p>On 5/18/17 at 8:35 am, the IDNS said neurological evaluations should be performed for 3 days after unwitnessed falls. The IDNS noted neuro-checks related to Resident #7's unwitnessed falls on 3/10/17 and 3/23/17, other than that conducted at 3:06 pm, could not be located in the resident's clinical record.</p> <p>4b. Resident #7's quarterly MDS assessment documented moderate cognitive impairment, mild signs and symptoms of depression, and no behaviors.</p> <p>A 4/3/17 Physician's Order documented Resident</p>	F 281			

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F 281	<p>Continued From page 22</p> <p>#7 was to receive Ativan 0.5 mg every 8 hours as needed for anxiety.</p> <p>Resident #7's Ativan Controlled Drug Record documented 0.5 mg of Ativan was administered on 5/2/17 at 1:00 pm and 2:30 pm, two doses within 1.5 hours. The May 2017 MAR documented Resident #7 received 0.5 mg Ativan on 5/2/17 at 3:15 pm.</p> <p>On 5/19/17 at 8:25 am, the IDNS stated nursing staff were to administer medications per physician order.</p> <p>5a. Resident #11 was readmitted to the facility on 1/28/16, with diagnoses which included malignant neoplasm of the lung [lung cancer], dementia and mood disorder.</p> <p>FSHW records documented Resident #11's experienced unwitnessed falls on 4/1/17 at 3:15 am, 4/3/17 at 9:00 am and 4:00 pm, and on 4/24/17 at 1:00 pm, and 5:40 pm.</p> <p>Resident #11's clinical records contained one Neuro Check - V 3 form, which documented her neurological status was monitored on 4/24/17 at 9:26 pm.</p> <p>On 5/18/17 at 8:35 am, the IDNS said neurological evaluations should be performed for 3 days after unwitnessed falls. The IDNS stated neuro-checks related to Resident #11's unwitnessed falls on 4/1/17 at 3:15 am, 4/3/17 at 9:00 am, 4/3/17 at 4:00 pm, 4/24/17 at 1:00 pm, and 4/24/17 at 5:40 pm, other than that already noted, could not be located in the clinical record.</p>	F 281			

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F 281	<p>Continued From page 23</p> <p>5b. Resident #11's April 2017 Physician's Orders documented:</p> <p>* 0.5 mg Ativan every 12 hours as needed for anxiety, ordered 8/23/16.</p> <p>* 5 mg Norco 5-325 mg (Hydrocodone - Acetaminophen) every 6 hours as needed for pain, ordered 2/23/17.</p> <p>** On 4/8/17, Resident #11's physician changed the Norco order from a PRN "as needed" administration to a scheduled administration of 4-times daily. This change was not reflected in the resident's recapitulated monthly orders nor the April and May 2017 MARs.</p> <p>Resident #11's January 2017 MAR documented Ativan was administered on 1/13/17 at 6:46 am and 7:26 am.</p> <p>Resident #11's Ativan Controlled Drug Record documented 0.5 mg of Ativan was administered on 1/15/17 at 3:30 pm and 10:00 pm.</p> <p>Resident #11's March 2017 MAR documented 0.5 mg of Ativan was administered on 3/13/17 at 2:30 pm and 10:30 pm. The Ativan was administered twice in 8 hours, instead of every 12 hours as ordered.</p> <p>The April 2017 MAR documented 0.5 mg of Ativan was administered on 4/23/17 at 12:00 pm, 12:30 pm, and 10:00 pm. The Ativan was administered twice in 30 minutes and then 9.5 hours later. On 4/24/17, the April 2017 MAR documented Resident #11 received 0.5 mg Ativan at 8:00 am, 12:00 pm, and 6:00 pm. Resident #11 received Ativan 0.5 mg three times</p>	F 281			

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F 281	<p>Continued From page 24</p> <p>in 10 hours, instead of once every 12 hours as ordered.</p> <p>Resident #11's Ativan Controlled Drug Record, as well as the January 2017 and April 2017 MARs, documented Ativan was administered on 18 additional occasions in a manner inconsistent with physician orders between 1/13/17 and 4/24/17.</p> <p>Resident #11's Norco Controlled Drug Record and MARs, between 2/15/17 and 4/24/17, documented similar findings involving the administration of Norco on 12 occasions in a manner inconsistent with physician orders, including 6 administrations of the medication on 4/23/17, and 2 administrations in 4 hours on 4/24/17, as follows:</p> <p>* On 4/23/17 Resident #11 was administered Norco 5-325 mg at 12:00 pm, 1:00 pm, 4:00 pm, 7:00 pm, 8:00 pm, and 10:30 pm.</p> <p>* On 4/24/17 Resident #11 was administered Norco 5-325 mg at 8:00 am and 12:00 pm.</p> <p>On 5/19/17 at 2:25 pm, the IDNS stated nursing staff were to administer medications per physicians' orders.</p> <p>6. Resident #5 was readmitted to the facility on 5/8/17, with multiple diagnoses including Parkinson's Disease.</p> <p>Resident #5's 5/8/17 admitting physician orders directed staff to administer Sinemet [for treatment of Parkinson's Disease] 25/100 1.5 tablets QID (4 times a day).</p>	F 281			

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F 281	<p>Continued From page 25</p> <p>Resident #5's May 2017 (MAR) documented Sinemet 25/100 1.5 tablets was administered daily, rather than 4 times a day as ordered, from 5/9/17 to 5/16/17.</p> <p>On 5/17/17 at 3:30 pm, the MDS Coordinator compared Resident #5's Admitting Orders for Sinemet to the MAR documentation and stated the facility's administration of Sinemet once daily was a medication error.</p> <p>On 5/17/17 at 6:00 pm, the IDNS said the order for Sinemet QID was "missed."</p> <p>7. Resident #1 was admitted to the facility on 8/3/16 with diagnoses which included hyponatremia [low sodium levels in the blood], hypertension, dementia, and anorexia.</p> <p>Resident #1's quarterly MDS assessment, dated 3/29/17, documented severe cognitive impairment.</p> <p>An 8/3/16 Physician's Order documented Resident #1 was to have a 1000 cubic centimeter [cc] fluid restriction, and no free water. Staff was to notify the charge nurse before providing any fluids to Resident #1 between meals and to document all fluids provided to her.</p> <p>Resident #1's Nutrition Care Plan, revised 1/19/17, documented she was on a fluid restriction of "400 cc between meals and with medications. (Day shift 150 cc; Evening shift 150 cc; Night shift 100 cc.) Fluids at meals 600 cc per day."</p> <p>On 5/16/17 at 8:49 am, Resident #1 was</p>	F 281			

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F 281	Continued From page 26 observed in her room pouring water from a large carafe into a cup and drinking the water with her meal tray.  On 5/17/17 at 2:40 pm, Resident #1 was observed in her room with a large, almost empty carafe of water setting on the table next to her.  On 5/18/17 at 11:20 am, Resident #1 was observed in her room with a large, half full, carafe of water. Resident #1 stated she had been drinking water "all day."  An Activities of Daily Living [ADL] Flow Sheet from 4/19/17 to 5/17/17 for the "intake of fluids outside of meals" contained no monitoring documentation of Resident #1's fluid intake.  Resident #1's ADL Flow Sheet from 4/19/17 to 5/17/17 for "cc's of fluids consumed with meal" documented an intake that was greater than 600 cc on 27 of 30 days.  On 5/18/17 at 5:45 pm, the IDNS stated she was not aware Resident #1 had fluid restriction orders.  On 5/19/17 at 9:15 am, the IDNS stated staff should have monitored the intake of Resident #1's fluids and the fluid restriction was a current order. The IDNS stated the carafe of water had been removed from Resident #1's room.	F 281			
F 309 SS=K	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	F 309		7/18/17	

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F 309	<p>Continued From page 27</p> <p>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.</p> <p>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:</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, record review, policy review, and resident and staff interview, it was determined the facility failed to:</p>	F 309	<p>F309 (1)Corrective actions for those residents identified:</p>		

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F 309	<p>Continued From page 28</p> <p>a) Ensure residents diagnosed with diabetes mellitus received care consistent with their needs, care plans, current standards of practice, and facility policy. This was true for 2 of 5 (#2 and #5) residents reviewed for diabetic management. As a result:</p> <ul style="list-style-type: none"> <li>* Residents' blood glucose [BG] levels were not monitored as ordered</li> <li>* Hyperglycemic BG levels were not reported to physicians</li> <li>* A policy for hyperglycemia was not developed</li> <li>* The facility's hypoglycemia policy was not followed</li> <li>* Insulin was administered without physician orders</li> </ul> <p>These systemic practices placed the health and safety of sampled residents #2 and #5, and 10 other residents in the facility with a diagnosis of diabetes [DM], in immediate jeopardy of serious harm, impairment, or death due to diabetic ketoacidosis [an acute, life-threatening complication of diabetes which may result in diabetic coma or death] related to hyperglycemia, and/or severe hypoglycemia, which has the potential to cause accidents, injuries, coma, and death.</p> <p>b) Ensure 1 of 13 (#11) sampled residents received timely assessments of injury and effective pain control. Resident #11 was harmed when the facility failed to promptly assess her complaint of rib injury in a timely manner and control the resulting pain after she experienced a fall.</p> <p>Findings include:</p>	F 309	<p>Resident #2, #5 Residents #14, 15,16,17,18,19, 20, 21,22 Blood glucose are monitored as ordered, have parameters for hyper/hypo glycemc episodes. BGs outside of ordered parameters are reported to physician.</p> <p>Blood glucose results and diabetic medication orders for Resident #2 and #5 have been reviewed by the PCP or Medical director/on call MD by 5/18/2017. Completed via phone call with Physician 05/18/2017. Vital signs were assessed for Resident #2 and Resident #5 on 05/18/2017. Responsible family members for resident #2 and Resident #5 were notified of blood glucose results on 05/18/2017.</p> <p>Guidelines for management hyper/hypo glycemc incidents was written on 05/18/2017 and approved by Physician on 05/18/2017. Prior to beginning work nurses and those nurses already on duty were in-serviced on blood glucose parameters for hyper/hypo glycemc guideline/treatment; When to notify the physician and responsible family members and documentation in PCC progress notes of notification and interventions.</p> <p>All diabetic residents have new</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>		
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F 309	<p>Continued From page 29</p> <p>1. Resident #2 was admitted to the facility on 4/14/17, with diagnoses which included Type II diabetes mellitus.</p> <p>The initial Minimum Data Set [MDS] assessment, dated 4/25/17, documented Resident #2 was cognitively intact.</p> <p>a. The Hyperglycemia Care Plan, revised 5/4/17, directed staff to monitor, document, and report to the physician, as needed, when Resident #2 experienced signs and symptoms [s/s] of hyperglycemia. The care plan did not document how often staff was to monitor Resident #2's BG levels, when staff was to notify the physician if BG levels were outside of physician-established parameters, when to administer insulin, or when to follow hyper/hypo glycemc protocols.</p> <p>Resident #2's May 2017 Physician's Orders included:</p> <p>* HumaLOG [Insulin Lispro] solution before meals and at bedtime [HS] per sliding scale for BGs [all measurements in milligrams/deciliters] of:</p> <p>70 - 130 = 0 units; 131 - 180 = 4 units; 181 - 240 = 8 units; 241 - 300 = 10 units; 301 - 350 = 12 units; 351 - 400 = 16 units; 401 - 499 = 20 units, and call physician for BG levels greater than 400 mg/dl, ordered 4/20/17.</p> <p>* 28 units of Tresiba (Insulin Degludec) solution</p>	F 309	<p>orders to follow facility guidelines for diabetic management. Care plans and MARs reflect the change in diabetic management orders.</p> <p>Licensed nurse that documented in progress note incorrect dosage of insulin administered. This nurse received corrective action on 05/18/2017. The administration record for resident #2 evidenced this nurse documented giving 20 units as per physician orders. Family was notified on 05/18/2017.</p> <p>Resident #5 physicians made aware of nursing failing to document the results of BG levels. Transcription error has been corrected BG levels have been completed per physicians order since 05/18/2017.</p> <p>Address how you will identify other residents who have the potential to be affected, what corrective action will be taken; All diabetic residents have the potential to be affected. All diabetic residents have new orders to follow facility guidelines for diabetic management. Care plans and MARs reflect the change in diabetic management orders; completed 05/18/2017.</p> <p>All residents receiving narcotic pain medications have the potential to</p>		

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F 309	<p>Continued From page 30 in the morning for DM, ordered 5/1/17.</p> <p>* Resident #2 was to have BG levels checked before meals and at bedtime related to Type II DM "for BG &gt; [greater than] 400 call physician for BG &lt; [less than] 70 and resident is able to swallow give a rapidly absorbing carbohydrate such as: 4 oz [ounces] juice. Repeat BG in 15 min [minutes] and repeat if carbohydrate [is] necessary," beginning 4/19/17.</p> <p>The physician's orders did not document at what BG level staff were to notify the MD when hypoglycemic BG levels were less than 70 mg/dl.</p> <p>A Nurse's Note, dated 4/18/17 at 5:00 am, documented Resident #2 experienced a BG level of 68 mg/dl. Resident #2 received apple juice, but the clinical record did not contain documentation the facility rechecked her BG level after 15 minutes, as stated in her care plan. The 68 mg/dl BG level was not documented on Resident #2's April Medication Administration Record [MAR].</p> <p>A Nurse's Note, dated 4/18/17 at 6:01 pm, documented Resident #2 experienced a BG level of 514 mg/dl.</p> <p>Resident #2's MAR from 4/19/17 through 4/30/17 documented:</p> <p>* BG levels ranging 209 - 509 mg/dl.</p> <p>* 13 BG levels greater than 400 mg/dl, including 1 BG greater than 500 mg/dl.</p> <p>Resident #2's record did not contain documentation of staff interventions for this time</p>	F 309	<p>be affected. Residents on narcotic pain medications will have the MAR and Narcotic book checked daily to ensure nurses are following physician orders.</p> <p>All residents with orders for Ativan have the potential to be affected. Residents receiving Ativan will have the MAR and Narcotic book checked daily to ensure nurses are following physician orders.</p> <p>What measures will be put in place and what systematic changes will be made:</p> <p>The QAPI process has identified the root cause of the deficiency as failure to follow physician orders. Prior to beginning work nurses and those nurses already on duty were in-serviced on blood glucose parameters for hyper/hypo glycemic guideline/treatment; When to notify the physician and responsible family members and documentation in PCC progress notes of notification and interventions. Newly hired licensed nurses will receive training prior to working on the floor. Audits will be completed on narcotic pain medication/ativan documentation of compliance with physicians' orders. indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and do not recur; All diabetics with orders for blood</p>		

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F 309	<p>Continued From page 31</p> <p>period. Resident #2's physician was notified of 3 of the 13 hyperglycemic BG levels above 400 mg/dl, on 4/20/17, 4/21/17, and 4/27/17.</p> <p>Resident #2's MAR from 5/1/17 to 5/16/17 documented:</p> <ul style="list-style-type: none"> <li>* BG levels ranging from 119 - 586 mg/dl.</li> <li>* 13 BG levels greater than 400 mg/dl, 6 of which were greater than 500 mg/dl.</li> <li>* BG of 586 mg/dl on 5/1/17 at 4:00 pm.</li> </ul> <p>Resident #2's record did not contain documentation of staff interventions for this time period. Resident #2's physician was notified of 1 of the 13 hyperglycemic BG levels above 400 mg/dl, on 5/14/17.</p> <p>A Nurse's Note, dated 5/1/17 at 4:21 pm, documented Resident #2 received 25 units of insulin for the 586 BG level, however, the clinical record did not contain orders for the 25 units of insulin that were administered.</p> <p>A Nurse's Note, dated 5/2/17 at 10:09 pm, documented Resident #2's BG levels "ranged over 600 ... used sliding scale." The 600 BG level was not documented on the 5/2/17 MAR and the Nurse's Note did not document the resident's physician was notified.</p> <p>The May 2017 MAR documented Resident #2's BG was 512 mg/dl on 5/7/17 MAR at 11:00 am and 4:00 pm. Resident #2's record did not document whether insulin was administered.</p>	F 309	<p>glucose monitoring have been audited daily X two weeks; weekly X two weeks; every two weeks X two months by the DNS and/or designee. QAPI will evaluate if monthly audits are indicated.</p> <p>All narcotic pain administration and Ativan administration audited daily X two weeks; weekly X two weeks; every two weeks X two months by the DNS and/or designee. QAPI will evaluate if monthly audits are indicated.</p> <p>(5) Include dates when corrective action will be completed; July 18, 2017</p>		

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F 309	<p>Continued From page 32</p> <p>A Nurse's Note, dated 5/7/17 at 8:38 pm, documented Resident #2's BG level was 591 mg/dl and 20 units of insulin were administered. The 591 mg/dl BG levels was not documented on the 5/7/17 MAR.</p> <p>Resident #2's MAR on 5/7/17 at 9:00 pm, conversely, documented a BG of 291 mg/dl for which 10 units of insulin were administered; it was not clear whether the resident received a total of 30 units of insulin - 20 units at 8:38 pm and 10 units at 9:00 pm.</p> <p>A Nurse's Note, dated 5/9/17 at 11:44 am, documented Resident #2's BG level was 500 mg/dl and 25 units of insulin was administered. Resident #2's clinical record did not contain physician orders for the 25 units of insulin that were administered.</p> <p>Resident #2's MAR documented she was administered insulin on 5/8/17 at 11:00 am and on 5/12/17 at 7:00 am. The dosages of insulin administered was not documented on the MAR and there were no corresponding Nurses' Notes documenting the insulin dosages.</p> <p>Resident #2's clinical record did not document:</p> <ul style="list-style-type: none"> <li>* Rechecks of her BG levels after she experienced hyperglycemic and hypoglycemic episodes. This was true for all episodes.</li> <li>* Physician notification, as ordered, for 25 of 30 hyperglycemic episodes</li> <li>* Evidence the facility followed its hypoglycemic protocol for low BG levels</li> </ul>	F 309			

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F 309	<p>Continued From page 33</p> <p>* The reason for the excess doses of insulin administered on 5/1/17 and 5/9/17.</p> <p>On 5/18/17 at 8:42 am, the Interim Director of Nursing Services (IDNS) stated facility staff were to notify the physician, as soon as possible, when BG levels exceeded parameters specified by the physician and re-check the resident's BG levels in 15-30 minutes to assess whether insulin administrations were effective. For a resident experiencing a hypoglycemic episode, the IDNS said staff was to recheck the BG 15 minutes after administering 15 grams [g] of carbohydrates and that this process would be repeated until the BG level reached 70 mg/dl or greater.</p> <p>On 5/18/17 at 11:15 am, Licensed Practical Nurse (LPN) #1 stated she would notify a physician when BG levels were outside established parameters and document that she called the physician in a Nurse's Note. She stated she would recheck BG levels depending on physician orders and document the rechecks in a Nurse's Note.</p> <p>On 5/18/17 at 3:15 pm, Resident #2's physician stated he was aware of Resident #2's elevated BG levels and he was not "all that upset" that he was not notified on "every" occasion, but that he expected nurses to follow his orders "all the time." He stated the facility would usually send a fax notifying him of elevated BG levels and that "sometimes" he received a phone call from nursing staff informing him Resident #2's BG levels were over 500 mg/dl, for which the nurse had administered 20 units of insulin.</p>	F 309			

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F 309	<p>Continued From page 34</p> <p>b. Physician's Order, dated 4/14/17, documented Resident #2 was to receive Ativan 0.5 milligrams [mg] every 4 hours as needed for anxiety related to her disease process.</p> <p>Resident #2's Antianxiety Care Plan, revised 5/4/17, documented staff was to monitor and document side effects and effectiveness of the Ativan. The Care Plan did not state the specific behaviors staff were to monitor and for which Resident #2 was to receive Ativan.</p> <p>Resident #2's Ativan Controlled Drug Record documented:</p> <ul style="list-style-type: none"> <li>* 0.5 mg of Ativan administered on 5/3/17 at 1:20 am.</li> <li>* 0.5 mg of Ativan administered on 5/3/17 at 2:00 am.</li> </ul> <p>2. Resident #5 was readmitted to the facility on 5/8/17, with multiple diagnoses including diabetes mellitus and Parkinson's Disease.</p> <p>Resident #5's 5/8/17 admitting physician orders directed staff to administer Actos 30 mg daily and Sinemet [for treatment of Parkinson's Disease] 25/100 1.5 tablets QID (4 times a day).</p> <p>a. Resident #5's recapitulated May 2017 orders directed staff to obtain a FSBS (Fingerstick Blood Sugar) once daily beginning 5/12/17.</p> <p>Resident #5's May 2017 MAR documented the FSBS was completed daily from 5/12/17 to 5/16/17, however BG levels were not documented.</p>	F 309			

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F 309	<p>Continued From page 35</p> <p>On 5/17/17 at 3:30 pm, the MDS Coordinator said Resident #5's daily FSBS results should be documented on the MAR or on vital signs (VS) documents. At 5:00 pm the same day, the MDS Coordinator provided a Blood Sugar Summary for 2015 and said she did not find any results for 2017.</p> <p>On 5/17/17 at 6:00 pm, the IDNS said Resident #5's FSBS result was documented only once, on 5/12/17, in progress notes. The results and any need of intervention to address hypo- or hyperglycemia for Resident #5 were unknown 4 of 5 times (80%) the FSBS was performed.</p> <p>On 5/17/17 at 6:00 pm, the facility provided a copy of its diabetic management policy and procedure.</p> <p>The Facility's Hypoglycemic Policy, revised December 2015, documented "For residents with diabetes, the practitioner should be called 'immediately' when the blood glucose value is less than 70 mg/dl...give 15 grams of carbohydrates...Repeat blood glucose test after 15 minutes." The Diabetic Management procedure did not address how staff was to manage residents with hyperglycemic episodes.</p> <p>The lack of a protocol for hyperglycemia created the potential for residents not to receive interventions for hyperglycemic episodes or to receive interventions that were incorrect.</p> <p>The combined effect of the facility's deficient diabetic management practices placed all 12 residents in the facility with diabetes at risk of imminent serious harm, impairment, or death due</p>	F 309			

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F 309	<p>Continued From page 36 to diabetic ketoacidosis or severe hypoglycemia.</p> <p>Notification and Removal of Immediate Jeopardy:</p> <p>On 5/18/17 at 1:35 pm, the facility was informed Resident #2 and Resident #5, as well as all 12 residents in the facility diagnosed with diabetes, were at risk of imminent serious harm or death due to the facility's deficient diabetes management practices. The facility was informed it needed to develop and implement an acceptable plan to remove the Immediate Jeopardy.</p> <p>On 5/19/17 at 2:24 pm, the facility provided evidence that an acceptable plan to remove the immediacy had been developed and implemented. The plan included:</p> <ul style="list-style-type: none"> <li>* BG levels and diabetic medication orders for Resident #2 and Resident #5 were reviewed with their physicians on 5/18/17.</li> <li>* Resident #2 and #5's vital signs were assessed by nursing staff.</li> <li>* Notifications to responsible parties were completed for Resident #2 and #5 on 5/18/17.</li> <li>* Physician orders, including those for insulin, and MARs were audited for those residents diagnosed with diabetes to assure blood glucose parameters and physician notification requirements were specified by 5/19/17.</li> <li>* Guidelines for managing hyper- and hypoglycemic incidents were approved by the MD on 5/18/17.</li> </ul>	F 309			

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F 309	<p>Continued From page 37</p> <p>* The IDNS will provide education to nursing staff prior to their next shift on BG level parameters for hypo and hyperglycemia; treatment guidelines for hypo and hyperglycemia; notification to the physician and responsible party; and appropriate documentation of notification and interventions for hyper/hypo glycemc episodes.</p> <p>* The MARs and physicians' orders of residents who are diabetic will be monitored daily for 2 weeks, weekly for 2 weeks and then every two weeks for two months. The facility's Quality Assessment and Assurance Committee will evaluate the potential need for monthly audits.</p> <p>4. Resident #11 was readmitted to the facility on 1/28/16, with diagnoses which included malignant neoplasm of the lung [lung cancer], dementia, and mood disorder.</p> <p>A quarterly MDS assessment, dated 2/22/17, documented Resident #11 was cognitively intact; required supervision with transfers and ambulation; had 1 non-injury fall prior the assessment; rejected cares 1-3 days during the look back period; and was administered PRN, rather than scheduled, pain medications.</p> <p>a. Resident #11's April 2017 Physician's Orders documented:</p> <p>* 650 mg Acetaminophen every 4 hours as needed for pain, ordered 2/23/17. * 5 mg Norco Tablet 5-325 mg (Hydrocodone - Acetaminophen) every 6 hours as needed for pain, ordered 2/23/17. * 50 mg Tramadol every 6 hours as needed for</p>	F 309			

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F 309	<p>Continued From page 38 pain, ordered 2/23/17.</p> <p>The Pain Care Plan, revised 12/12/16, documented Resident #11 had acute and chronic pain related to lung cancer as evidenced by non-verbal indicators such as grimacing, resistive to cares, and complaints of (c/o) itching or burning. She was able to call for assistance and able to ask for pain medication. Care Plan interventions included:</p> <p>* Staff was to monitor Resident #11 for signs and symptom (s/s) of non-verbal pain, initiated 2/1/16.</p> <p>* Staff was to evaluate the resident using the Pain Assessment in Advanced Dementia [PAINAD] scale, revised 12/12/16.</p> <p>On 5/19/17 at 2:25 pm, the IDNS stated the facility evaluated residents' pain levels at least once per shift and immediately prior to the administration of PRN pain medications. Staff also assessed residents who received PRN pain medication to determine whether it was effective.</p> <p>Resident #11's MARs for January 2017 through 4/24/17, did not contain documentation that her pain was consistently assessed prior to- or following the administration of pain medication.</p> <p>The April 2017 MAR documented Resident #11 received 9 doses of the PRN Tramadol from 4/3/17 through 4/24/17.</p> <p>The Controlled Drug Record for PRN Tramadol documented Resident #11 received 21 doses between 4/3/17 through 4/24/17. Resident #11's pain was not assessed prior to- or following 12 of</p>	F 309			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/22/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>		
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F 309	<p>Continued From page 39</p> <p>the 21 PRN Tramadol administrations during this time period.</p> <p>The April 2017 MAR documented Resident #11 was administered 34 doses of PRN Norco between 4/3/17 and 4/24/17. Resident #11's Controlled Drug Record for Norco documented she was administered 61 doses of Norco from 4/3/17 through 4/24/17. Resident #11's pain and was not assessed prior to- or following 27 of the 61 PRN Norco administrations. The conflicting records also created the potential for harm related to excessive dosage and this was not addressed in the resident's clinical record.</p> <p>b. Incident &amp; Accident reports documented Resident #11 experienced a fall on 4/1/17 and 2 falls on 4/3/17.</p> <p>Progress Notes, for 4/3/17 through 4/7/17, included 24 entries that Resident #11 complained of left sided pain, requested pain medications, or that she suspected her ribs were broken.</p> <p>A Nurse's Note, dated 4/3/17, documented Resident #11 had fallen twice that day, and told the LPN she thought she had broken a rib. The note did not document physician notification of Resident #11's complaint of a broken rib.</p> <p>A Nurse's Note, dated 4/4/17 at 5:00 am, documented Resident #11 had a "marked dark purple bruise on the left thorax from the 4/3/17 fall and "[complains of] pain in rib area...and reports that she feels the rib was broken." The note did not document physician notification of Resident #11's pain and complaint of a broken rib.</p>	F 309			

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F 309	<p>Continued From page 40</p> <p>A Nurse's Note, dated 4/5/17 at 6:53 am, documented Resident #11 complained of "pain on left flank rib area from [the] falls [she] sustained on 4/3/17...[and] stated 'it feels like my rib is cutting me on the inside.'"</p> <p>A Nursing Communication, dated 4/7/17 at 4:03 pm, documented two progress notes regarding Resident #11's complaint of left sided rib pain were sent to the physician. The first Progress Note, dated three days after the fall on 4/7/17 at 10:19 am, documented, "Resident fell last Monday, she has a 10 x 10 discoloration on her upper waist. She has 8/10 pain at times. May we send her for a left rib x-ray at [hospital] today?" The second Progress Note, dated 4/7/17 at 11:49 am, documented, "Asking for an order to send [Resident #11] down for a x-ray for her left side..."</p> <p>The physician responded to the facility on 4/8/17, ordering an x-ray of Resident #11's left ribs and changing the resident's Norco schedule from three times daily (TID) to four times daily (QID).</p> <p>On 4/8/17, an RN noted the orders and documented Norco was already ordered for every 6 hours PRN, and the clinical record did not document Resident #11's Norco order was changed from PRN administrations every six hours to scheduled dosages four times daily.</p> <p>Progress Notes 4/8/17- 4/24/17 documented Resident #11 complained of pain to the left rib area, was holding her left side in pain, and/or received PRN pain medications 37 more times.</p> <p>A Nurse's Note, dated 4/24/17 at 10:13 pm,</p>	F 309			

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F 309	Continued From page 41 documented Resident #11 was being transferred to hospice services for pain management. The note documented Resident #11 said she wanted hospice services because "her pain definitely was not being controlled at this time. She also mentioned that she was relieved to finally get some help with her pain, rolled her eyes, and said, 'Finally!'"  On 5/19/17 at 8:25 am, the IDNS stated nursing staff were to administer medications per physicians' orders.  On 5/19/17 at 2:25 pm, the IDNS stated if a resident requested more frequent administration of PRN pain medications the facility was to notify the physician, who then evaluated whether scheduled pain medications would be more appropriate for that resident. The IDNS stated she did not see changes to Resident #11's ordered pain medications. When asked about the 7-day delay between Resident #11's 4/3/17 fall with complaints of rib pain and the request for an x-ray, the IDNS stated Resident #11 declined an offer to go to the hospital on the day of the fall, but the nurse still should have notified the physician of the incident and complaints of pain. The IDNS stated a second x-ray on 4/24/17 documented Resident #11 had sustained "acute fractures of the ribs."  On 5/22/17 at 11:10 am, Resident #11's Physician stated he would expect nursing staff to notify him of a resident's complaints of increased pain after a fall and/or suspected injury.	F 309			
F 310 SS=D	483.24(a)(b) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE	F 310		7/18/17	

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F 310	<p>Continued From page 42</p> <p>(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:</p> <p>(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section, ...</p> <p>(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:</p> <p>(1) Hygiene -bathing, dressing, grooming, and oral care,</p> <p>(2) Mobility-transfer and ambulation, including walking,</p> <p>(3) Elimination-toileting,</p> <p>(4) Dining-eating, including meals and snacks,</p> <p>(5) Communication, including</p> <p>(i) Speech,</p> <p>(ii) Language,</p> <p>(iii) Other functional communication systems.</p>	F 310			

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F 310	<p>Continued From page 43</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure 1 of 10 (#6) residents reviewed for Activities of Daily Living (ADLs) was provided oral care. This failure created the potential for a decline in activities of living and emotional distress from unmet needs and decreased socialization. Findings include:</p> <p>Resident #6 was admitted to the facility on 12/30/16, with diagnoses which included dementia and deposits on teeth.</p> <p>Resident #6's quarterly Minimum Data Set [MDS] assessment, dated 3/24/17, documented moderate cognitive impairment, mild signs and symptoms of depression, and extensive staff assistance required for personal hygiene.</p> <p>The ADL Care Plan, revised 3/28/17, documented Resident #6 required assistance with ADL's. The care plan documented Resident #6 was able to brush her teeth with staff set-up and cueing.</p> <p>ADL flowsheets from 5/1/17 through 5/17/17 did not contain documentation that daily oral care was provided to Resident #6.</p> <p>On 5/18/17 at 5:12 pm, the Interim Director of Nursing Services stated oral care should be performed in the morning, especially for a resident with diagnoses of dementia and deposits on teeth, and should be documented on the ADL flowsheet.</p>	F 310	<p>F310</p> <p>(1)Corrective actions for those residents identified;</p> <p>Resident #6; ability to independently provide oral care will be re-evaluated using Oral/Dental UDA with Care Plan reviewed and updated.</p> <p>(2)Address how you will identify other residents who have the potential to be affected, what corrective action will be taken;</p> <p>All residents have the potential to be affected. All resident□s will have oral care self- performance re-evaluated using Oral/Dental UDA with Care Plan reviewed and updated.</p> <p>(3)What measures will be put in place and what systematic changes will be made;</p> <p>CNAs will receive education to offer, encourage and assist residents with oral care as indicated from the Oral/Dental UDAs and per POC instructions and Care Plans.</p> <p>(4)indicate how the facility plans to monitor performance</p>		

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F 310	Continued From page 44	F 310	to ensure the corrective action(s) are effective and do not recur;  All resident's oral care and assistance needed will be monitored by DNS/Designee daily x2 weeks, weekly x2, every 2 weeks x2 months and monthly x3. QAPI will evaluate if monthly audits need to be continued.  (5)Include dates when corrective action will be completed;  July 18, 2017		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER  (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.  (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-  (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;  (ii) A resident who enters the facility with an	F 315		7/18/17	

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F 315	<p>Continued From page 45</p> <p>indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure catheter care was consistently performed for 1 of 3 residents (#7) reviewed for Foley catheter use. This failure created the potential for more than minimal harm if Resident #7 developed a Urinary Tract Infections [UTI] or other complication due to lack of catheter care. Findings include:</p> <p>Resident #7 was admitted to the facility on 3/9/17 with diagnoses which included UTI's.</p> <p>Resident #7's 4/28/17 quarterly Minimum Data Set [MDS] assessment documented moderate cognitive impairment and always incontinent of bladder.</p> <p>A 5/8/17 Physician's Order documented Resident #7 was to have a Foley catheter placed for</p>	F 315	<p>F315</p> <p>(1)Corrective actions for those residents identified: Resident#7; expired 6/7/2017 prior to needing a catheter change.</p> <p>(2)Address how you will identify other residents who have the potential to be affected, what corrective action will be taken;</p> <p>All residents with urinary catheters have the potential for being affected. Orders for resident□s with urinary catheters will be</p>		

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F 315	Continued From page 46 urinary retention. The Foley catheter was to remain in place pending a urinalysis.  Resident #11's Physician's Orders did not document when staff was to change the Foley drainage bag or when to perform Foley catheter care.  The Catheter Care Plan, initiated 5/9/17, directed staff to document Resident #7's fluid intake and output and provide catheter care twice a day. The care plan did not document when staff was to change the Foley drainage bag.  Resident #7's Activities of Daily Living (ADL) Flowsheet and Medication Treatment Administration did not contain documentation that catheter care was provided twice daily.  On 5/18/17 at 8:25 am, the Staff Development Coordinator stated catheter care should be completed twice a day and as needed. The Staff Development Coordinator stated the catheter tubing should be changed monthly. She said the catheter was new and the facility would address the orders for tubing changes if Resident #7's catheter was to remain in place.	F 315	obtained for: appropriate diagnosis, size of catheter, changing schedule for catheter & bag, catheter care and output documentation in POC.  (3)What measures will be put in place and what systematic changes will be made:  All residents with a urinary catheter will have physician orders and care plans reviewed and updated as needed, clinical staff will be educated on the orders needed for a urinary catheter and how to perform urinary catheter care.  (4)indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and do not recur;  MDSC\Designee will audit all orders urinary catheters, related care plans and urinary catheter care weekly x 4, every 2 weeks x 2 months, monthly x3. QAPI will evaluate if monthly audits continue to be indicated.  (5)Include dates when corrective action will be completed; July 18, 2017		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  (d) Accidents. The facility must ensure that -  (1) The resident environment remains as free	F 323		7/18/17	

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F 323	<p>Continued From page 47 from accident hazards as is possible; and</p> <p>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</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 observations, staff interview, and review of clinical records and incident/accident reports, it was determined the facility failed to ensure residents received sufficient supervision, toileting assistance, every 15 minute checks as care planned, and care plan updates to prevent falls and injuries for 2 of 7 sample residents (#3 &amp; #11) reviewed for falls. As a result:</p> <p>a) Resident #3, was harmed when she fell 4 times in 24 days and sustained fractures to the right femur that required surgical intervention.</p> <p>b) Resident #11 experienced 3 falls in 2 days that resulted in extensive bruising and severe pain to</p>	F 323	<p>F323</p> <p>(1)Corrective actions for those residents identified:</p> <p>Resident #3; will be reassessed for: toileting assistance using the Bowel &amp; Bladder UDAs , fall risk using the Fall Tool UDA, cognitive function via BIMs, and transfer assistance using the Mobilization Support Data Collection Tool. Non-pharmacological interventions will be</p>		

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F 323	<p>Continued From page 48</p> <p>her left chest and rib area and required increased use of 2 pain medications and an antianxiety medication. Resident #11 was harmed when she fell twice more and was diagnosed with 3 rib fractures.</p> <p>c) Resident #3, who wandered into other residents' rooms, rummaged through other residents' things, layed on other residents' beds, and hit, kicked, and spit when redirected, was placed at risk of harm, as were other residents who may encounter Resident #3, if an altercation developed between them and one or both residents were injured.</p> <p>Findings include:</p> <p>1. Resident #3 was admitted to the facility in May 2016 with multiple diagnoses, including dementia with behavioral disturbance, restlessness, and agitation. She was readmitted on 2/20/17 for orthopedic aftercare following surgical intervention of a right hip fracture related to a fall in the facility.</p> <p>Resident #3's most recent quarterly and significant change MDS assessments, dated 1/19/17 and 2/27/17 respectively, documented short- and long-term memory impairment; severely impaired cognition; delusions, and frequent urinary and bowel incontinence.</p> <p>The 1/19/17 quarterly MDS assessment also documented physical behavioral symptoms such as hitting, kicking, pushing, scratching, and grabbing directed toward others; verbal behavioral symptoms, such as threatening and/or screaming at others; and behavioral symptoms</p>	F 323	<p>reviewed and updated as indicated by the IDT. Medications will be reviewed by pharmacy or the physician. Family will be updated regarding changes.</p> <p>Resident's care plan will be reviewed and updated based data from these UDAs. Resident #11; was transferred to North Idaho in-patient hospice on 4/25/2017.</p> <p>(2)Address how you will identify other residents who have the potential to be affected, what corrective action will be taken; All residents with behaviors have the potential for being a risk. Residents with behaviors will be reassessed for: toileting assistance using the Bowel &amp; Bladder UDAs, fall risk using the Fall Tool UDA, cognitive function via BIMs, and transfer assistance using the Mobilization Support Data Collection Tool. Medications will be reviewed by pharmacy or the physician. Family will be updated regarding changes.</p> <p>Care plan's will be reviewed and updated</p>		

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F 323	<p>Continued From page 49</p> <p>not directed at others, such as pacing, rummaging, and disrobing in public, all of which occurred 4-6 days during the look back period; rejection of care 1-3 days and wandered daily; supervised assistance with bed mobility, transfers and eating; limited 1 person assistance with ambulation in room/corridors and locomotion on/off the unit; extensive 1 person assistance with dressing, personal hygiene and bathing; and use of antipsychotic medication for 7 days.</p> <p>The 2/27/17 significant change MDS assessment documented the physical behavioral symptoms, rejection of care and wandering occurred 1-3 days in the look back period; extensive 2 person assistance with bed mobility, transfers, dressing, toileting, and personal hygiene; extensive 1 person assistance with eating, total 1 person assistance with bathing; ambulation in room/corridors did not occur; and total 2 person assistance with locomotion on/off unit, and no antipsychotic medication use.</p> <p>On 5/17/17 at 3:10 pm, the MDS Coordinator said 2 non-injury falls and 1 fall with major injury were documented in Resident #3's 2/15/17 discharge MDS assessment.</p> <p>Resident #3 was observed in a wheelchair in the common areas of the facility, including the main dining room and hallways, with a staff member next to her on 5/15/17 at 5:20 pm; on 5/16/17 from 7:55 am to 8:05 am, 8:30 am to 8:45 am, 9:55 am, 10:55 am, 11:15 am, 11:55 am, 12:10 pm, and 3:15 pm; and on 5/17/17 at 9:05 am to 9:15 am, and 11:00 am. She was also observed in her room, either in bed with staff present or while being toileted by staff, on 5/16/17 at 11:20</p>	F 323	<p>based upon data from UDAs and medication review.</p> <p>(3)What measures will be put in place and what systematic changes will be made: Residents with behaviors that could cause self- harm and/or harm to others willResidents with behaviors that could cause self- harm and/or harm to others will;</p> <p>Staff education on following the care plan. All residents with behaviors will be reassessed for: toileting assistance using the Bowel &amp; Bladder UDAs, fall risk using the Fall Tool UDA, cognitive function via BIMs, and transfer assistance using the Mobilization Support</p> <p>All care plans are being reviewed for accuracy Of content.</p> <p>(4)indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and do not recur;</p> <p>Care plans will be reviewed and updated and monitored for accuracy Quarterly and with each condition</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/22/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>		
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F 323	<p>Continued From page 50 am to 11:25 am and on 5/17/17 at 3:00 pm.</p> <p>a. On 5/19/17 at 12:30 pm, the care plan in place in January and February prior to Resident #3's falls was provided by the facility's medical records department.</p> <p>The care plan in place prior to 3 falls in February 2017 included focus areas and associated interventions related to falls, Activities of Daily Living (ADL), and bladder incontinence as follows:</p> <ul style="list-style-type: none"> <li>* ADL self care performance deficit - independent ambulation with four wheeled walker (FWW), needs cues, supervision to locations such as the dining room and her own room, revised 8/18/16; 1 staff assistance with toilet use, revised 1/25/17.</li> <li>* Bladder incontinence - prefers to use the bathroom for toileting and take to the bathroom before and after meals, at bedtime and when she indicates the need to void, revised 1/25/17.</li> <li>* Risk for falls - monitor every 15 minutes, initiated 5/24/16 and revised 1/25/17.</li> </ul> <p>On 5/18/17 at 5:30 pm, the MDS Coordinator and Staff Development Nurse (SDC) said that in addition to every 15 minute checks, the facility also began 1:1 monitoring (1 staff to 1 resident) and audio/visual monitoring when Resident #3 was alone in her room, was recently added. They agreed to provide documentation of every 15 minutes checks and 1:1 monitoring.</p> <p>On 5/19/17 at 9:30 am, the MDS Coordinator provided Progress Notes, dated 2/17/17 through</p>	F 323	<p>change. As new behaviors are observed care plans will be Updated.</p> <p>Staff involved with care planning will be educated On the need for accuracy, updating to ensure the care Plan matches the resident. This will be completed by 06/23/2017 Monitoring will be: weekly X2; every 2 week X 2; two X per month X2 months; Monthly X3. The results will be reported to QAPI for Additional monitoring/modification.</p> <p>(5)Include dates when corrective action will be completed; July 18, 2017</p> <p>(4)indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and do not recur;</p> <p>(5)Include dates when corrective action will be completed; July 18, 2017</p>		

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F 323	<p>Continued From page 51</p> <p>4/3/17, which she said documented 1:1 monitoring. She said that 1:1 monitoring started after Resident #3 returned to the facility on 2/20/17 and "ended when Medicare ended."</p> <p>Resident #3's Fall Scene Huddle Worksheets (FSHW) and Investigations documented the following:</p> <p>* 1/22/17 at 5:25 pm - unwitnessed fall, no injury, last toileted at 5:00 pm, roommate notified staff the resident fell in the bathroom while "sitting on trashcan trying to go to the bathroom." Resident #3 said she was "going potty." Factors that may have contributed to the incident: "Had been restless during the day [up arrow and down arrow]. Highly demented; does not understand instructions or safety needs." Corrective actions: Continue 15 minute checks and "assistive device near door."</p> <p>Every 15 minute checks on 1/22/17 contained documentation that Resident #3 was checked at 3:19 pm and 6:09 pm, 2 hours and 50 minutes between checks.</p> <p>* 2/13/17 at 9:30 am - unwitnessed fall, no injury, incontinent when last toileted at 8:30 am, dry at time of incident, 15 minutes between last staff member contact and fall, Resident #3 said she was trying to go to the bathroom, "Lost balance one foot in pants leg all the way through, the other not." Factors that may have contributed to the incident: Attempting to toilet self. "Highly confused, poor safety awareness." Corrective actions: Motion light added and "toilet before breakfast."</p>	F 323			

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F 323	<p>Continued From page 52</p> <p>A 2/13/17 unsigned typed note attached to the FSHW documented Resident #3 was at high risk for falls, and exhibited "poor safety awareness and decline in cognition."</p> <p>Breakfast started at 7:00 am in the facility, which was 2 1/2 hours before Resident #3's fall at 9:30 am. The FSHW documented Resident #3 was toileted at 8:30 am, an hour before the fall.</p> <p>Every 15 minute checks on 2/13/17 contained documentation that Resident #3 was checked at 8:58 am and 9:58 am, an hour between checks.</p> <p>* 2/13/17 at 11:10 pm - unwitnessed fall, no injury, time last toileted was blank, time between last staff contact and fall "unknown." Factors that may have contributed to the incident: "unsteady gait, shuffling gait, poor balance, anxious [and] restless." Comments included, "Unaware of dangerous situations. Disregard for safety [no] longer has antianxiety med[ication] &amp; very anxious/restless..." Corrective actions: "Toilet before all meals."</p> <p>Resident #3's 2nd fall on 2/13/17 occurred more than 3 hours after the last meal service of the day at 5:00 pm, and her care plan prior to the fall included toileting assistance before and after meals. The corrective action, toilet before all meals, did not address the factors that contributed to the fall or add interventions to further protect Resident #3 from falls.</p> <p>A 2/14/17 unsigned typed note attached to the FSHW documented Resident #3 was at high risk for falls and, "2/13/17...found sitting on the floor...at 11:10 PM...unknown when or who last</p>	F 323			

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F 323	<p>Continued From page 53</p> <p>checked in on [Resident #3]...[Resident #3] had a fall at 10:00 am and has been on 15 minute checks...poor safety awareness, does not always remember to use her walker...continues to be restless and agitated...will not wait for staff and does not have the cognitive ability to use her call light when she has the urgency to urinate...anxious this morning and had been redirected back to her room. Continue with all current interventions per care plan."</p> <p>Every 15 minute checks on 2/13/17 contained documentation that Resident #3 was checked at 10:41 pm and 11:23 pm, 42 minutes between checks.</p> <p>* 2/15/17 at 12:30 pm - "No injury" fall witnessed by roommate, time last toileted 12:25 pm. The time between last staff contact and the fall was blank. Factors that may have contributed to the incident: "Confusion, did not use walker for ambulation." Corrective actions: "Do not leave seated on toilet by self."</p> <p>A 2/15/17 unsigned, typed note attached to the FSHW documented Resident #3 was at high risk for falls and that the roommate said Resident #3 had exited the bathroom and fell while attempting to open the door to the main hallway. It documented Resident #3 complained of pain with right leg movement and Emergency Medical Services was called to transport her to a local hospital.</p> <p>A facility Suggestion or Concern form, dated "2/15/16," and signed as reviewed by the LSW (Licensed Social Worker) on 2/16/17 and by the Administrator on 2/17/17, documented Resident</p>	F 323			

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F 323	<p>Continued From page 54</p> <p>#3 had an injury fall and was transported to a local hospital then to a regional hospital for surgery for "2 breaks in her leg." The Concern form investigation documented a CNA assisted Resident #3 to the bathroom and placed the walker at the bathroom door. It documented that when Resident #3 exited the bathroom, the bathroom door swung into the door to the hallway causing it to close and Resident #3 fell when she attempted to open the door to the hallway. It also documented that the care plan for toileting was "in compliance" but indicated the CNA left Resident #3's room while she was in the bathroom. Therefore, the care plan for 1 staff assistance with toileting was not implemented.</p> <p>Every 15 minute checks on 2/15/17 were out of sequence chronologically. For example, 7:30 am was followed by 12:16 pm, which was followed by 9:30 am, then 12:16 pm again, then 10:30 am. In addition, every 15 minute checks were documented as done on 2/15/17, 2/16/17, 2/17/16, 2/18/17, 2/19/17, and 2/20/17, when the resident was hospitalized and not in the facility.</p> <p>On 5/19/17 at 3:30 pm, the Interim Director of Nursing Services [IDNS] said that out of sequence documentation of every 15 minute checks may have been due to more than one staff documenting the checks. She said multiple entries with the same time may have occurred because the staff documented multiple checks at the same time. The IDNS said documentation of every 15 minute checks after Resident #3 left the facility on 2/15/17 was not accurate and it called into question the accuracy of all the documentation.</p>	F 323			

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F 323	<p>Continued From page 55</p> <p>Falls Tools documented Resident #3 was at medium risk for falls on 1/22/17 at 5:21 pm (4 minutes before a fall), high risk for falls on 2/13/17 at 9:20 am (10 minutes before the 1st fall on this day), medium risk for falls on 2/13/17 at 11:10 pm (the time of the 2nd fall on this day), and at high risk for falls on 2/15/17 at 12:30 pm (the time of the fall that day).</p> <p>Resident #3 was harmed when she fell and sustained fractures to the right femur which required surgical intervention. The facility did not provide staff assistance with toileting on 2/15/17 as care planned and failed to ensure every 15 minutes checks were consistently implemented as care planned.</p> <p>b. Resident #3's care plan focus areas and associated interventions related to wandering, resistance to cares, and physically aggressive behavior included:</p> <p>* Psychosocial well-being problem, interventions included:</p> <ul style="list-style-type: none"> <li>- Assistance/supervision/support to reduce/eliminate causative and contributing factors: may be redirected when she needs assistance, "cued she is in the wrong room or bed..." revised 11/3/16.</li> <li>- Wandering: "ask if you can assist her back to her home," revised 1/25/17.</li> </ul> <p>* Mood/behavior problem, revised 1/25/17, interventions included:</p> <ul style="list-style-type: none"> <li>- Walking without assistance, forgets walker, unsafe: calmly approach and engage in</li> </ul>	F 323			

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F 323	<p>Continued From page 56</p> <p>conversation, cue her for walker/wheelchair assistance.</p> <ul style="list-style-type: none"> <li>- Sitting/sleeping in roommates' bed: in calm manner inform her where her bed is.</li> <li>- Rummaging through others' belongings: redirect in calm manner and in quiet tone of voice. Inform her the things belong to her roommate, assist her to find her own things.</li> <li>- Physical abuse towards staff: if resident becomes agitated put enough space in between yourself and resident and speak calmly in a soft tone of voice.</li> </ul> <p>* Behavior symptom, "physical abuse directed at others," interventions included:</p> <ul style="list-style-type: none"> <li>- Intervene as necessary to protect the rights and safety of others. Divert attention. Remove from situation and take to alternate quiet location, revised 7/26/16. Minimize potential for disruptive behaviors, such as hitting, offer distractions which may divert her attention after meals, revised 1/25/17.</li> <li>- Hitting/spitting: attempt non-pharmacological interventions, assess for possible needs, fear or disorientation, revised 1/25/17.</li> <li>- Physically abusive to others, hits, kicks, spits: remove from over stimulating situations which could cause increased agitation and escalate behaviors. If resident refuses to leave and becomes more agitated, give her space to walk where she can be monitored. Change of care provider may help, revised 1/25/17.</li> </ul> <p>Resident #3's Medication Review Report of current orders on or after 12/30/16 documented:</p> <ul style="list-style-type: none"> <li>* Aricept [to treat dementia] 10 mg one time a day for dementia started 12/28/16;</li> </ul>	F 323			

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F 323	<p>Continued From page 57</p> <ul style="list-style-type: none"> <li>* Namenda [to treat dementia] 10 mg two times a day started 5/23/16;</li> <li>* Zyprexa [antipsychotic] 2.5 mg in the morning started 11/13/16;</li> <li>* Zyprexa 5 mg one time a day started 11/14/16; and</li> <li>* Zyprexa 5 mg every 8 hours as needed for aggressive behavior, spitting, hitting, scratching, biting, started 12/30/16.</li> </ul> <p>All of these medications were ordered for dementia with behavioral disturbance.</p> <p>The Medication Review Report of current orders on or after 1/31/17 documented the same order for Aricept and Zyprexa 5 mg two times a day started 1/24/17. The other noted medications were not ordered.</p> <p>The Medication Review Report of current orders on or after 2/20/17, 2/28/17, and 3/31/17 documented Zyprexa 5 mg two times a day. The other noted medications were not ordered.</p> <p>The Medication Review Report of current orders on or after 5/16/17, documented Zyprexa was decreased to 5 mg in the evening on 4/18/17.</p> <p>Resident #3's Progress Notes, dated 6/29/16 to 2/15/17, documented the following:</p> <ul style="list-style-type: none"> <li>* 9/11/16 at 3:48 am - Awake and "eager" to enter other residents rooms, unable to redirect. When brought to her room, "sat on her roommate's legs." Roommate was "kind and understanding" of situation. Brought out to day room where she tried to go outside. Hit staff 3 times when guided away.</li> </ul>	F 323			

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

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F 323	Continued From page 58  * 11/8/16 at 9:53 am - Hit her daughter. Leaving "messes" in the bathroom.  * 11/13/16 at 3:33 pm - Out of room wandering around several times this morning. Difficult to redirect and at one point tried to "smack, punch, hit and scratch this nurse."  * 12/17/16 at 12:38 pm - Slapped caregiver redirecting her away from another resident's room.  * 12/27/16 at 3:22 pm - Very agitated, gets verbally abusive and physically abusive with staff when redirected. Took resident for a "long walk" offered warm blanket and her recliner. This worked for about 5 minutes and she was back up wandering into other rooms. When redirected, she slapped at and grabbed staffs' arms and "led us to the door of another residents [sic] room and pushed us out and she turned around and went back in." A staff offered to walk resident to her room and she was willing to go. "[H]as been this way all weekend."  * 12:30/16 at 12:33 pm - Resident "smacked, tried to bite, scratched and spit" in nurse's face.  * 1/16/17 at 10:28 am - Continues to exhibit significant behavioral problems. She will hit, scratch, kick and spit at staff. Recent addition of PRN sublingual Zyprexa has been effective when used.  * 1/17/17 at 8:56 am - Wandering this morning. Tried to go into another resident's room, removed he pull up. Redirected to her room.	F 323			

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F 323	<p>Continued From page 59</p> <p>* Date illegible (hole punch over month and day) 2017 at 3:43 pm - At breakfast time, resident wandered into a resident's room and was redirected to her room. Resident did not stay in her room and wandered down hall into another resident's room. Unable to redirect and she laid on the resident's bed. Resident informed her she was in the wrong room and bed. She tried to kick the staff member repeatedly and said to leave her alone. The resident was eventually redirected to her room.</p> <p>* 2/7/17 at 10:21 am - Combative with cares, got angry with CNA trying to change her. Shoved CNA into closet doors and tried to slap CNA. A second CNA came to help and while assisting the resident with soiled clothing the resident punched and kicked at the staff. They stepped back and tried to calm the resident. The resident then kicked one CNA in the stomach.</p> <p>* 2/8/17 at 10:21 am - Continues to be combative with cares. Out of room walking and very upset when redirected to her room. Punched and tried to bite nurse. Eventually went to her room and laid down.</p> <p>* 2/10/17 at 4:35 pm - Got into bed with her roommate. Redirected back to her bed without incident.</p> <p>* 2/15/17 at 1:46 pm - 1:1 with resident while waiting for ambulance.</p> <p>CNA records included "Monitor [Resident #3] every 15 minute for safety. 1:1 with staff as directed by nurse, PRN" and contained</p>	F 323			

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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 323	<p>Continued From page 60</p> <p>documentation that every 15 minute checks were not consistently implemented January through March 2017 and ended on 4/14/17 at 5:46 pm. In addition, there was no documentation of when 1:1 was provided.</p> <p>On 5/19/17 at 9:30 am, the MDS Coordinator said that 1:1 care started when Resident #3 returned to the facility on 2/20/17 and ended "when Medicare ended."</p> <p>On 5/19/17 at 11:45 am, the LSW said Resident #3's physical aggression was "not predictable" and it had "everything to do with approach." The LSW said Resident #3 was able to self toilet, was independent, and that she wandered when she first came to the facility. The LSW said, "Yes," when asked if another resident could be harmed if Resident #3 directed physical or verbal behaviors toward them. She said, "Yes," that Resident #3 could be harmed if another resident did not tolerate her intrusion into their room, onto their bed or rummaging through their things. The LSW said Resident #3's physical and verbal behaviors had only occurred with staff.</p> <p>2. Resident #11 was readmitted to the facility on 1/28/16, with diagnoses which included malignant neoplasm of the lung (lung cancer), dementia, and mood disorder.</p> <p>Resident #11's quarterly Minimum Data Set (MDS) assessment, dated 2/22/17, documented no cognitive impairment, staff supervision required with transfers and ambulation, 1 non-injury fall prior to the assessment, and rejection of cares 1-3 days during the look back period.</p>	F 323			

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F 323	<p>Continued From page 61</p> <p>Resident #11's April 2017 Physician's Orders included:</p> <ul style="list-style-type: none"> <li>* 5 mg Norco Tablet 5-325 mg every 6 hours as needed (PRN) for pain, ordered 2/23/17.</li> <li>* 50 mg Tramadol Tablet every 6 hours PRN for pain, ordered 2/23/17.</li> <li>* 0.5 mg Ativan Tablet every 12 hours PRN for anxiety, ordered 8/23/16.</li> </ul> <p>Resident #11's Limited Physical Mobility Care Plan, revised 7/7/16, documented she was at risk for falls. Interventions included:</p> <ul style="list-style-type: none"> <li>* Resident #11 required non-weight bearing staff support with mobility and required "staff distant supervision" of stand by assist and contact guard assist PRN with use of her All Terrain Walker (ATW). Resident #11 "usually" ambulated independently, revised 12/12/16.</li> <li>* Resident #11 used a wheelchair for locomotion and her ATW for ambulation, revised 2/18/16.</li> </ul> <p>Resident #11's Fall Care Plan, revised 9/22/16, documented she had an actual fall with minor injury related to weakness as evidenced by her history of falls, poor balance, unsteady gait, and poor safety awareness. Interventions included:</p> <ul style="list-style-type: none"> <li>* Staff was to encourage Resident #11 to do activities and exercise whenever possible and support Restorative Nursing Aide (RNA) walking program, initiated 3/22/16.</li> <li>* Staff was to ensure Resident #11 was wearing appropriate footwear, revised 9/22/16.</li> <li>* Resident #11's bed was to be unplugged to keep the bed in one position due to Resident</li> </ul>	F 323			

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F 323	<p>Continued From page 62</p> <p>#11's inability to understand she cannot adjust the bed height for safety reasons, revised 7/7/16.</p> <p>* Staff was to ensure Resident #11's bed height was correct to the marking on the wall, to the headboard, or the mattress, initiated 3/22/16.</p> <p>* Resident #11 was to be reviewed for significant changes in cognition, safety awareness, and decision-making capacity, initiated 3/28/16.</p> <p>* Staff was to monitor Resident #11 every 15 minutes for whereabouts and keep her door ajar when cares were not being provided for ease in observation, revised 3/22/16.</p> <p>Resident #11's Activities of Daily Living [ADL] Care Plan documented an intervention that she required assistance of 1 staff member, as needed, and self-toileted often, initiated 2/1/16.</p> <p>a. Resident #11 experienced 5 falls between 4/1/17 and 4/25/17.</p> <p>* Fall on 4/1/17 at 3:15 am:</p> <p>Resident #11's 4/1/17 at 3:15 am, Fall Scene Huddle Worksheet (FSHW) documented she was found on her hands and knees crawling out of the bathroom. The worksheet documented she seemed "forgetful," "confused" and "had just been out to [the] nurses station looking for her husband stating she had seen him outside her window." Resident #11's FSHW documented she had no injuries from this fall. The Incident Report had a Social Service Note attached, dated 4/1/17, which documented "[Resident #11] had a large bruise to her left thorax. [Resident #11] stated she fell and her ribs hurt...SSD [Social Service Director] asked [Resident #11] if she hurt herself, had any bruising, [Resident #11] stated</p>	F 323			

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F 323	<p>Continued From page 63</p> <p>she did not think so but her ribs hurt. SSD asked [Resident #11] to lift her shirt and show SSD and SSD did not see any bruising at this time." The note documented Resident #11's Interested Party was contacted in regards to what "appears" to be a "non-injury" incident from a fall.</p> <p>Resident #11's clinical record did not contain the Social Services Note attached to the 4/1/17 Incident Report. Resident #11's clinical record did not contain documentation that her physician was informed of her 4/1/17 fall and her complaint of her ribs hurting. On 5/22/17 at 10:05 am, the SSD stated the Social Service Note attached to the 4/1/17 Incident Report was not in Resident #11's clinical record. The SSD stated she wrote the note to herself, to remind her of the incident and what she needed to do.</p> <p>A 4/1/17 Fall Tool documented Resident #11 had experienced a recent fall. The Fall Tool documented she was taking more than two psychoactive medications and had a moderate cognitive impairment. The "Action Plan" portion of the document was blank. Additional preventative measures to protect Resident #11 from falls were not initiated.</p> <p>Resident #11's Care Plan was not updated following the 4/1/17 fall.</p> <p>* Fall on 4/3/17 at 9:00 am:</p> <p>Resident #11's FSHW, dated 4/3/17 at 10:15 am, documented she was found on the floor in the hallway. The worksheet documented she seemed "agitated," and the documented root cause was, "consider disease processes</p>	F 323			

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

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F 323	<p>Continued From page 64 progressing." Resident #11's FSHW documented she had no injuries from this fall.</p> <p>A Fall Tool, dated 4/3/17 at 10:16 am, documented Resident #11 had experienced a recent fall. The Fall Tool documented she was taking more than two psychoactive medications and had a moderate cognitive impairment. The "Action Plan" documented she was referred to the RNA program and her physician, and her care plan was updated.</p> <p>The following interventions were added to Resident #11's Fall Care Plan on 4/3/17:</p> <ul style="list-style-type: none"> <li>- Staff was to encourage Resident #11 to ambulate with staff.</li> <li>- Staff was to modify her environment for maximum safety. Staff was to ambulate with Resident #11 "all the way."</li> <li>- When Resident #11 was out of her room staff was to ambulate with her when she went back to her room.</li> </ul> <p>Resident #11's 4/3/17 Fall Care Plan, continued to include interventions found on her 9/22/16 Fall Care Plan. These included:</p> <ul style="list-style-type: none"> <li>- Staff was to encourage Resident #11 to do the RNA walking program.</li> <li>- Resident #11's bed was to be unplugged to keep the bed in one position due to Resident #11's inability to understand she cannot adjust the bed height for safety reasons.</li> <li>- Staff was to monitor Resident #11 every 15 minutes for whereabouts.</li> <li>- Staff was to keep her door ajar when cares were not being provided. "As resident allows,"</li> </ul>	F 323			

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F 323	<p>Continued From page 65</p> <p>was added at the end of this intervention on 4/3/17.</p> <p>* Fall on 4/3/17 at 4:00 pm:</p> <p>Resident #11's FSHW, dated 4/3/17 at 4:00 pm, documented she was found on the floor in her room attempting to ambulate. The worksheet documented she seemed "agitated," and the documented root cause was, "agitated; refusing to move away from the med-cart." Resident #11's FSHW documented she had no injuries from this fall.</p> <p>Resident #11's clinical record did not contain a Fall Tool for the second fall on 4/3/17 at 4:00 pm or care plan updates. Resident #11's clinical record did not contain documentation that the facility reported the fall Resident #11 experienced on 4/3/17 at 4:00 pm, to her physician.</p> <p>Progress Notes between 4/3/17 and 4/23/17 (21 days) documented 55 entries that Resident #11 complained of (c/o) left sided/left rib pain, requested pain medications, was holding her left side in pain, and/or that she suspected her ribs were broken. Progress Notes and x-ray reports included:</p> <ul style="list-style-type: none"> <li>- A Nurse's Note, dated 4/3/17, documented Resident #11 had fallen twice that day, once in the morning and once in the afternoon. The note documented she was given all the medication available to her. The note documented Resident #11 told the Licensed Practical Nurse (LPN) she thought she had broken a rib.</li> <li>- A Nurse's Note, dated 4/4/17 at 5:00 am,</li> </ul>	F 323			

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F 323	<p>Continued From page 66</p> <p>documented Resident #11 had a "marked dark purple bruise on the left thorax from the fall last shift. She c/o pain in [her] rib area under [her] left breast and reports that she feels the rib was broken. I medicated her for pain and advised her to drink plenty of fluids, rest, and intentionally take slow deep breaths for lung expansion to avoid complications."</p> <p>- A Nurse's Note, dated 4/5/17 at 5:14 am, documented Resident #11 stated, "It feels like my rib is cutting me on the inside."</p> <p>- A Nurse's Note, dated 4/5/17 at 9:35 am, documented Resident #11 was given Ativan, her anti-anxiety medication, because she was "anxious about falling."</p> <p>- A Nurse's Note, dated 4/6/17 at 7:24 pm, documented Resident #11 did not want to take a bath and was finally talked into taking one. The note documented Resident #11's reason for not wanting a bath was due to her hurting "too bad."</p> <p>- A Mood and Behavior Note, dated 4/7/17 at 8:36 am, documented Resident #11 complained of pain in her rib area.</p> <p>- A Medication Review Note, dated 4/7/17 at 10:42 am, documented Resident #11 had increased behaviors and the writer was unsure if the behaviors were due to an increase in pain from an injury to her left rib from a fall or changes in her lung cancer.</p> <p>- A Nurse's Note, dated 4/17/17 at 10:11 am, documented Resident #11 had increased pain, was sleeping more, and experienced a decrease</p>	F 323			

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F 323	<p>Continued From page 67 in mobility.</p> <p>- A Nurse's Note, dated 4/18/17 at 3:55 am, documented Resident #11 had a nose bleed and did "not know" how it happened. The note documented, "She stayed up all night and remained confused."</p> <p>- A Nurse's Note, dated 4/23/17 at 1:11 pm, documented Ativan was given due to Resident #11's complaint of "anxiety due to severe pain level 9."</p> <p>- A 4/23/17 at 1:03 pm, Nurse's Note documented Resident #11 had "severe pain under her left breast and left side, giving her pain medication...she wakes up in severe pain."</p> <p>- A Nurse's Note, dated 4/24/17 at 11:41 am, documented Resident #11 slept in and did "not" want to wake up. The note documented Resident #11 was "tired."</p> <p>* Fall on 4/24/17 at 1:00 pm:</p> <p>Resident #11's FSHW, dated 4/24/17 at 1:00 pm documented staff found her on her hands and knees crawling out of the bathroom. The worksheet documented she seemed "forgetful" and was "not sure what she was doing...then stated that she was coming out of the bathroom." Resident #11's FSHW documented she complained of "left chest" pain and "left hip" pain from this fall.</p> <p>A Fall Tool, dated 4/24/17 at 1:00 pm, documented Resident #11 had experienced a recent fall. The Fall Tool documented she was</p>	F 323			

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F 323	<p>Continued From page 68</p> <p>taking more than two psychoactive medications and had a moderate cognitive impairment. The "Action Plan" documented she was referred to her physician.</p> <p>A Nurse's Note, dated 4/24/17 at 1:43 pm, documented Resident #11 was transferred to a hospital, after a fall, for evaluation of her complaint of "severe pain under [her] left breast near ribs."</p> <p>A Rib X-Ray Report, dated 4/24/17 at 3:04 pm, documented Resident #11 had a Posteroanterior [PA] x-ray and 2 additional "rib detail view" x-rays of her left side. The "obliques rib detail view" showed "nondisplaced acute appearing" fractures of the lateral portions of her left 6th, 7th, and 8th ribs.</p> <p>* Fall on 4/24/17 at 5:40 pm:</p> <p>Resident #11's FSHW, dated 4/24/17 at 5:40 pm, documented she was found on her right hip sitting on the floor trying to go to the bathroom. The worksheet documented she seemed "forgetful, confused and agitated." Resident #11's FSHW documented she complained of "left chest" pain and "right hip" pain from this fall.</p> <p>Resident #11's clinical record did not contain a Fall Tool for the second fall on 4/24/17 at 5:40 pm.</p> <p>A Nurse's Note, dated 4/24/17 at 5:45 pm, documented Resident #11 fell on her way to the bathroom unassisted. The note documented she had "increased intermittent confusion."</p>	F 323			

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F 323	<p>Continued From page 69</p> <p>Resident #11's Limited Physical Mobility Care Plan interventions were revised as follows:</p> <ul style="list-style-type: none"> <li>- Resident #11 required "(specify: PT [Physical Therapy]/OT [Occupational Therapy] recommended adaptations, horn, adjusted speed, use of protective gear, rearview mirror, safety flag, reflective tape on device and/or clothing, etc,)" initiated 4/24/17.</li> <li>- Resident #11 required the "use of a gait belt during transfers and ambulation," initiated 4/24/17.</li> </ul> <p>Resident #11's Limited Physical Mobility Care Plan interventions were revised on 4/25/17, to require non-weight bearing staff support with mobility and "staff distant supervision" of stand-by assistance and contact guard assistance, as needed, with use of her ATW.</p> <p>Resident #11's ADL Care Plan was revised on 4/25/17, to include that she required assistance of 1 staff member, and staff was not to leave her unassisted in the bathroom.</p> <p>On 5/19/17 at 2:25 pm, the IDNS stated she was not working at the facility during the time of Resident #11's first falls in April 2017. The IDNS stated when Resident #11 complained of her rib "cutting" her on the "inside" the facility should have called the physician for orders and directions. The IDNS stated the x-ray on 4/24/17 documented "acute fractures of the ribs." The IDNS stated Resident #11 was known to wander and walk without assistance. She stated she could not speak to what happened when she was not in the facility. The IDNS stated from experience staff should have reinforced/educated</p>	F 323			

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F 323	<p>Continued From page 70</p> <p>Resident #11 on the risks of not following care planned interventions and documented the refusals.</p> <p>On 5/22/17 at 11:10 am, Resident #11's Physician stated he would expect nursing staff to notify him when residents' complaints of pain increased after a fall and/or there was a suspected injury.</p> <p>The facility failed to ensure Resident #11 was provided sufficient supervision and care plan updates to prevent repeated falls. The facility failed to perform timely post-fall risk assessments for Resident #11 to determine the cause of the fall and how to prevent future falls. Additionally, the facility failed to notify Resident #11's physician of the falls she sustained and her ongoing complaints of severe rib pain after her first fall, which may have contributed to subsequent falls.</p> <p>b. Resident #11's 15 minutes checks for safety were not consistently completed as follows:</p> <p>Resident #11's 9/22/16 and 4/3/17 Fall Care Plans documented staff was to monitor Resident #11 every 15 minutes for whereabouts.</p> <p>Resident #11's ADL Flowsheet, where 15 minute checks were to be documented, was not completed on 4/7/17 from 10:00 pm to 12:00 am.</p> <p>A Chest X-Ray Report, dated 4/10/17 at 9:11 am, was included in Resident #11's clinical record. On 5/22/17 at 9:00 am, the IDNS stated Resident #11 was sent out for the chest x-ray on the 4/10/17. She stated she did not know how long</p>	F 323			

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F 323	Continued From page 71 the procedure took but Resident #11 was out of the building.  Resident #11's ADL Flowsheet for 4/10/17, documented completion of 15 minute checks throughout the day. The Flowsheet did not indicate Resident #11 was out of the facility.  Documentation of every 15 minute monitoring on Resident #11's ADL Flow-sheet ended on 4/18/17. Resident #11's clinical record did not contain documentation of the reason the 15 minutes checks were stopped or discontinued.  On 5/19/17 at 3:30 pm, the IDNS said continued documentation of every 15 minute checks after a resident left the facility was not accurate and it called into question the accuracy of all the documentation.  The facility failed to ensure 15 minute checks of Resident #11 were accurately documented and consistently completed.	F 323			
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--  (1) In excessive dose (including duplicate drug therapy); or  (2) For excessive duration; or  (3) Without adequate monitoring; or	F 329		7/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/22/2017</b>
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F 329	<p>Continued From page 72</p> <p>(4) Without adequate indications for its use; or</p> <p>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--</p> <p>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure:</p> <ul style="list-style-type: none"> <li>* Residents' behaviors were identified prior to the administration of medications</li> <li>* Physicians' medication orders included specific indications for use</li> <li>* Medications were monitored for effectiveness</li> </ul> <p>This was true for 4 of 7 residents (#2, #6, #7, and</p>	F 329	<p>F 329</p> <p>(1)Address what corrective action(s) will be accomplished for those residents found to have en affected; Resident #11 was transferred to in Northern Idaho Hospice in -patient; 04/25/2017.  Resident #7 expired on 06/07/2017.</p>		

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F 329	<p>Continued From page 73</p> <p>#11) reviewed for psychoactive medication use. Findings include:</p> <p>1. Resident #11 was readmitted to the facility on 1/28/16, with diagnoses which included malignant neoplasm of the lung [lung cancer], dementia, and mood disorder.</p> <p>The quarterly Minimum Data Set [MDS] assessment, dated 2/22/17, documented Resident #11 was cognitively intact, required supervision with transfers and ambulation, experienced 1 non-injury fall prior the assessment, and rejected cares 1-3 days during the look back period. The MDS documented Resident #11 received PRN pain medication, rather than scheduled analgesics.</p> <p>An Antianxiety Care Plan, revised 4/14/17, documented staff were to monitor and document for side effects and effectiveness of Resident #11's antianxiety medication. The care plan did not document resident-specific behaviors staff was to monitor.</p> <p>Resident #11's Pain Care Plan, revised 12/12/16, documented she experienced acute and chronic pain related to lung cancer as evidenced by grimacing, resisting cares, and complaints of [c/o] itching or burning. Staff was to evaluate Resident #11 through the Pain Assessment in Advanced Dementia [PAINAD] scale, revised 12/12/16. The Plan documented Resident #11 was able to call for assistance when in pain and ask for medication, revised 12/12/16.</p> <p>Resident #11's April 2017 Physician's Orders included:</p>	F 329	<p>Resident #6 orders will obtained to include identified behaviors and indications for Lexapro use and to document the effectiveness of this medication. The MAR and care plan will be updated to include the above information and non-pharmacological interventions. Point of care documentation for CNAs will be updated to include identified behaviors and non-pharmacological interventions.</p> <p>Resident #2 was transferred to North Idaho in-patient hospice on 05/24/2017</p> <p>(2) Address how you will identify other residents who have the potential to be affected, what corrective action will be taken;</p> <p>All residents having behaviors have the potential to be affected.</p> <p>Orders will be obtained to include identified behaviors and indications for psychotropic medication use and to document the effectiveness of these medications. The MARs and care plans will be updated to include the above information and non-pharmacological interventions. Point of care documentation for CNAs will be updated to include identified behaviors and non-pharmacological interventions.</p>		

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F 329	<p>Continued From page 74</p> <p>* 5 mg Norco 5-325 mg (Hydrocodone - Acetaminophen) every 6 hours PRN for pain, 2/23/17. * 50 mg Tramadol every 6 hours PRN for pain, 2/23/17. * 0.5 mg Ativan every 12 hours PRN for anxiety, 8/23/16. * 650 mg Acetaminophen every 4 hours PRN for pain, 2/23/17.</p> <p>A Nurse's Note, dated 4/3/17, documented Resident #11 fell twice that day, once in the morning and once in the afternoon. The Note documented she received all the medication which was available to her and that she told a Licensed Practical Nurse [LPN] she thought she had broken a rib.</p> <p>a. Progress Notes from 4/3/17 through 4/24/17 included 21 entries that Resident #11 experienced anxiety, decreased energy, behaviors, and/or increased confusion following the two falls on 4/3/17. Progress Notes included:</p> <p>A Nurse's Note, dated 4/17/17 at 10:11 am, documented Resident #11 was experiencing increased pain, sleeping more, and was exhibiting a decrease in mobility.</p> <p>A Medication Review Note, dated 4/7/17 at 10:42 am, documented Resident #11 exhibited increased behaviors that were attributed to either an increase in pain from an injury to her left ribs from a fall or changes in her lung cancer.</p> <p>A Nurse's Note, dated 4/18/17 at 3:55 am, documented Resident #11 had a nose bleed of</p>	F 329	<p>All residents with orders for Ativan have the potential to be affected. Residents receiving Ativan will have the MAR and Narcotic book checked daily to ensure nurses are following physician orders.</p> <p>All residents receiving Hypnotic medications and/or medications for insomnia have the potential to be affected. Orders will be obtained to include monitoring of hours of sleep. The MARs and care plans will be updated to include the above information.</p> <p>All residents receiving narcotic pain medications have the potential to be affected. Residents on narcotic pain medications will have the MAR and Narcotic book checked daily to ensure nurses are following physician orders.</p> <p>(3) What measures will be place and what systematic changes will be made:</p> <p>SSD will review and update all behavior care plans to include specific behaviors staff are to monitor and non-pharmacological interventions.</p> <p>MDSC will update MAR(s) to document monitoring of; specific behaviors and side</p>		

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F 329	<p>Continued From page 75 unknown origin and that "she stayed up all night and remained confused."</p> <p>A Mood / Behavior Note, dated 4/20/17 at 4:29 pm, documented Resident #11 did "not want to go to counseling anymore, she states she does not have the energy."</p> <p>A Nurse's Note, dated 4/22/17 at 8:35 am, documented Resident #11 was "very anxious."</p> <p>A Nurse's Note, dated 4/24/17 at 11:41 am, documented Resident #11 slept in and did not want to be awakened. The Note documented Resident #11 was "tired."</p> <p>A Nurse's Note, dated 4/24/17 at 5:45 pm, documented Resident #11 fell on her way to the bathroom and exhibited "increased intermittent confusion."</p> <p>The April 2017 MAR documented Resident #11 was administered 13 doses of PRN Ativan between 4/3/17 and 4/24/17. Resident #11's clinical record did not contain documentation of behaviors prompting administration of the Ativan or that nonpharmacological interventions were attempted prior to her receiving the medication for 4 of the 13 doses documented on the MAR. Resident #11's Controlled Drug Record for Ativan documented she received 29 doses of Ativan during the same time frame. Resident #11 was not assessed for pain prior to- or following administration of the PRN Ativan on 16 occasions.</p> <p>b. On 4/23/17, Resident #11's Controlled Drug Reviews and MARs documented the following</p>	F 329	<p>effects of medications ordered for specific behaviors.</p> <p>Audits will be completed on narcotic pain medication/Ativan documentation of compliance with physician orders. DNS and/or designee will review and update care plans and MARs for residents receiving hypnotic medications and medications for insomnia to include hours of sleep.</p> <p>All staff will be trained on where to find behaviors And find interventions on residents with behaviors, How to document these behaviors and how to report New behaviors.</p> <p>Behaviors will be reviewed monthly at Behavior meeting.</p> <p>(4) indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and do not recur;</p> <p>All staff will be trained on where to find behaviors And find interventions on s residents with behaviors, How to document these behaviors and how to report New behaviors. 06/23/2017</p>		

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F 329	<p>Continued From page 76 medication administrations:</p> <ul style="list-style-type: none"> <li>* Ativan - 12:00 pm, 1:00 pm, and 8:00 pm</li> <li>* Norco - 12:00 pm, 1:00 pm, 4:00 pm, 7:00 pm, 8:00 pm, and 10:30 pm</li> <li>* Tramadol - 1:00 pm and 8:00 pm</li> <li>* Acetaminophen - 1:00 pm</li> </ul> <p>The April 2017 MAR did not document administration of Ativan, Norco, or Tramadol on 4/24/17. On 4/24/17, the Controlled Drug Reviews documented the following medication administration:</p> <ul style="list-style-type: none"> <li>* Ativan - 8:00 am, 12:00 pm, and 6:00 pm</li> <li>* Norco - 8:00 am, 12:00 pm, 6:00 pm, 9:00 pm</li> <li>* Tramadol - 8:00: am, and again at an undocumented time</li> </ul> <p>The manufacturer's recommendation for Ativan document the medication is useful for short-term relief of excessive anxiety, but may result in cardiac complications, increased depression, sedation, fatigue, unsteadiness, insomnia, and other potential adverse side effects for the elderly. Long-term use of Ativan was not recommended.</p> <p>According to the Nursing Drug Handbook 2017, Ativan's overdose signs and symptoms included drowsiness, confusion, ataxia, hypotonia, hypotension, hypnotic state, coma, and death. The Drug Handbook documented Norco's potential adverse reactions included light-headedness, dizziness, sedation, drowsiness, mental clouding, lethargy, anxiety, fear, and mood changes. The Drug Handbook documented Tramadol's potential adverse</p>	F 329	<p>Behaviors will be reviewed monthly at Behavior meeting.</p> <p>All narcotic pain administrations and Ativan administrations will be audited daily X two weeks; weekly X two weeks; every two weeks X two months by the DNS and/or designee. QAPI will evaluate if monthly audits are indicated.</p> <p>All orders, care plans, MARs and point of care tasks related to behaviors, medication side effects, diagnosis and non-pharmacological interventions will be audited daily X two weeks; weekly X two weeks; every two weeks X two months by the DNS and/or designee. QAPI will evaluate if monthly audits are indicated.</p> <p>All orders, care plans, and MARs related to hours of sleep will be audited daily X two weeks; weekly X two weeks; every two weeks X two months by the DNS and/or designee. QAPI will evaluate if monthly audits are indicated.</p> <p>(5) Include dates when corrective action will be completed;</p> <p>July 18, 2017.</p>		

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F 329	<p>Continued From page 77</p> <p>reactions included dizziness, anxiety, confusion and nervousness.</p> <p>Resident #11 fell twice on 4/24/17; the facility's Fall Scene Huddle Worksheets (FSHW) for these two events documented Resident #11 was "forgetful...not sure what she was doing...confused...agitated."</p> <p>On 5/19/17 at 2:25 pm, the IDNS stated nursing staff were to administer medications as ordered by the physician.</p> <p>On 5/22/17 at 11:40 am, the Consultant Pharmacist stated he did not compare Controlled Drug Records to residents' MARs and was not aware Resident #11's medications were not administered as ordered by the physician.</p> <p>2. Resident #7 was admitted to the facility on 3/9/17, with diagnoses which included depression, insomnia, and pseudobulbar effect [a condition that causes uncontrollable crying and/or laughing that happens suddenly and frequently].</p> <p>Resident #7's MDS assessment, dated 4/28/17, documented moderate cognitive impairment, mild signs and symptoms of depression, and no behaviors.</p> <p>a. A 4/3/17 Physician's Order documented Resident #7 was to receive Ativan 0.5 mg every 8 hours as needed for anxiety.</p> <p>Resident #7's Antianxiety Care Plan, revised 4/17/17, documented staff were to monitor and document side effects and efficacy of the</p>	F 329			

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F 329	<p>Continued From page 78</p> <p>antianxiety medication. Resident #7's care plan did not document resident-specific behaviors staff were to monitor.</p> <p>The 5/1/17 through 5/15/17 MAR documented Resident #7 was administered 13 doses of PRN Ativan. Resident #7's clinical record did not contain documentation of behaviors prompting administration of the Ativan or that nonpharmacological interventions were attempted prior to her receiving the medication for 5 of the 13 doses documented on the MAR. In addition, Resident #7's Controlled Drug Record for Ativan documented she was administered 18 doses of Ativan during the same time frame. Resident #7 was not assessed for pain prior to, or following, administration of the PRN Ativan on 5 occasions.</p> <p>On 5/19/17 at 8:25 am, the IDNS stated Resident #7's anxious behavior presented as repeated yelling that escalated until she became visibly upset. The IDNS stated Resident #7 presented with a fearful and anxious affect when she became forgetful.</p> <p>b. A 5/1/17 Physician's Order documented Resident #7 was to receive Melatonin 4 mg at bedtime related to insomnia. The physician's order allowed for a repeat dosage if the first administration was ineffective.</p> <p>Resident #7's Sleep Disturbance Care Plan, revised 4/17/17, documented staff was to monitor hours of sleep on the MAR to determine if the medication was effective.</p> <p>Resident #7's 5/1/17 through 5/16/17 MAR did</p>	F 329			

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F 329	<p>Continued From page 79</p> <p>not document that the facility was monitoring her hours of sleep.</p> <p>On 5/19/17 at 8:25 am, the IDNS and Staff Development Coordinator [SDC] stated "hours of sleep" documentation could not be located in Resident #7's clinical record.</p> <p>3. Resident #6 was admitted to the facility on 12/30/16, with diagnoses which included dementia and depression.</p> <p>Resident #6's quarterly MDS assessment, dated 3/24/17, documented moderate cognitive impairment, mild signs and symptoms of depression, and extensive staff assistance required for all cares.</p> <p>A 12/30/16 Physician's Order documented Resident #6 received Lexapro 10 mg related to major depression.</p> <p>Resident #6's Depression Care Plan, revised 3/29/17, documented the presence of depression as evidenced by a sad, flat affect, and self-isolation.</p> <p>The April and May 2017 MARs and the April and May 2017 Progress Notes did not contain documentation that the facility monitored Resident #6 for signs and symptoms of depression or potential side effects of Lexapro.</p> <p>On 5/18/17 at 4:43 pm, the IDNS stated the facility should monitor residents for signs and symptoms of depression and/or side effects of related to the use of anti-depressants.</p>	F 329			

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

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F 329	Continued From page 80 Resident #6's clinical record did not contain documentation of persistent signs and symptoms of depression, there was no behavior monitoring for depression, and the facility did not monitor for potential side effects associated with Lexapro.  4. Resident #2 was admitted to the facility on 4/14/17, with diagnoses which included anxiety disorder.  Resident #2's initial MDS assessment, dated 4/25/17, documented no cognitive impairment.  A 4/14/17 Physician's Order documented Resident #2 was to receive Ativan 0.5 mg every 4 hours PRN for anxiety related to her disease process.  Resident #2's Antianxiety Care Plan, revised 5/4/17, documented staff was to monitor and document side effects and efficacy related to the use of Ativan. Resident #2's care plan did not document resident-specific behaviors staff was to monitor.  The 5/1/17 through 5/15/17 MAR documented Resident #2 received 4 doses of PRN Ativan; the Controlled Drug Record documented Resident #2 received 18 doses of Ativan during the same time frame. Resident #2 was not assessed for specific behaviors or for the efficacy of the PRN Ativan provided to address behaviors on 14 occasions.	F 329			
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION  483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post	F 356		7/18/17	

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F 356	Continued From page 81 the following information on a daily basis:  (i) Facility name.  (ii) The current date.  (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:  (A) Registered nurses.  (B) Licensed practical nurses or licensed vocational nurses (as defined under State law)  (C) Certified nurse aides.  (iv) Resident census.  (2) Posting requirements.  (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.  (ii) Data must be posted as follows:  (A) Clear and readable format.  (B) In a prominent place readily accessible to residents and visitors.  (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356			

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F 356	Continued From page 82  (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure nurse staffing information was posted and the data was retained for at least 18 months. These failures had the potential to affect all residents living in the facility, their family members, and/or visitors who wanted or needed the information to be uninformed of facility staffing levels. Findings include:  Nurse staffing information was not observed posted anywhere in the facility on 5/15/17, 5/16/17 and 5/17/17.  On 5/17/17 at 11:10 am, the Administrator said that nurse staffing information was not posted in the facility and she may have had "maybe a month's worth" of staffing information.  The facility failed to post nurse staffing information and retain the information for 18 months.	F 356	F356 1.Current nursing staffing will be posted at the front entrance in the designated entrance. 2. All residents have the potential to be affected by not posting the data. 3.The QAPI process identified the lack of a consistent process as the root cause of not posting the staffing data. A process has been developed to ensure the information is posted daily. 4.the administrator and/or designee will audit the posting, daily X7, weekly X3 and monthly X4. All audit findings will be reported to the QAPI committee for further monitoring and modification.  All office staff were in-serviced on June 2, 2017 to ensure ongoing compliance with posting of staff  5.Date of compliance 07/18/2017		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.  (i) This may include food items obtained directly from local producers, subject to applicable State	F 371		7/18/17	

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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>		
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F 371	<p>Continued From page 83 and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure food was stored under sanitary conditions. This was true for 10 of 10 (#1-#10) sampled residents and 31 of 31 other residents who resided in the facility and ate food prepared in the facility's kitchen. The deficient practice resulted in the storage of food without labeling of when opened, which created the potential for exposure to disease causing pathogens. Findings include:  On 5/15/17 at 12:00 pm, the walk-in refrigerator was observed with outdated and un-dated food items. Food items included:  * An opened, undated box of carrot cake which direction to staff to use within 4 days of opening</p>	F 371	<p>F 371</p> <p>(1)Address what corrective action(s) will be accomplished for those residents found to have been affected;  Residents#1,#2, #3, #4, #5, #6, #7, #8, #9, #10, and 31 other residents residing in facility;  Unlabeled food items were immediately discarded.</p> <p>(2)Address how you will identify other residents who have the potential to be affected, what corrective</p>		

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F 371	Continued From page 84 * An opened, undated package of smoked ham * An opened, undated package of pre-sliced cheese  On 5/15/17 at 12:34 pm, the Dietary Manager stated the facility should throw food items away within 5-7 days after opening and that all food should be labeled with a date the item was opened.	F 371	action will be taken;  All residents have the potential for being affected.  Food will be stored under sanitary conditions, dated when opened and discarded when outdated.  (3)What measures will be place and what systematic changes will be made:  DSM and/or designee;  DSM will educate staff on federal guidelines for food storage, dating of food and disposal of outdated food.  (4)indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and do not recur;  Food storage and labeling be audited daily X two weeks; weekly X two weeks; every two weeks X two months by the DSM and/or designee. QAPI will evaluate if monthly audits are indicated.  (5) Include dates when corrective action will be completed;	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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F 371	Continued From page 85	F 371			
F 431 SS=D	<p>483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--</p> <p>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>(g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p>	F 431	July 18, 2017.	7/18/17	

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F 431	<p>Continued From page 86</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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure medications were labeled. This was true for 1 of 8 residents (#13) observed during medication pass and created the potential for infection from cross contamination if Resident #13's unlabeled Symbicort inhaler was used for another resident. Findings include:  On 5/16/17 at 8:10 am, Licensed Practical Nurse (LPN) #2, who was being oriented by Registered Nurse (RN) #1, was observed as she removed an unlabeled Symbicort inhaler from a clear plastic bag at the medication cart. Resident #13's name was written on the plastic bag. LPN #2, with RN #1 in attendance, then took the inhaler to Resident #13's room and administered 2 puffs of the medication to the resident.</p>	F 431	<p>F 431</p> <p>(1)Address what corrective action(s) will be accomplished for those residents found to have been affected;  Resident #13 a labeled Symbicort inhaler was obtained from the pharmacy.</p> <p>(2)Address how you will identify other residents who have the potential to be affected, what corrective action will be taken;  All residents have the potential to be affected. All residents medications will have a pharmaceutical label.</p>		

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F 431	Continued From page 87 Immediately afterward, upon return to the medication cart, RN #1 said Resident #13 once self-administered the Symbicort and the bag with the label must have been thrown away.	F 431	(3) What measures will be place and what systematic changes will be made:  All licensed nurses will be in-serviced on having medications labeled by the pharmacy.  (4) indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and do not recur;  Medications will be audited for pharmaceutical labeling; daily X two weeks; weekly X two weeks; every two weeks X two months by the DNS and/or designee. QAPI will evaluate if monthly audits are indicated.  (5) Include dates when corrective action will be completed;  July 18, 2017.		
F 490 SS=F	483.70 EFFECTIVE 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:	F 490		7/18/17	

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F 490	<p>Continued From page 88</p> <p>Based on observation, resident and staff interviews, and review of facility policies, investigations, grievances, and Incident and Accident Reports, it was determined the facility was not administered in a manner that effectively used its resources to assist residents attain or maintain their highest practicable well-being. Sufficient staff supervision was not provided to residents, policies were not followed, updated to reflect current standards of practice, and/or developed to provide staff guidance. Physician orders and care plans were not followed and care plans were not followed and revised as necessary. These failed practice:</p> <p>a) Placed 2 of 5 (#2 and #5) sampled residents reviewed for diabetic management, and the other 10 residents in the facility with a diagnosis of diabetes mellitus [DM], in Immediate Jeopardy of serious harm, impairment, or death, due to hypo/hyperglycemia.</p> <p>b) Resulted in harm to 1 of 13 (#11) sampled residents when the facility failed to assess her complaint of injury in a timely manner or control the resulting pain after she experienced a falls.</p> <p>c) Resulted in harm to 2 of 7 sample residents (#3 &amp; #11) reviewed for falls when they experienced repeated falls resulting in bone fractures.</p> <p>d) Resulted in harm to Resident #11 when she experienced 3 falls in 2 days that resulted in extensive bruising and severe pain to the left chest and rib cage area and required an increase in 2 as-needed (PRN) pain medications and an anti-anxiety medication. The pain and</p>	F 490	<p>F490</p> <p>(1)Address what corrective action(s) will be accomplished for those residents found to have en affected; Resident #2 resident transferred to North Idaho in-patient hospice 05/25/2017.</p> <p>Resident #14 expired 06/06/2017.</p> <p>Resident #5,15,16,17,18,19,20,21 blood glucose are monitored as ordered, have parameters for hyper/hypo glycemc episodes. BGs outside of ordered parameters are reported to physician.</p> <p>Resident #11 was transferred to North Idaho in-patient hospice 04/25/2017.</p> <p>Resident #3 has not had any falls.</p> <p>(2)Address how you will identify other residents who have the potential to be affected, what corrective action will be taken;</p> <p>All diabetic residents have new orders to follow facility guidelines for diabetic management, care plans and MARs reflect the change in diabetic management orders; completed 05/18/2017.</p> <p>All residents have the potential</p>		

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F 490	<p>Continued From page 89</p> <p>anti-anxiety medications were administered without consistent indication for use, resident specific behaviors, or monitoring for effectiveness. Resident #11 subsequently experienced two more falls and 3 fractured ribs.</p> <p>These deficient practices, and the failure of the facility's administration to ensure previously cited deficient practices did not recur, had the potential to harm all residents in the facility if care and services were not provided in a manner that was safe and effective. Findings include:</p> <p>1. Refer to F309 of the current 5/22/17 recertification survey as it relates to the failure of facility administration to ensure sample residents Resident #2 and #5, and the other 10 residents in the facility with a diagnosis of DM, were not placed in Immediate Jeopardy of serious harm, impairment, or death, due to hypo/hyperglycemia.</p> <p>The deficient practices described at F309 describe the failure of facility administration to ensure:</p> <ul style="list-style-type: none"> <li>* Physician orders of residents who were diabetic were followed.</li> <li>* Staff followed the facility's diabetes policies and procedures.</li> <li>* Policies and procedures related to hyperglycemia were in place to provide guidance to staff.</li> <li>* Residents were not administered medications without physician orders.</li> </ul> <p>Additionally, refer to F309 of the current 5/22/17 recertification survey as it relates to harm to</p>	F 490	<p>to fall and be affected.</p> <p>Residents will be assessed for fall risk using the fall tool UDA.</p> <p>Residents having accidents will be assessed for injuries and pain in a timely manner and receive pain medications as ordered by the physician.</p> <p>All residents receiving narcotic pain medications have the potential to be affected. Residents on narcotic pain medications will have the MAR and narcotic book checked daily to ensure nurses are following physician orders.</p> <p>All residents with orders for Ativan have the potential I to be affected. Residents receiving Ativan will have the MAR and Narcotic book checked daily to ensure nurses are following physician orders.</p> <p>(3)What measures will be place and what systematic changes will be made:</p> <p>The DNS and/or designee will obtain orders for</p>		

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F 490	<p>Continued From page 90</p> <p>Resident #11 when the facility failed to assess and provide treatment without delay when she complained of increased pain and injury following a fall.</p> <p>The facility was previously cited at F309 during the prior 3 recertification surveys and 1 revisit survey:</p> <ul style="list-style-type: none"> <li>* 6/24/16 recertification survey - related to resident harm due to delayed treatment, potential for harm due lack of effective pain management, and lack of indications for use and monitoring of psychotropic medications resulting in harm</li> <li>* 10/26/16 revisit survey - resulting in harm</li> <li>* 9/26/14 recertification survey</li> <li>* 7/19/13 recertification survey</li> </ul> <p>No surveys were completed at the facility during calendar year 2015.</p> <p>2. Refer to F323 of the current 5/22/17 recertification survey as it relates to the failure of the facility to provide supervision, ensure staff followed care plans, and updated care plans to prevent repeated falls and related fractures. Resident #3, was harmed when she fell 4 times in 24 days and sustained fractures to the right femur that required surgical intervention. Resident #11 experienced 3 falls in 2 days that resulted in extensive bruising and severe pain to her left chest and rib area and required increased use of 2 pain medications and an antianxiety medication. Resident #11 was harmed when she fell twice more and was diagnosed with 3 rib fractures.</p> <p>The facility was previously cited at F323 during</p>	F 490	<p>hyper/hypo glyceemic protocols, when to administer insulin, and when to notify physician if BG levels are outside of the physician established parameters.</p> <p>Audits will be completed on narcotic pain medication/Ativan documentation of compliance with physicians' orders.</p> <p>All falls will be audited for injuries, pain assessment and the administration of pain medications as ordered by the physician.</p> <p>(4)indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and do not recur;</p> <p>Weekly interchange with RVP or designee to review progress and accuracy of audits. Audits chosen governing board representative will Be reviewed weekly X 4 weeks; every two weeks X 2 month; monthly X 3. QAPI evaluate if monthly Audits are indicated with the input of the governing Body.</p>		

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F 490	<p>Continued From page 91 the prior 3 recertification surveys and 1 revisit survey:</p> <ul style="list-style-type: none"> <li>* 6/24/16 recertification survey - related to lack of supervision and assistance to prevent falls</li> <li>* 10/26/16 revisit survey - related to lack of supervision to prevent falls</li> <li>* 9/26/14 recertification survey</li> <li>* 7/19/13 recertification survey</li> </ul> <p>3. Refer to F329 of the current 5/22/17 recertification survey as it relates to the facility's failure to provide residents with medications as ordered by a physician and avoid excessive dosing, with specific target behaviors identified for monitoring, administered following identified behaviors, with specific indications for use, and monitored for effectiveness. Resident #11 was harmed when she experienced 3 falls in 2 days that resulted in extensive bruising and severe pain to the left chest and rib cage area and required an increase in 2 as-needed (PRN) pain medications and an anti-anxiety medication. The pain and anti-anxiety medications were administered without consistent indication for use, resident specific behaviors, or monitoring for effectiveness. Resident #11 subsequently experienced two more falls and 3 fractured ribs.</p> <p>The facility was previously cited at F329 during the prior 3 recertification surveys and 2 revisit surveys:</p> <ul style="list-style-type: none"> <li>* 6/24/16 recertification survey</li> <li>* 10/26/16 revisit survey</li> <li>* 12/13/16 revisit survey</li> <li>* 9/26/14 recertification survey</li> <li>* 7/19/13 recertification survey</li> </ul>	F 490	<p>All diabetics with orders for blood glucose monitoring will be audited daily X two weeks; weekly X two weeks; every two weeks X two months by the DNS and/or designee. QAPI will evaluate if monthly audits are indicated.</p> <p>All narcotic pain administration and Ativan administration audited daily X two weeks; weekly X two weeks; every two weeks X two months by the DNS and/or designee. QAPI will evaluate if monthly audits are indicated.</p> <p>The DNS and/or designee will review falls daily Monday <input type="checkbox"/> Friday for injuries, pain assessment and the administration of pain medications as ordered by the physician.</p> <p>Administrator will review QAPI policy and procedure and process for identifying resident concerns. Administrator will review previous deficiencies in past years and ensure QAPI formulates measurable plans maintain and achieve compliance for effective administration/resident well-being</p> <p>(5) Include dates when corrective</p>		

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F 490	Continued From page 92  4. The facility administration also failed to ensure previously cited deficient practices at F157 and F315 did not recur.  * Refer to F157 of the current 5/22/17 recertification survey as it relates to the failure of the facility to notify physicians of hyperglycemic events and falls in a timely manner. Deficient practices at F157 were also identified during the previous recertification survey completed on 6/24/16 and subsequent revisit survey completed on 10/26/16.  * Refer to F315 of the current 5/22/17 recertification survey as it relates to the facility's failure to provided adequate catheter care. Deficient practices at F315 was also cited during the previous recertification survey completed on 6/24/16.  On 5/19/17 at 3:37 pm, the Administrator stated the facility had not identified the diabetic management concern as an issue, but had been "working on" falls, behavior monitoring, and abuse and neglect concerns.	F 490	action will be completed;  July 18, 2017.		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  (i) Medical records.	F 514		7/18/17	

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F 514	Continued From page 93 (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-  (i) Complete;  (ii) Accurately documented;  (iii) Readily accessible; and  (iv) Systematically organized  (5) The medical record must contain-  (i) Sufficient information to identify the resident;  (ii) A record of the resident's assessments;  (iii) The comprehensive plan of care and services provided;  (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;  (v) Physician's, nurse's, and other licensed professional's progress notes; and  (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined the facility failed to ensure each resident's clinical record was accurate. This was true for 3 of 13 sample residents (#3, #6, & #11) and created the	F 514	F514 (1)Address what corrective action(s) will be accomplished for those residents found to have been affected;		

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F 514	<p>Continued From page 94</p> <p>potential for more than minimal harm if medical decisions were based on documentation that was out of chronological order and when the residents were not in the facility, or if residents experienced embarrassment or withdrew socially due to the lack of oral hygiene. Findings include:</p> <p>1. Resident #3 was admitted to the facility in May 2016, with multiple diagnoses including dementia with behavioral disturbance, restlessness, and agitation. She was readmitted on 2/20/17, for orthopedic aftercare following surgical intervention of a right hip fracture related to a fall in the facility.</p> <p>Resident #3's care plan documented staff was to monitor her every 15 minutes, initiated 5/24/16 and revised 1/25/17.</p> <p>On 2/15/17, Resident #3 experienced a 4th fall in 24 days. She sustained 2 fractures to the right femur. Resident #3 was transported out of the facility by emergency medical services on 2/15/17 and hospitalized until 2/20/17.</p> <p>Documentation of Resident #3's every 15 minute checks on 2/15/17, was out of sequence chronologically. For example, 7:30 am was followed by 12:16 pm, which was followed by 9:30 am, then 12:16 pm again, then 10:30 am.</p> <p>Every 15 minute checks were also documented on 2/15/17 after Resident #3 was transported to the hospital, and on 2/16/17, 2/17/16, 2/18/17, 2/19/17 and 2/20/17 when she remained hospitalized.</p> <p>On 5/19/17 at 3:30 pm, the Interim Director of</p>	F 514	<p>Resident #3 every fifteen minute checks were discontinued 04/14/2017.</p> <p>Resident #6 every fifteen minute checks were discontinued 04/13/2017.</p> <p>Resident #6; ability to independently provide oral care will be re –evaluated using oral/dental UDA with care plan reviewed and updated.</p> <p>Resident #11 was transferred to North Idaho In-patient hospice on 04/25/2017.</p> <p>(2)Address how you will identify other residents who have the potential to be affected, what corrective action will be taken;</p> <p>All residents have the potential to be affected.</p> <p>All resident will have oral care self-performance re-evaluated using oral/dental UDA with care plan reviewed and updated.</p> <p>(3)What measures will be put in place and what systematic changes will be made:</p> <p>Residents that necessitate with behaviors that could</p>		

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F 514	<p>Continued From page 95</p> <p>Nursing Services (IDNS) said the out of sequence documentation for every 15 minute checks may have been due to more than one staff documenting the checks and that multiple entries with the same time may have been because staff documented multiple checks at one time. The IDNS said that documentation of every 15 minute checks after Resident #3 left the facility on 2/15/17, and when the resident was not in the facility, was not accurate and it called into question the accuracy of all the related documentation.</p> <p>2. Resident #11 was readmitted to the facility on 1/28/16, with diagnoses which included malignant neoplasm of the lung [lung cancer], dementia, and mood disorder.</p> <p>Resident #11's quarterly Minimum Data Set [MDS] assessment, dated 2/22/17, documented no cognitive impairment, staff supervision required with transfers and ambulation, 1 non-injury fall prior the assessment, and rejection of cares 1-3 days during the look back period.</p> <p>Resident #11's Fall Care Plan, updated on 4/3/17, documented staff was to monitor Resident #11 every 15 minutes.</p> <p>Resident #11's Activities of Daily Living [ADL] Flowsheet for 4/7/17, where the 15 minute checks were to be documented, did not include documentation she was monitored every 15 minutes from 10:00 pm to 12:00 am.</p> <p>A Chest X-Ray Report, dated 4/10/17 at 9:11 am, documented Resident #11 received a lateral and posteroanterior [PA] chest x-ray for "lung cancer"</p>	F 514	<p>cause self-harm and/or harm to others will be transferred for further evaluation</p> <p>Clinical staff will be in serviced on providing accurate documentation to ensure clinical records are complete and accurate.</p> <p>CNAs will receive education to offer, encourage and assist residents with oral care as indicated from the Oral/Dental UDAs per POC instructions and care plans.</p> <p>(4)indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and do not recur;</p> <p>All resident's oral care and assistance needed will be monitored by DNS/designee daily X 2 ; weekly X 2; every 2 weeks X 2 months and monthly X 3 months. QAPI will evaluate if monthly audits need to be continued.</p> <p>HIM/designee will monitor documentation accuracy when residents are not in the facility to ensure accurate documentation. Weekly X 4; every two weeks X2 months; Monthly X 3 Months. QAPI will evaluate if monthly audits need to be continued.</p>		

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F 514	<p>Continued From page 96 and "left sided pain."</p> <p>On 5/22/17 at 9:00 am, the IDNS stated Resident #11 was out of the building for the chest x-ray on the 4/10/17. She stated she did not know how long Resident #11 was out of the building.</p> <p>Resident #11's ADL Flowsheet for 4/10/17, documented staff completed the 15-minute checks throughout the day, including the time she was out of the building for an x-ray.</p> <p>On 5/19/17 at 3:30 pm, the IDNS said that documentation of every 15 minute checks after a resident left the facility was not accurate and it called into question the accuracy of all the resident's related documentation.</p> <p>The facility failed to ensure clinical records were complete and accurate.</p> <p>3. Resident #6 was admitted to the facility on 12/30/16, with diagnoses which included dementia and deposits on teeth.</p> <p>Resident #6's quarterly Minimum Data Set [MDS] assessment, dated 3/24/17, documented moderate cognitive impairment, mild signs and symptoms of depression, and extensive staff assistance required for personal hygiene.</p> <p>The ADL Care Plan, revised 3/28/17, documented Resident #6 required assistance with ADL's. The care plan documented Resident #6 was able to brush her teeth with staff set-up and cueing.</p> <p>ADL flowsheets from 5/1/17 through 5/17/17 did</p>	F 514	(5) Include dates when corrective action will be completed; July 18, 2017.		

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

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F 514	Continued From page 97 not contain documentation that daily oral care was provided to Resident #6.  On 5/18/17 at 5:12 pm, the Interim Director of Nursing Services stated oral care should be performed in the morning, especially for a resident with diagnoses of dementia and deposits on teeth, and should be documented on the ADL flowsheet.	F 514			
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  (g) Quality assessment and assurance.  (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:  (i) The director of nursing services;  (ii) The Medical Director or his/her designee;  (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and  (g)(2) The quality assessment and assurance committee must :  (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and  (ii) Develop and implement appropriate plans of	F 520		7/18/17	

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F 520	<p>Continued From page 98 action to correct identified quality deficiencies;</p> <p>(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.</p> <p>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and review of facility policies, grievances, investigations, and Incident and Accident Reports, it was determined the facility's QAA program failed to ensure sufficient monitoring of facility care processes to protect residents from harm and ensure previously identified deficient practices did not recur. These failed practice:</p> <p>a) Placed 2 of 5 (#2 and #5) sampled residents reviewed for diabetic management, and the other 10 residents in the facility with a diagnosis of diabetes mellitus [DM], in Immediate Jeopardy of serious harm, impairment, or death.</p> <p>b) Resulted in harm to 1 of 13 (#11) sampled residents when the facility failed to assess her complaint of injury in a timely manner or control the resulting pain after she experienced a fall.</p> <p>c) Resulted in harm to 2 of 7 sample residents (#3 &amp; #11) reviewed for falls when they</p>	F 520	<p>1)Corrective actions for those residents identified: Resident #2,#5 Blood glucose are monitored as ordered, have parameters for hyper/hypo glycemc episodes. BGs outside of ordered parameters are reported to physician.</p> <p>Blood glucose results and diabetic medication orders for Resident #2 and #5 have been reviewed by the PCP or Medical director/on call MD by 5/18/2017. Completed via phone call with Physician 05/18/2017. Vital signs were assessed for Resident #2 and Resident #5 on 05/18/2017. Responsible family members for resident #2 and Resident #5 were notified of blood glucose results on 05/18/2017.</p>		

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F 520	<p>Continued From page 99 experienced repeated falls resulting in bone fractures.</p> <p>d) Resulted in harm to Resident #11 when she experienced 3 falls in 2 days that resulted in extensive bruising and severe pain to the left chest and rib cage area and required an increase in 2 as-needed (PRN) pain medications and an anti-anxiety medication. The pain and anti-anxiety medications were administered without consistent indication for use, resident specific behaviors, or monitoring for effectiveness. Resident #11 subsequently experienced two more falls and 3 fractured ribs.</p> <p>Findings include:</p> <p>1. Refer to F309 of the current 5/22/17 recertification survey as it relates to:</p> <p>*The failure of facility's QAA program to identify deficient practices which placed sample residents Resident #2 and #5, and the other 10 residents in the facility with a diagnosis of DM, in Immediate Jeopardy of serious harm, impairment, or death, due to lack of, or incorrect, treatment of hypo and hyper glycemia.</p> <p>* The failure of the facility's QAA program identify deficient practices which harmed Resident #11 when she complained of increased pain and injury following a fall and did not receive prompt treatment.</p> <p>The facility was previously cited at F309 during the prior 3 recertification surveys and 1 revisit survey, as follows:</p>	F 520	<p>Guidelines for management hyper/hypo glycemc incidents was written on 05/18/2017 and approved by Physician on 05/18/2017. Prior to beginning work nurses and those nurses already on duty were in-serviced on blood glucose parameters for hyper/hypo glycemc guideline/treatment; When to notify the physician and responsible family members and documentation in PCC progress notes of notification and interventions.</p> <p>All licenses staff have been trained on 05/18/2017 As indicated.</p> <p>QAPI monitor compliance.</p> <p>Resident #11 was transferred to Northern Idaho in-patient hospice 04/25/2017</p> <p>Resident #3 All falls with this resident will Be reviewed by the fall committee the next Working day to ensure interventions have been put into place To prevent further falls.</p> <p>The fall committee has been reeducated On the necessary monitoring to ensure Residents safety.</p> <p>(2)Address how you will identify other residents who have the potential to be affected,</p>		

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F 520	<p>Continued From page 100</p> <ul style="list-style-type: none"> <li>* 6/24/16 recertification survey - related to resident harm due to delayed treatment, potential for harm due lack of effective pain management, and lack of indications for use and monitoring of psychotropic medications</li> <li>* 10/26/16 revisit survey</li> <li>* 9/26/14 recertification survey</li> <li>* 7/19/13 recertification survey</li> </ul> <p>No surveys were completed at the facility in calendar year 2015.</p> <p>2. Refer to F323 of the current 5/22/17 recertification survey as it relates to the failure of the facility's QAA program to ensure residents received sufficient supervision and interventions to protect residents from falls. Resident #3, was harmed when she fell 4 times in 24 days and sustained fractures to the right femur that required surgical intervention. Resident #11 experienced 3 falls in 2 days that resulted in extensive bruising and severe pain to her left chest and rib area and required increased use of 2 pain medications and an antianxiety medication. Resident #11 was harmed when she fell twice more and was diagnosed with 3 rib fractures.</p> <p>The facility was previously cited at F323 during the prior 3 recertification surveys and 1 revisit survey:</p> <ul style="list-style-type: none"> <li>* 6/24/16 recertification survey - related to lack of supervision and assistance to prevent falls</li> <li>* 10/26/16 revisit survey - related to lack of supervision to prevent falls</li> <li>* 9/26/14 recertification survey</li> <li>* 7/19/13 recertification survey</li> </ul>	F 520	<p>what corrective action will be taken; All diabetic residents have the potential to be affected. All diabetic residents have new orders to follow facility guidelines for diabetic management. Care plans and MARs reflect the change in diabetic management orders; All LN received training on 05/18/2017.</p> <p>ALL residents who complain of pain will be assessed immediately as to the cause of the pain and Physicians will be notified. If the resident continues to complain the Physicians will be notified of this and encouraged to seek further evaluation of the root cause of the pain. This evaluation will be completed by using the Pain UDA and Mobility UDA, and e Interact Change in condition assessment form.</p> <p>All resident having falls will have their falls reviewed the next working day to ensure the interventions that have been placed into action will help prevent further falls and participate in the education of staff and monitoring of the resident.</p>		

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F 520	Continued From page 101  On 5/19/17 at 3:37 pm, the Administrator stated the facility was currently processing falls through the QAA process and determined the root cause of falls in the facility was lack of staff training and resident supervision. She stated the facility held Fall Committee meetings after a fall occurred, identified the cause of the fall, and then reviewed and implemented interventions to determine effectiveness.  3. Refer to F329 of the current 5/22/17 recertification survey as it relates to the failure to the failure of the facility's QAA program to ensure residents received medications as ordered by a physician, with specific target behaviors identified, specific indications for use, and monitoring of effectiveness. Resident #11 was harmed when she experienced 3 falls in 2 days that resulted in extensive bruising and severe pain to the left chest and rib cage area, and pain and anti-anxiety medications were administered without consistent indication for use, without resident-specific behaviors identified, and monitoring for effectiveness. Resident #11 subsequently experienced two more falls and 3 fractured ribs.  The facility was previously cited at F329 during the prior 3 recertification surveys and 1 revisit survey:  * 6/24/16 recertification survey - related to lack of supervision and assistance to prevent falls * 10/26/16 revisit survey - related to lack of supervision to prevent falls * 9/26/14 recertification survey * 7/19/13 recertification survey	F 520	QAPI will audit (every working day) diabetic management assessment, pain management and fall follow through and educate as indicated  (3)What measure will be put in place: Orders were obtained for diabetic residents specifying how to manage hyper/hypo glycemc episodes and including blood glucose parameters for physician notification. Care plans were updated. Staff education on 5/18/17 (and on-going) on the management of hyper/hypo glycemc episodes and when to notify the physician/family. Physician/family will be notified of all incidents as they occur.  All residents with new onset of pain will have a physical assessment and pain assessment communicated to the physic for orders as indicated.  All resident having falls will have their falls reviewed the next working day to ensure the interventions that have been placed into action will help prevent further falls and participate in the education of staff and monitoring of		

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F 520	<p>Continued From page 102</p> <p>4. The facility's QAA program also failed to ensure previously cited deficient practices at F157 and F315 did not recur.</p> <p>* Refer to F157 of the current 5/22/17 recertification survey as it relates to the failure of the facility to notify physicians of hyperglycemic events and falls in a timely manner. Deficient practices at F157 were also identified during the previous recertification survey completed on 6/24/16 and subsequent revisit survey completed on 10/26/16.</p> <p>* Refer to F315 of the current 5/22/17 recertification survey as it relates to the facility's failure to provided adequate catheter care. Deficient practices at F315 were also cited during the previous recertification survey completed on 6/24/16.</p> <p>On 5/19/17 at 3:37 pm, the Administrator said she attended the facility's QAA committee meeting, but did not keep the notes for those meetings. The Administrator stated the QAA committee also identified abuse related issues, behavior monitoring issues, and notification of change concerns, and were working on these, as well. The Administrator stated the QAA committee had not recently identified diabetic management, pain management, implementation of physician orders, completion of neuro-checks after resident falls, and lack of catheter care, identified during the current 5/22/17 survey as resident care concerns.</p>	F 520	<p>the resident.</p> <p>QAPI will audit (every working day) diabetic management assessment, pain management and fall follow through and educate as indicated</p> <p>All residents All diabetics with orders for blood glucose monitoring have been audited daily X two weeks; weekly X two weeks; every two weeks X two months by the DNS and/or designee. QAPI will evaluate if monthly audits are indicated. All narcotic pain administration and Ativan administration audited daily X two weeks; weekly X two weeks; every two weeks X two months by the DNS and/or designee. QAPI will evaluate if monthly audits are indicated.</p> <p>(4)Indicate how the facility plans to monitor Performance to ensure the corrective actions are effective;</p> <p>Weekly interchange with RVP or designee to review progress and accuracy of audits. Audits chosen governing board representative will Be reviewed weekly X 4 weeks; every two</p>		

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F 520	Continued From page 103	F 520	<p>weeks X 2 month; monthly X 3. QAPI evaluate if monthly Audits are indicated with the input of the governing Body.</p> <p>All diabetics with orders for blood glucose monitoring have been audited daily X two weeks; weekly X two weeks; every two weeks X two months by the DNS and/or designee. QAPI will evaluate if monthly audits are indicated.</p> <p>All narcotic pain administration and Ativan administration audited daily X two weeks; weekly X two weeks; every two weeks X two months by the DNS and/or designee. QAPI will evaluate if monthly audits are indicated.</p> <p>All residents with new onset of pain will have a physical assessment and pain assessment communicated to the physic for orders as indicated.</p> <p>All resident having falls will have their falls reviewed the next working day to ensure the interventions that have been placed into action will help prevent</p>		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/22/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>		
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F 520	Continued From page 104	F 520	<p>further falls and participate in the education of staff and monitoring of the resident.</p> <p>All residents with new onset pain and falls audited daily X two weeks; weekly X two weeks; every two weeks X two months by the DNS and/or designee. QAPI will evaluate if monthly audits are indicated.</p> <p>(5)Date facility will be in compliance: July 18th</p>		