



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RUSS BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR  
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P.O. Box 83720  
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July 6, 2017

Richard Strong, Administrator  
Meridian Center Genesis Healthcare  
1351 West Pine Avenue  
Meridian, ID 83642-5031

Provider #: 135125

Dear Mr. Strong:

On **June 16, 2017**, a survey was conducted at Meridian Center Genesis Healthcare 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 no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

Richard Strong, Administrator  
July 6, 2017  
Page 2 of 4

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 **July 17, 2017**. Failure to submit an acceptable PoC by **July 17, 2017**, may result in the imposition of penalties by **August 10, 2017**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **July 21, 2017 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **September 14, 2017**. A change in the seriousness of the deficiencies on **July 31, 2017**, may result in a change in the remedy.

Richard Strong, Administrator  
July 6, 2017  
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **September 14, 2017** includes the following:

Denial of payment for new admissions effective **September 14, 2017**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 13, 2017**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **September 14, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

Richard Strong, Administrator  
July 6, 2017  
Page 4 of 4

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 **July 17, 2017**. If your request for informal dispute resolution is received after **July 17, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

A handwritten signature in cursive script that reads "Nina Sanderson LSW".

Nina Sanderson, LSW, Supervisor  
Long Term Care

NS/lj

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

PRINTED: 07/26/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/16/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN CENTER GENESIS HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification survey conducted at the facility from June 12, 2017 to June 16, 2017.  The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Susan Costa, RN Rachel Moorehead-Lopez, MSW Melanie Tatom, RN  Survey Abbreviations: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CDM = Certified Dietary Manager CHF = Congestive Heart Failure CNA = Certified Nurse Assistant DON = Director of Nursing g = Gram LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligram MRR = Medication Review Report PPD = Purified Protein Derivative PRN = As Needed TB = Tuberculosis UM = Unit Manager	F 000			
F 166 SS=E	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES  (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.  (j)(3) The facility must make information on how	F 166		8/10/17	

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

TITLE

(X6) DATE

Electronically Signed

07/17/2017

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 166	<p>Continued From page 1 to file a grievance or complaint available to the resident.</p> <p>(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:</p> <p>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;</p> <p>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written</p>	F 166			

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F 166	<p>Continued From page 2</p> <p>grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;</p> <p>(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;</p> <p>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;</p> <p>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;</p> <p>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and</p> <p>(vii) Maintaining evidence demonstrating the</p>	F 166			

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F 166	<p>Continued From page 3</p> <p>result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on Resident Council Meeting minutes, Resident Group interview, and staff interview, it was determined the facility failed to resolve grievances that residents were not routinely offered bedtime snacks. This deficient practice was true for 6 of 8 residents in a Group interview and potentially affected any resident in the facility filing a formal grievance. This failed practice created the potential to negatively affect residents' psychosocial well-being related to unresolved concerns. Findings include:</p> <p>1. The 3/14/17 Resident Council Meeting minutes documented residents were not offered a bedtime snack. The minutes documented the DON [Director of Nursing] would address the concern.</p> <p>On 6/13/17 at 2:00 pm, during the Resident Group interview, 6 of 8 residents said they still were not offered a bedtime snack and there had not been follow-up by staff on the grievance.</p> <p>On 6/15/17 at 2:20 pm, the DON said he or his staff did not follow-up with the Resident Council's concern regarding bedtime snacks.</p> <p>2. Refer to F368 as it relates to the failure of the facility to ensure residents were offered bedtime snacks.</p>	F 166	<p>Residents Affected: A grievance was initiated by the Center Executive Director (CED) on 07/17/2017 related to resident concerns that they were not being offered HS snacks. A re-implementation plan was developed and approved by the CED and reviewed with the residents at a follow-up resident council meeting on 07/18/2017.</p> <p>Potential Residents Affected: A review of resident council meeting minutes for the last 90 days was completed by the CED on or before 07/21/2017 for any un-addressed resident concern or grievances. Any issues found will be documented as a formal grievance.</p> <p>Systematic Change/Education: Meridian Genesis Center staff will be educated by the CED or designee on or before 07/21/2017 on providing written follow up to grievances, resident council concerns/issues or other complaints made by residents and or families. Documented of follow-up education, training, individual counseling must be provided to CED for the grievance file.</p> <p>Activity Directors were educated on or before 07/21/2017 on providing formal</p>		

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F 166	Continued From page 4	F 166	<p>grievances regarding resident complaints from monthly resident council meeting to CED for follow up.</p> <p>Staff was re-educated by CED or designee on or before 07/21/2017 on the formal grievance process, timeliness of grievance response, and providing written documentation for all grievances.</p> <p>Beginning the week of 07/17/2017, Resident Council Minutes will be reviewed by IDT in morning meeting to address any concerns and/or grievances brought forward from Resident Council</p> <p>Monitors: Beginning the week of 07/17/2017, The CED will audit resident council meeting minutes to ensure that resident concerns are addressed in a timely manner and that the grievance procedure is followed.</p> <p>These audits will be conducted monthly X3 months or until resolved.</p> <p>The results of these audits will be compiled by the CED and reported to the QAPI committee for review for three months or until substantial compliance is maintained. The CED is responsible for monitoring and follow-up.</p>		
F 221 SS=D	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS  §483.10(e) Respect and Dignity.	F 221		8/10/17	

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F 221	<p>Continued From page 5</p> <p>The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).</p> <p>42 CFR §483.12, 483.12(a)(2) 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.</p> <p>(a) The facility must-</p> <p>(1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, record and policy review, and staff interview, it was determined the facility failed to ensure a resident was free from unwarranted restraints. This was true for 1 of 1 (#1) resident reviewed for restraints and had the potential for physical harm if restraints were improperly used, and the potential for</p>	F 221	<p>Residents Affected: Resident #1 was reviewed by members of the IDT for fall prevention, safety, and wheelchair positioning on or before 07/28/2017. An OT therapy evaluation for wheelchair positioning was completed by the OT on or before 07/31/2017. Upon</p>	

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F 221	<p>Continued From page 6</p> <p>psychosocial harm if the resident experienced a decline related to restricted movement. Findings include:</p> <p>The facility's Use of Restraints policy, revised 11/28/16, documented:</p> <ul style="list-style-type: none"> <li>* "When the use of restraints is indicated, the Center must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.</li> <li>* "If the device cannot be easily removed by the [resident] and/or restricts freedom of movement, the Restraint Evaluation/Reduction or restraint evaluation will be completed...prior to the application of any restraint.</li> <li>* "[Residents] with a restraint will be re-assessed as follows or per state regulations: <ul style="list-style-type: none"> <li>- monthly for 3 months,</li> <li>- then quarterly, and</li> <li>- with any significant change in condition."</li> </ul> </li> </ul> <p>Resident #1 was admitted to the facility on 8/4/16, with multiple diagnoses which included dementia with behavioral disturbances, Stage IV pressure ulcer, Alzheimer's disease, and anxiety.</p> <p>Resident #1's 8/5/16 admission MDS assessment documented:</p> <ul style="list-style-type: none"> <li>* Physical restraints used daily</li> <li>* Severely cognitive impairment</li> <li>* Extensive staff assistance required for bed mobility and transfers</li> </ul> <p>Resident #1's clinical record included a</p>	F 221	<p>completion of the review and evaluating a trial reduction of the resident seat belt restraint, the unit manager will updated the resident's MD and resident responsible party on or before 08/03/2017. Follow-up will be completed as indicated by resident response to restraint reduction and MD review. The resident's plan of care was updated to include supervision and activities prior to the trial reduction and evaluation. Social services will evaluate resident #1 for any psychosocial issues related to not trialing a least restrictive device prior to placing a restraint on or before 07/28/2017.</p> <p>LN #4 was re-educated by the Practice Development Manager (NPE) or designee on or before 07/26/2017 related to restraint utilization, and requirements for release.</p> <p>Potential Residents Affected: A review of current residents in the facility that have restrictive devices will be completed on or before 07/26/2017. Follow-up including device evaluation, consent, and potential reduction will be completed as indicated.</p> <p>Systematic Change/Education: Nursing staff will be re-educated by the Practice Development Manager (NPE) on restraints including required evaluation (safety, less restrictive devices, and</p>		

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F 221	<p>Continued From page 7</p> <p>physician's order, dated 8/4/16, for an "alarming seat belt to wheelchair."</p> <p>A Restrictive Device Consent for an alarming seatbelt, dated 11/30/16, documented the device was necessary for safety. The form did not include a signature by Resident #1 or his/her Power of Attorney, but documented the consent was "verbal" and included the signature of two nurses.</p> <p>A Device Evaluation, initiated 11/30/16, documented, "This device has been assessed for safety and does not pose a risk for this resident." The areas for an initial and date were blank. Sections of the form titled, "Interventions Attempted to Date," and "Can [resident] self release the device on command?" were blank. The form documented "safety" as the medical justification for use of a restraint, and noted quarterly evaluations took place 3/3/17 and 5/30/17.</p> <p>From 6/12/17 to 6/16/17, Resident #1 was observed in her wheelchair with a fastened alarming seatbelt in place under what appeared to be an apron.</p> <p>On 6/13/17 at 3:50 pm, with LN #4 in attendance, Resident #1 did not respond when asked to unfasten the seatbelt. LN #4 stated Resident #1 was provided an apron covering the alarming seatbelt to discourage her from releasing its Velcro strap.</p> <p>On 6/14/17 at 3:45 pm, Unit Manager [UM] #2 stated Resident #1 was able to release the seatbelt independently, however Resident #1 did</p>	F 221	<p>medical justification), informed consent, and requirements for restraint use and release on or before 07/26/2017.</p> <p>Beginning 08/10/2017 the Center Nurse Executive or Unit Manager will validate that components of the restraint evaluation, informed consent, and plan of care are in place prior to initiation of a restraint.</p> <p>Monitors: Beginning the week of 07/31/2017 the CNE or designee will review center residents with restraints for completed informed consent, evaluation, safety and medical justification, and plan for release. These audits will be completed weekly times 4 weeks, monthly times 2 months, quarterly and with any change of condition. The CNE or designee will compile. The results of the audits and report to the QAPI committee for review monthly times 3 months or until substantial compliance is achieved. The CNE is responsible for monitoring and oversight.</p>		

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F 221	Continued From page 8 not respond when prompted to release the seatbelt. UM #2 demonstrated how the seatbelt alarmed when the Velcro strap was released. When the alarm sounded, Resident #1 attempted to reattach the seatbelt and appeared agitated.  A letter from Resident #1's physician, dated 6/15/17, documented Resident #1's family member requested the seatbelt to help with positioning and safety due to severe cognitive impairment. The physician stated in the letter that he ordered the seatbelt as a means of improving Resident #1's quality of life and dignity.  On 6/14/17 at 2:55 pm, LN #4 stated the Device Evaluation form was incomplete, Resident #1 was in the wheelchair for most of her waking hours, and the restraint seatbelt device was "always" used. LN #4 stated she was not aware of any attempt to use a less restrictive device.	F 221			
F 241 SS=E	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY  (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, Resident Group Interview, and resident and staff interview, it was determined the facility failed to maintain or enhance residents' dignity during dining when residents seated at the same table were served at different times and those in the assisted area of the dining room were served their meals	F 241	Residents Affected: Residents #5,6,16,21,23,25,26, & 27 were assessed by LMSW for any related psycho-social affects related to meals not being served at the same time as those residents needing assistance, residents sitting at the same table, and staff failing to knock	8/10/17	

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F 241	<p>Continued From page 9</p> <p>before other residents in the dining room and when staff failed to respect residents' privacy when they did not knock or announce themselves before entering residents' rooms. This was true for 8 of 8 residents in the Resident Group Interview, 3 of 17 (#5, #6 &amp; #16) sampled residents and 5 (#21, #23, #25, #26, &amp; #27) random residents. This failure had the potential to impact residents who dined in the facility and residents who wanted privacy in their rooms. This deficient practice had the potential to cause a decrease in residents' sense of self-worth and psycho-social well being. Findings include:</p> <p>1. Dining:</p> <p>Observations included:</p> <p>* On 6/12/17 at 5:20 pm, a posted meal time sign was observed outside of the main dining room and documented lunch began at 12:30 pm and dinner began at 5:00 pm. The sign did not document the main dining room was divided by those who required assistance verses those who did not.</p> <p>* On 6/12/17 at 4:55 pm, 22 residents were observed seated in the main dining room with 12 of those seated in the assisted area of the dining room. At 5:20 pm, the first meal tray was served to the assisted area of the dining room.</p> <p>* On 6/13/17 at 12:18 pm, 40 residents were observed in the main dining room. At 12:30 pm, 44 residents were observed in the main dining room. At 12:40 pm, the first three meal trays were served to residents who had family members with them in the dining room. From</p>	F 241	<p>and announce prior to entering residents rooms on or before 07/21/2017. Any concerns will be followed up on as indicated.</p> <p>Potential Residents Affected: Resident interviews were conducted by LMSW on or before 07/21/2017 of alert and oriented residents who eat their meals in the dining room for psycho-social issues related to meals not being served at the same time other residents at the table. Any issues will be followed up on as indicted.</p> <p>Center Rounds were completed by CED or Designee on or before 07/21/2017 to identify any concerns with resident dignity including staff members failing to knock and announce on residents <input type="checkbox"/> doors prior to entering rooms. Education was provided immediately to staff as indicated for breach of dignity.</p> <p>A dining review was completed for breakfast, lunch, and dinner on or before 07/21/2017 to identify if meals were being served on-time and to residents and the same time by the CED. Any identified concerns were immediately addressed by the CED at the time of identification.</p> <p>Systematic Change/Education: Beginning the week of 07/24/2017, Dining and Meal service will be changed to serve out 1 table (All residents at the table) per</p>		

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F 241	<p>Continued From page 10 12:40 pm to 1:05 pm, trays were served for those residents in the assisted area and then those in the main dining room were served last.</p> <p>* On 6/13/17 at 12:42 pm, Resident #21 and her tablemate were seated at a table in the assisted area of the main dining room. Resident #21's tablemate had her food and was being assisted by CNA [Certified Nursing Assistant] #7, while Resident #21 did not have her meal and watched her tablemate eat. At 12:51 pm, Resident #21's meal tray arrived at the table.</p> <p>* On 6/13/17 at 12:42 pm, Resident #5 and her two tablemate's were seated at a table in the assisted area of the main dining room. Resident #5's tablemate's both had their food and were assisted by a staff member, while Resident #5 did not have her meal and watched her tablemate's eat. At 12:50 pm, Resident #5's meal tray arrived at the table.</p> <p>* On 6/13/17 at 1:00 pm, Resident #16 and her two tablemate's were seated at a table in the main dining room. Resident #5 did not have her meal and was dozing off, while her two tablemate's ate their meals. At 1:04 pm, Resident #16's meal tray arrived at the table.</p> <p>Resident interviews included:</p> <p>* On 6/13/17 at 9:35 am, Resident #6 said the meals were not always served at the same table at the same time and said residents had to watch other residents eat, while waiting for their own trays.</p> <p>* On 6/13/17 at 2:00 pm, during the Resident</p>	F 241	<p>tray line. Tray service will alternate between unassisted resident table and assisted resident tables.</p> <p>Beginning the week of 07/24/2017, resident meal tickets will be placed on ticket holder on individual tables. This will allow the turn in of 1 set of tickets per table to insure all residents at the table will be served together.</p> <p>Genesis Meridian Center staff that assist in the dining room will be educated on or before 07/21/2017 regarding new dining and meal service system to serve one table per tray line and the placement of resident meal tickets in the holder at the residents' table.</p> <p>Dietary Staff were educated by Director of Food service on or before 07/21/2017 regarding new dining service and services residents seated at the same table together, one table per tray line.</p> <p>Beginning the week of 07/24/2017, dining room signage will be amended by Dietary Manager to read "Beverage Service Begins" and "Meal Service Begins" to inform residents when the dining room meal service will commence.</p> <p>Center Staff was educated by LSW on or before 07/21/2017 regarding resident dignity, including staff knocking on doors prior to entering residents' rooms. Center staff will complete a written post-test to validate competency on or</p>		

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F 241	<p>Continued From page 11</p> <p>Group Interview, 8 of 8 residents said the meals were not always served at the same table at the same time and said residents would often watch their tablemate's eat while waiting for their own trays and vice versa.</p> <p>Staff interviews included:</p> <p>* On 6/13/17 at 12:25 pm, Unit Manager #1 said she thought residents at the same table were not always served at the same time because of the different types of diets the residents required.</p> <p>* On 6/15/17 at 1:22 pm, CNA #13 said she and the other staff waited until most of the residents were in the dining room before residents' meal tickets were turned into the kitchen and tickets for those who needed assistance with their meal were turned in first. CNA #13 said if a resident had a guest with them, then those tickets were turned in first.</p> <p>* On 6/15/17 at 1:35 pm, CNA #14 said tickets for those who needed assistance with their meal were turned in first. CNA #14 said if a resident had a guest with them, then those tickets were turned in first. CNA #14 said tables with more residents at them had their tickets given to the kitchen ahead of those tables where there were less residents. CNA #14 said staff tried to turn in tickets for the whole table at the same time.</p> <p>* On 6/15/17 at 3:20 pm, the Certified Dietary Manager [CDM] said the kitchen relied on nursing staff in the dining room to turn in meal tickets and were supposed to be served on a first come, first served basis. The CDM said tables in the assisted area were to be alternated with</p>	F 241	<p>before 07/21/2017.</p> <p>Monitors: Beginning the week of 07/24/2017 a dignity audit will be completed by the center Executive Director or designee including dignified dining, and assurance that staffs are providing residents <input type="checkbox"/> dignity with cares. These audits will be completed weekly X 4 weeks and then monthly X 2 months. Audits will be conducted in the dining room and resident care areas to ensure that resident dignity needs are met</p> <p>Beginning the week of 07/24/2017, audit of dining room service will be conducted by the Administrator or designee to insure residents sitting together will be served at the same time. These audits will be conducted weekly x4 weeks and then monthly x 2 months.</p> <p>Beginning the week of 07/24/2017, dignity rounds will be completed by CED, CNE, or Designee to ensure resident dignity is maintained including staff knocking on residents <input type="checkbox"/> doors prior to entering the room. These audits will be conducted weekly x 4 weeks and then monthly x 2 months.</p> <p>The results of these audits will be compiled and reported to the QAPI committee for review monthly for 3 months or until substantial compliance is maintained. The Executive Director is responsible for monitoring and follow-up.</p>		

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F 241	<p>Continued From page 12</p> <p>service to the main part of the dining room, so the service could be evenly distributed. She said the tickets should also be turned in by table so all the residents received their meals at the same time.</p> <p>* On 6/15/17 at 5:00 pm, the DON said nursing staff were to turn in meal tickets on a first come, first served basis. He said staff should not prioritize residents who need assistance over those who do not need the assistance.</p> <p>2. Knocking</p> <p>* On 6/14/17 at 7:54 pm, CNA #11 was observed to enter into Resident #27's room to retrieve a pair of disposable gloves near the sink, without knocking. Resident #27 was in the room in her wheelchair at the time.</p> <p>* On 6/14/17 at 8:25 pm, Residents #25 and #26 were awake in their beds in their room. The surveyor was having a private conversation with Resident #26 in the bed furthest from the door, when CNA #11 walked into the room and approached Resident #26 and the surveyor, without knocking or announcing himself. CNA #11 asked Resident #26 a question and then left the room. Resident #26 said staff sometimes forgot to knock.</p> <p>* On 6/14/17 at 8:30 pm, CNA #11 was observed to walk from the nurses' station and into Residents #25 and #26 room without knocking or announcing himself.</p> <p>* On 6/14/17 at 8:40 pm, CNA #11 said he may have forgotten to knock prior to entering Resident</p>	F 241			

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F 241	Continued From page 13 #25, #26 and #27's rooms.  * On 6/15/17 at 9:20 am, Resident #27 said she was not sure if she was upset when staff failed to knock on her door before entering.  * On 6/15/17 at 3:00 pm, the DON said staff were to knock and ask permission to enter residents' rooms.	F 241			
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.  (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  (i) Certification (1) A registered nurse must sign and certify that the assessment is completed.  (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-  (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or	F 278		8/10/17	

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F 278	<p>Continued From page 14</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</p> <p>(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview and record review, it was determined the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the status for 2 of 4 residents (#5 and #8) reviewed for hospice services. Residents certified with terminal conditions were not coded as having a life expectancy of less than 6 months. The failure to accurately assess the resident has the potential to affect the plan of care and the services provided to the resident. Findings include:</p> <p>1. Resident #5's Hospice Certification and Plan of Care, dated 3/10/17, included the Medical Director's statement that documented, "I certify that the patient [resident] is terminally ill with a life expectancy of six (6) months or less if the disease process runs its normal course."</p> <p>Resident #5's Significant Change MDS, dated 3/23/17, documented: "Prognosis - Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?" The MDS documented, "No," but noted the resident received hospice care.</p> <p>Resident #5's Physician Orders, dated 4/24/17 documented, "I re-certify that the above named patient has a chronic progressive illness and is</p>	F 278	<p>Residents Affected: Resident #5 and #8 MDS will be reviewed and modified by the MDS coordinator and validated by the CNE or designee on or before 07/26/2017.</p> <p>Potential Residents Affected: A review of MDS assessments for residents on Hospice Services for the last 90 days will be completed by the MDS coordinator and validated by the CNE or designee on or before 07/26/2017 for accuracy.</p> <p>Systematic Change/Education: The MDS coders will be educated by the RAI specialist of clinical reimbursement on or before 07/26/2017 regarding accuracy in coding including residents diagnosis, medical conditions, and election of hospice services.</p> <p>Beginning 07/31/2017 residents who elect the hospice benefit, or those who have a terminal diagnosis will have their MDSs reviewed by the CNE or designee at morning clinical meeting prior to MDS submission to validate accuracy.</p>		

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F 278	<p>Continued From page 15 still considered terminally ill with a life expectancy of six months or less. Continue with current hospice plan of care."</p> <p>On 6/15/17 at 4:00 pm, the Director of Nursing (DON) stated the MDS was coded an error.</p> <p>2. Resident #8 was admitted to the facility on 2/16/17 and placed on hospice services with diagnoses that included end stage respiratory failure and heart failure.</p> <p>A Hospice Physician Verbal Order, dated 5/2/17, documented, "I certify the patient [resident] is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course."</p> <p>Resident #8's Significant Change MDS, dated 5/11/17, documented, "Prognosis: Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?" The MDS documented, "No," but noted the resident received hospice care.</p> <p>On 6/12/17 at 8:40 am, LN #1 stated, "Resident #8 was on hospice services. She was placed on hospice services about six to eight weeks ago with a terminal diagnosis. I think it is due to end stage congestive heart failure, but I'm not sure. They [hospice staff] come in 3-4 times a week."</p> <p>On 6/14/17 at 9:20 am, Resident #8 stated, "Hospice comes on Monday, Wednesday, and Friday. I'm on hospice for end stage heart failure."</p>	F 278	<p>Monitors: Beginning the week of 07/31/2017 the CNE or designee will review 5 MDSs for accuracy in documentation. These audits will be completed weekly times 4 weeks, monthly times 2 months, quarterly and with any change of condition. The CNE or designee will compile the results of the audits and report to the QAPI committee for review monthly times 3 months or until substantial compliance is achieved. The CNE is responsible for monitoring and oversight</p>		

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F 278	Continued From page 16 On 6/14/17 at 11:00 am, the MDS Coordinator stated, "When I find out someone goes onto hospice services, then I do a Significant Change on the MDS. I see there was a physician order for hospice services and the Significant Change on the MDS was done by me on 5/11/17." When asked why the MDS documented Resident #8 did not have a terminal diagnosis, the MDS Coordinator stated, "Very rarely does the [physician] write a terminal diagnosis of 6 months or less. I do see where I coded it 'Yes' for hospice services though."  On 6/14/17 at 2:20 pm, the DON stated, "The expectation was the MDS nurse ... open a Significant Change MDS ... [The MDS Coordinator] probably didn't see the physician order ... I see that section is coded incorrectly. We will have to look more closely again at the MDS to ensure they are done correctly."	F 278			
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS  483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.  483.21 (b) Comprehensive Care Plans  (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights	F 279		8/10/17	

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

PRINTED: 07/26/2017  
FORM APPROVED  
OMB NO. 0938-0391

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F 279	<p>Continued From page 17</p> <p>set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative (s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p>	F 279			

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F 279	<p>Continued From page 18</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure care plans based on residents' comprehensive assessments were developed and implemented. This was true for 1 of 3 residents (#18) reviewed for dialysis. This deficient practice created the potential for residents to receive inappropriate or inadequate care with a subsequent decline in health. Findings include:</p> <p>Resident #18 was admitted to the facility on 5/12/17, following a fall at home which resulted in multiple fractures, with diagnoses that included End Stage Renal Disease (ESRD), for which she required dialysis 3 times weekly; anemia; osteoporosis; hypertension, chronic pain, and weakness.</p> <p>Resident #18's fall at home resulted in fractures to the upper right arm and lower left leg. With a hemodialysis fistula located on the left arm, the only remaining site for monitoring Resident #18's blood pressure was to the lower right leg.</p> <p>Physician orders received 5/23/17, documented, "Do not take B/P in ___ arm." There was no location specified in the physician's orders.</p> <p>A hemodialysis center communication note to the facility documented, "B/P on [right] ankle only. B/P 20 - 30 mmHg higher than arm."</p>	F 279	<p>Residents Affected: Resident #18 <input type="checkbox"/> discharged from facility on 06/06/2017.</p> <p>Potential Residents Affected: A review of residents on dialysis services will be completed by the CNE or designee on or before 07/26/2017 to ensure physician orders and comprehensive care plans were updated with the physiological location of where to take the BP and frequency of monitoring. Follow-up will be completed by the licensed nurse on or before 07/26/2017.</p> <p>Systematic Change/Education: LN staff will be educated by Practice Development Manager (NPE) or designee on caring for residents who require hemodialysis including identifying where to take BPs on dialysis residents and how frequently to monitor them by 07/26/2017.</p> <p>Beginning 07/31/2017 residents who admit or who have new orders for hemodialysis will be reviewed in morning clinical meeting by the Center Nurse Executive or designee to ensure that dialysis care and services are reflected in the plan of care including instructions related to obtaining blood pressures.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/16/2017</b>
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F 279	Continued From page 19 Resident #18's care plan did not direct staff in obtaining blood pressure assessments from the right ankle as specified by the hemodialysis center. Interventions did not include frequency of blood pressure monitoring, or precautions to assess blood pressure using the right ankle.  On 6/16/17 at 9:40 am, the Unit Manager stated Resident #18's care plan did not address the physiological location staff were to assess the resident's blood pressure.	F 279	Monitors: Beginning the week of 07/31/2017 the CNE or designee will review residents on dialysis to ensure physician orders and comprehensive care plans were updated with the physiological location of where to take the BP and frequency of monitoring. These audits will be completed weekly times 4 weeks, monthly times 2 months, quarterly and with any change of condition. The CNE or designee will compile the results of the audits and report to the QAPI committee for review monthly times 3 months or until substantial compliance is achieved. The CNE is responsible for monitoring and oversight.		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  (b)(3) Comprehensive Care Plans  The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-  (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, record review, and resident and staff interview, it was determined the facility failed to ensure physician orders were followed and physician notification was completed as ordered. This was true for 1 of 17 (#6) residents and had the	F 281	Residents Affected: Resident #6 had a head to toe assessment completed by the licensed nurse including a current weight on or before 07/26/2017. The results of this assessment will be sent to the residents	8/10/17	

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F 281	<p>Continued From page 20</p> <p>potential for harm if residents received too much medication and physician notification was not completed. Findings include:</p> <p>Resident #6 was readmitted to the facility on 2/2/17 with multiple diagnoses, including CHF [Congestive Heart Failure] and muscle weakness.</p> <p>a. Resident #6's current cardiovascular care plan, dated 2/3/17, documented an intervention directing staff to assess medications for effectiveness and report any abnormalities to the physician.</p> <p>The May and June 2017 [MRR] Medication Review Report and MAR [Medication Administration Record] documented a 2/3/17 physician order for staff to weigh Resident #6 daily related to CHF and to notify Resident #6's CHF clinic of an increase of three pounds in one day or five pounds in one week.</p> <p>Resident #6's May and June 2017 MAR and Weights Summary from 5/1/17 to 6/13/17 documented daily weights were not performed or recorded on 11 of 44 opportunities. The weights summary on 5/9/17 documented the resident weighed 167.8 pounds and on 5/10/17 the resident was documented as weighing 172 pounds, a 4.2 pound increase in one day.</p> <p>A 5/10/17 Progress Note did not document the resident's CHF clinic was notified of the single-day 4.2-pound increase in weight.</p> <p>On 6/13/17 at 9:35 am, Resident #6 was observed in a wheelchair in her room with</p>	F 281	<p>MD for review. Follow-up will be completed by the Center Nurse Executive or designee on or before 07/31/2017.</p> <p>A summary of resident #6's weights completed within the last 30 days was sent to the MD on or before 07/26/2017 with no new orders received.</p> <p>On or before 07/26/2017 the Unit Manager clarified resident #6's Tylenol order with the MD and the MAR was updated to reflect the clarified order. .</p> <p>Potential Residents Affected: A review of resident's weights for the last 30 days and physician's orders for monitoring was completed on or before 07/26/2017 by the Center Nurse Executive or designee to ensure accuracy in documentation and physician notification. Weight variances outside ordered parameters will be reported to resident's physician with follow-up completed as indicated.</p> <p>A review of residents' current medications as compared to current physicians' orders will be completed by the Center Nurse Executive or designee on or before 07/31/2017, with follow-up including physician notifications, and order clarifications completed as indicated.</p> <p>Systematic Change/Education:  Licensed Nursing staff will be re-educated</p>		

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F 281	<p>Continued From page 21 compression hose on both lower legs. Resident #6 said staff weighed her "most days" because her body retained fluid due to CHF.</p> <p>On 6/14/17 at 9:30 am, the DON (Director of Nursing) said residents' weights should be documented on the MAR.</p> <p>On 6/15/17 at 9:30 am, LN #6 said Resident #6's daily weights were recorded either in the MAR or the Weights Summary.</p> <p>On 6/15/17 at 2:30 pm, the DON said Resident #6 received a diuretic for edema and was to be weighed daily to monitor for fluid retention. The DON stated several of Resident #6's weights were not documented and the physician was not notified when weights increased.</p> <p>b. The facility's revised Transcription of Orders policy, dated 10/1/12, documented a licensed nurse must verify the accuracy and sign transcribed physician orders.</p> <p>Resident #6's May 2017 MRR and MAR documented the following 2/20/17 physician's orders: *Tylenol 325 mg (Acetaminophen) 650 mg two times daily for pain, *Acetaminophen 325 mg, 2 tablets, every 4 hours as needed (PRN) for temperature of 100 degrees or greater. Notify physician. Do not exceed 3 g (grams) a day, and *Acetaminophen 325 mg, 2 tablets, every 4 hours PRN for mild pain. Notify physician if pain persists. Do not exceed 3 g a day.</p> <p>Resident #6's 5/23/17 Physician's Orders</p>	F 281	<p>on completion of weights including daily weights, and documentation, and notification requirements by the Nurse Practice Educator or designee on or before 07/21/2017.</p> <p>Beginning 07/24/2017 weights will be reviewed by the clinical team in the morning clinical meeting for any variances outside of the physicians ordered parameter to ensure timely follow-up.</p> <p>Licensed Nurses will be re-educated on order transcription and educated on the 24 hour chart check process for new order validation by the Practice Development Manager (NPE) or designee on or before 07/21/2017.</p> <p>Beginning 07/24/2017 new physicians <input type="checkbox"/> orders will be validated for accurate processing and transcription to the MAR utilizing the daily 24 hour chart check process.</p> <p>Monitors: Beginning the week of 07/31/2017 the CNE or designee will audit 5 resident records for weights and notifications completed per physician order, and new orders accurately transcribed to the residents MAR. Audits will be completed weekly times 4 weeks, monthly times 2 months, quarterly and with any change of condition. The CNE or designee will compile the results of the audits and report to the QAPI committee for review</p>		

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F 281	<p>Continued From page 22</p> <p>discontinued all previous Acetaminophen dosages; a new order directed staff to provide the resident with 1,000 mg of Acetaminophen three times a day. The May 2017 MAR was not updated to reflect the 5/23/17 order.</p> <p>Resident #6 May 2017 MAR from 5/24/17 to 5/31/17 documented the resident received 650 mg of Tylenol two times daily on each of those days; 650 mg of PRN Acetaminophen on 5/29/17 and 5/31/17; and two 650 mg dosages of PRN Acetaminophen on 5/30/17.</p> <p>Resident #6's June 2017 MRR and MAR documented the following physician's orders:</p> <p>* 5/23/17 - Tylenol 1,000 mg three times daily for pain. "Do not exceed this dose."</p> <p>* 2/20/17 - Acetaminophen 325 mg, 2 tablets every 4 hours PRN for elevated temperature of 100 degrees or greater. Notify physician. Do not exceed 3 g a day.</p> <p>*2/20/17 - Acetaminophen 325 mg, 2 tablets every 4 hours PRN for mild pain. Notify physician if pain persists. Do not exceed 3 g a day.</p> <p>On 6/13/17 at 9:10 am and 6/14/17 at 10:30 am, Resident #6 was observed walking through facility hallways using a walker and assisted by a therapist.</p> <p>On 6/13/17 at 9:35 am, Resident #6 said her pain was managed "fairly well."</p> <p>On 6/15/17 at 2:30 pm, the DON said Resident #6's PRN orders for Acetaminophen should have</p>	F 281	<p>monthly times 3 months or until substantial compliance is achieved. The CNE is responsible for monitoring and oversight.</p>		

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F 281	Continued From page 23 been discontinued and the Tylenol 1,000 mg order should have been started with the 5/23/17 physician's order.	F 281			
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.  483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:  (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.  (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards	F 309	8/10/17		

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F 309	<p>Continued From page 24 of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, policy review, and record review, the facility failed to provide the necessary care and services to attain or maintain residents' highest practicable level of physical, mental, and psychosocial well-being, for 2 of 8 residents (#3 and #5) reviewed for pain, and for 3 of 3 residents (#13, #14, and #18) reviewed for dialysis services, specifically fistulas (surgically created blood vessel access areas) were not assessed after returning to the facility from dialysis and routinely as specified in individual care plans. Findings include:</p> <p>* Pain Management</p> <p>Review of facility policy titled, "Pain Management" revised 11/28/16 revealed residents receiving interventions for pain, staff were to document the effectiveness of PRN medications.</p> <p>1. Resident #3 was admitted to the facility on 1/8/15 with multiple diagnoses, including non-pressure chronic ulcers of bilateral right and left heel and midfoot.</p> <p>Review of Resident #3's May 2017 MAR revealed acetaminophen (Tylenol) 325 mg 2 tablets prn was administered once on 5/17/17.</p> <p>Review of Resident #3's May 2017 "PRN Pain Management Flow Sheet" revealed three entries there was no documentation in the pre-printed</p>	F 309	<p>Residents Affected:</p> <p>Resident #3 discharge from Meridian Center on 06/29/2017. Resident #5 will have a pain assessment completed by the Unit Manager or designee on or before 07/26/2017 to ensure that current pain management plan is adequate. Follow-up will be completed as indicated by the assessment.</p> <p>Residents #13 was assessed including an assessment of their dialysis access site by a licensed nurse. No concerns were identified. Resident #14 discharged from Meridian Center on 06/17/2017. Resident #18 discharged from Meridian Center on 06/06/2017.</p> <p>Potential Residents Affected:</p> <p>A review of resident PRN pain management flow sheets for the last 30 days will be completed by the Center Nurse Executive or designee on or before 07/31/2017 for accuracy in documentation related to effectiveness of treatment. Residents who have missing assessment of pain medication efficacy will have a follow-up pain assessment completed by the licensed nurse on or before 08/04/2017; any additional follow-up including physician notification will be completed as indicated.</p>		

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F 309	<p>Continued From page 25</p> <p>columns for "effectiveness of treatment." There was no data documented to reflect follow up assessment of pain rating or level of sedation after prn pain medication was given on 5/1/17 for Norco 10/325 mg, 5/12/17 for Norco 10/325 mg, and 5/17/17 for Tylenol 650 mg.</p> <p>Review of Resident #3's June 2017 medication administration record (MAR) revealed Norco 10-325 (hydrocodone 10 milligrams [mg] and acetaminophen 325 mg prn (as needed) was administered at 7:20 a.m. on 6/1/17.</p> <p>Review of Resident #3's June 2017 "PRN Pain Management Flow Sheet" revealed one entry dated 6/1/17 at 7:20 a.m. that documented Norco 10-325 was administered. There was no entry in the pre-printed columns for "effectiveness of treatment" and no data that reflected follow up assessment of pain rating or level of sedation after medication administration.</p> <p>An interview on 6/16/17 at 5:10 p.m., the Director of Nursing (DON) acknowledged the nursing staff were not consistent with assessing and documenting the effectiveness of pain medications being administered.</p> <p>2. Resident #5 was admitted to the facility on 5/24/14 with multiple diagnoses, including shortness of breath and a contracture with pain to the left hand.</p> <p>Review of Resident #5's "Order Summary Report" dated 6/14/17 revealed an order for morphine sulfate concentrate 20 mg/ml give 0.5 ml every 1 hour as needed for pain or shortness</p>	F 309	<p>A review of current resident□s with dialysis services will be completed by the Center Nurse Executive or designee on or before 07/26/2017 to ensure complete documentation of post dialysis assessments and fistula monitoring. Follow-up including assessment and physician notification will be completed by the unit manager or designee on or before 08/04/2017 as indicated by the review.</p> <p>Systematic Change/Education: Licensed nurses will be re-educated by the Practice Development Manager (NPE) or designee on pain management including pain medication efficacy assessment and documentation requirements, and dialysis care including post dialysis follow-up and fistula assessment on or before 07/26/2017. Licensed nurses will complete a post-test on or before 08/04/2017 to validate competency.</p> <p>Monitors: Beginning the week of 07/31/2017 the CNE or designee will review 5 residents with PRN pain medication orders for accuracy in documentation of efficacy. Beginning the week of 07/31/2017 the CNE or designee will review residents receiving dialysis services for post dialysis assessment of the fistula. These audits will be completed weekly times 4 weeks, monthly times 2 months, quarterly and with any change of condition. The CNE or designee will compile the results</p>		

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F 309	<p>Continued From page 26 of breath, initiated 3/9/17.</p> <p>Review of Resident #5's care plan reviewed 4/6/17 revealed interventions for pain included to administer pain medication as per MD (medical doctor) order and note the effectiveness.</p> <p>Review of Resident #5's May 2017 MAR revealed PRN morphine sulfate concentrate 20 mg/ml was administered on 5/19/17.</p> <p>Review of Resident #5's May 2017 "PRN Pain Management Flow Sheet" revealed no entry for 5/19/17.</p> <p>Review of Resident #5's June 2017 MAR revealed morphine sulfate concentrate 20 mg/milliliter (ml) was administered three times during the month on 6/8/17, 6/9/17, and 6/10/17.</p> <p>Review of Resident #5's June 2017 "PRN Pain Management Flow Sheet" revealed no entries.</p> <p>During an interview on 6/15/17 at 1:30 p.m. the Unit Manager (UM) #1 stated the nurses should have documented the effectiveness on the "PRN Pain Management Flow Sheet" after administering prn pain medications.</p> <p>* Dialysis Fistulas</p> <p>Review of the website <a href="https://www.davita.com/kidney-disease/dialysis/treatment/arteriovenous-av-fistula-%2597-the-gold-standard-hemodialysis-access/e/1301">https://www.davita.com/kidney-disease/dialysis/treatment/arteriovenous-av-fistula-%2597-the-gold-standard-hemodialysis-access/e/1301</a> on 6/18/17 at 5:00 p.m. revealed: "Hemodialysis cleans blood by removing it from</p>	F 309	<p>of the audits and report to the QAPI committee for review monthly times 3 months or until substantial compliance is achieved. The CNE is responsible for monitoring and oversight.</p>		

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F 309	<p>Continued From page 27</p> <p>the body and passing it through an artificial kidney. The filtered blood is then returned to the body. A fistula used for hemodialysis is a direct connection of an artery to a vein. Once the fistula is created it is a natural part of the body. The fistula is created from natural parts of the body and can be repeatedly "stuck" to perform hemodialysis treatments. Fistulas should be monitored for pain, tenderness, swelling or redness around the access area which can indicate infection. The vibration of blood going through the fistula is called the "thrill." It should be checked several times a day. If the "thrill" changes or stops a blood clot may have formed. Using a stethoscope, one can hear the sound of blood flowing through the access. This sound is called the "bruit." If the sound gains in pitch and sounds like a whistle, the blood vessels could be tightening (called stenosis). If the tightening becomes too severe, blood flow could be cut off completely."</p> <p>Review of a (Name of dialysis provider) Memorandum dated 1/24/12 revealed the company had entered into a written agreement with the facility to provide dialysis services for residents who had end stage renal disease.</p> <p>Three residents at the facility were reviewed for dialysis services. Each of those residents had a form in their clinical record that was titled "HEMODIALYSIS COMMUNICATION RECORD." The form was separated into three sections.</p> <p>* The first section included instructions it was to be completed by a licensed nurse for the dialysis patient prior to each dialysis treatment.</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/16/2017</b>
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F 309	<p>Continued From page 28</p> <p>-The section included assessment of access site, auscultation of the shunt, blood pressure, temperature, pulse, time of last meal, type of diet, and space for the LN to write a note to the dialysis center related to the resident's general condition, the LN signature, and date.</p> <p>* The second section included instructions it was to be completed by the Dialysis Center following dialysis treatment and was to accompany the patient upon their return to the Center post-dialysis.</p> <p>- The second section included communications from the dialysis center to the facility.</p> <p>* The third section was to be completed by a Licensed Nurse post-dialysis treatment.</p> <p>- The section included instructions the LN was to perform an assessment of the access site, auscultation of the shunt, if there were any orders from the dialysis center to be acknowledged, a space for any notes, the LN signature, and date completed.</p> <p>The facility failed to ensure assessments and documentation of pre and post dialysis were completed as specified in their policy and to ensure comprehensive care coordination and care-planning occurred. The following resident records included the Hemodialysis Communication Record [HCR] for their dialysis days, however, the facility assessment sections before and after the dialysis were partially or totally incomplete. Examples include:</p> <p>a. Resident #13 was admitted to the facility on</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/16/2017</b>
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F 309	<p>Continued From page 29</p> <p>4/18/16. Her record was reviewed for dialysis coordination and communication from 5/9/17 to 6/9/17. Her record included 11 HCRs.</p> <p>- The HCR third section was not completed for the following dates: 5/9/17, 5/11/17, 5/13/16, 5/16/17, 5/18/17, 5/20/17, 6/3/17, 6/5/17, 6/7/17, 6/9/17.</p> <p>b. Resident #18 was admitted to the facility from 5/12/17 to 6/5/17. Resident #18's record documented she received dialysis on 8 days during her stay at the facility.</p> <p>- 5/13/17, The HCR first section was partially completed, the third section was not completed. - 5/16/17, The HCR first section was partially completed, the third section was not completed. - 5/18/17, The HCR first section was partially completed, the third section was not completed. - 5/20/17, The HCR third section was not completed. - 5/23/17, The HCR third section was not completed. - 5/27/17, The HCR third section was not completed. - 6/3/17, The HCR third section was not completed.</p> <p>On 6/16/17 at 9:40 am, the RN UM reviewed Resident #13 and #18's records and stated the HCR should be completed before and after dialysis treatments. She stated she did not perform audits to ensure the forms were completed. The RN UM was unable to find further documentation in Resident #13 and #18's records of the facility and dialysis center sharing of resident information.</p>	F 309			

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F 309	<p>Continued From page 30</p> <p>c. Resident #14 was admitted to the facility on 5/24/17 with multiple diagnoses, including end stage renal disease.</p> <p>Review of Resident #14's care plan for risk of complications related to hemodialysis included monitoring dialysis access (fistula) for positive (+) bruit and + thrill every shift and as needed. The plan included sending the communication book to dialysis and nursing to review it upon return.</p> <p>Review of Resident #14's paper clinical record on 6/14/17 at 7:55 p.m. revealed no documentation that Resident #14's fistula had been assessed.</p> <p>During an interview with the DON on 6/15/17 at 4:05 p.m., the DON stated it would be standard nursing practice to regularly assess a fistula site. The DON accessed the electronic chart system and stated he did not see an order to assess the fistula site. The Regional Registered Nurse (RN) who was present stated that nurses would not need a physician's order to assess the fistula site. The DON asked for time to research evidence of fistula assessment for Resident #14.</p> <p>During an interview on 6/15/17 at 5:10 p.m. the DON provided copies of Resident #14's "Progress Notes" from the admission date of 5/24/17 to 6/15/17. The DON stated that the notes revealed nursing sometimes documented assessment of the fistula, but did not document all of the time they should have. The "Progress Notes" revealed that nursing had assessed the fistula on 6/4/17, 6/11/17, and 6/12/17.</p> <p>Review of Resident #14's "Dialysis Binder"</p>	F 309			

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F 309	Continued From page 31 revealed "Hemodialysis Communication Record" pages with incomplete documentation for the following dates:  * 5/27/17- Post-dialysis treatment assessment by facility nurse was checked for bruit and thrill but not signed or dated. * 5/30/17 No post dialysis assessment by facility nurse. * 6/1/17 No post dialysis assessment by facility nurse. * 6/3/17- Post-dialysis treatment assessment by facility nurse was "+" for bruit and thrill but not signed or dated. * 6/8/17 No post dialysis assessment by facility nurse. * 6/10/17 -No post dialysis assessment by facility nurse. * 6/15/17- Post-dialysis treatment assessment by facility nurse was "+" for bruit and thrill but not signed or dated.  During an interview on 6/15/17 at 5:35 p.m. the DON stated that entries in Resident #14's "Dialysis Binder" served as the record of attendance at dialysis.	F 309			
F 332 SS=E	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  (f) Medication Errors. The facility must ensure that its-  (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to	F 332	Residents Affected: Resident #16 and #28 had a medication	8/10/17	

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F 332	<p>Continued From page 32</p> <p>ensure medications were prepared and administered according to manufacturers instructions, medications were administered as ordered, and doses of medications were administered as ordered, resulting in a medication administration error rate of 12%. This was true for 3 of 25 medications (12%) administered during medication pass observations and affected 2 of 5 residents (#16 and #28) observed during medication pass. Failure to administer medications as ordered places residents at risk for harm. Findings include:</p> <p>1. LN #1 was observed as she prepared medications for Resident #16 on 6/13/17 beginning at 9:30 AM.</p> <p>Resident #16 physician orders for the morning administration included:</p> <p>*Potassium Chloride ER tablet Extended Release 20 meq one table by mouth in the morning. * Senna two tables twice a day by mouth for constipation.</p> <p>a. The MAR listed KCL ER (Potassium Chloride Extended Release) 20 meq tablet, 1 tablet every morning.</p> <p>The medication was dispensed from a bubble pack that included a label which stated "Not to be crushed, avoid lying down for 10 minutes after administration, take with plenty of water."</p> <p>- LN #1 dispensed 1 tablet from the bubble pack, placed it in a plastic bag, and crushed the tablet. She poured the crushed tablet fragments into a</p>	F 332	<p>error event report and assessment completed by the licensed nurse. Follow up was completed including physician and resident/ resident responsible party notifications completed by the licensed nurse on 07/26/2017.</p> <p>Resident # 28 medication order for Depakote Sprinkles will be clarified and the MAR will be updated by the unit manager on or before 07/26/2017.</p> <p>Licensed Nurses #1 and #4 will have medication pass education and a medication pass competency completed by the Center Nurse Executive or designee completed on or before 07/26/2017, licensed nurses #1 and #4 will completed a posttest to validate competency.</p> <p>Potential Residents Affected: A comprehensive MAR to cart audit will be completed by the CNE or designee on or before 07/31/2017 to identify any potential discrepancies between physician's orders and the medications available in the medication carts. Any variances will be reported to the resident's physician and pharmacy.</p> <p>Licensed Nurses will be observed completing a resident medication pass to validate competency by the Center Nurse Executive or designee on or before 07/31/2017. Follow-up including education and training will be completed as indicated.</p>		

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F 332	<p>Continued From page 33</p> <p>dispenser cup with the other medications and added approximately 2 teaspoons of applesauce to the mixture.</p> <p>b. The MAR included Senna 2 tablets, twice daily.</p> <p>- LN #1 dispensed 1 Senna tablet from a bottle that she identified as being "Floor Stock." The bottle did not have dispensing information specific to Resident #16. LN #1 placed the Senna tablet into a dispensing cup with Resident #16's other medications. She added applesauce to the mixture and fed the applesauce mixture to Resident #16.</p> <p>- The medications were presented to Resident #16, who was lying in bed. LN #1 repositioned the bed to a more upright position, and fed the spoonfuls of applesauce/medications to Resident #16.</p> <p>- The LN offered Resident #16 a sip of water from a mug, and returned her bed back to the lying down position.</p> <p>Upon return to the medication cart, LN #1 was questioned about crushing the KCL ER tablet. She stated that it was a huge tablet and too big for Resident #16 to swallow. She stated that she should probably order another form of the medication, or a liquid that would be easier to administer. LN #1 was asked to review the bubble pack for the KCL ER and explain why the label stated "Do not crush." She appeared surprised to read the label and confirmed the medication was crushed, that Resident #16 was not offered additional fluids and she was returned</p>	F 332	<p>Systematic Change/Education: Licensed Nurses will be re-educated and had a medication pass competency completed on medication administration by the Practice Development Manager (NPE) or designee on or before 07/31/2017. Licensed Nurses will complete a written posttest to validate competency on or before 07/31/2017.</p> <p>Monitors: Beginning the week of 07/31/2017 the CNE or designee will complete observed medication administration competencies for 4 LN staff to validate competency and to ensure that the medication available matches the physician order. These audits will be completed weekly times 4 weeks, monthly times 2 months, quarterly and with any change of condition. The CNE or designee will compile the results of the audits and report to the QAPI committee for review monthly times 3 months or until substantial compliance is achieved. The CNE is responsible for monitoring and oversight.</p>		

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

PRINTED: 07/26/2017  
FORM APPROVED  
OMB NO. 0938-0391

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F 332	<p>Continued From page 34 to the lying down position after taking the medication.</p> <p>LN #1 confirmed she dispensed 1 tablet of Senna from the bottle. She was unable to provide her rationale for dispensing of 1 tablet rather than the 2 that were ordered.</p> <p>2. During a medication pass observation on 6/14/17 at 8:00 PM, LN #4 was observed to prepare and dispense medications for Resident #28. Her MAR included Depakote DR [delayed release] 500 mg, 1 tablet by mouth twice daily.</p> <p>- The medication was packaged in a bubble pack and was labeled as Depakote Sprinkles 125 mg. LN #4 removed 4 capsules, for a total of 500 mg, opened them into a dispenser cup, added applesauce to the mixture, and administered it to Resident #28.</p> <p>LN #4 was asked why the MAR differed from the medication that was provided by the pharmacy. She stated Resident #28 had difficulty swallowing the tablet form, the pharmacy was contacted, and they provided the medication in the capsule form. LN #4 confirmed the MAR and Physician order specified (1) 500 mg tablet rather than (4) 125 mg capsules, and stated the MAR should have been re-written to include the sprinkle/capsules.</p> <p>During a phone interview on 6/15/17 at 4:45 PM, the Consultant Pharmacist stated Resident #16's KCL should not have been crushed. He stated the medication contained "Microbeads" and the tablet could have been placed in water to make it mushy before administration. He stated crushing the tablet would also crush the microbeads, and</p>	F 332			

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F 332	Continued From page 35 the medication would not then be in "Extended Release" form. The Consultant Pharmacist stated the KCL could have been changed to another form if the facility had requested.  The Consultant Pharmacist stated Resident #28 received the correct dose of Depakote. He confirmed that the MAR directed that (1) 500 mg tablet was to be administered, and stated the (4) 125 mg capsules were equivalent to the original dose of medication that Resident #28's physician ordered.	F 332			
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  483.45(f) Medication Errors.  The facility must ensure that its-  (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, policy and record review, and staff interview, it was determined the facility failed to prevent significant medication errors. This was true for 1 of 5 sampled residents whose medication administration was observed (#16) and had the potential to result in less than therapeutic drug effectiveness for Resident #16 and for her to experience gastrointestinal irritation. Findings include:  A facility policy titled "Medication Errors," revised 1/2/14, stated "A medication error is defined as a	F 333	Residents Affected: Resident #16 had a medication error event report and assessment completed by the licensed nurse. Follow up was completed including physician and resident/ resident responsible party notifications completed by the licensed nurse on 07/26/2017.  Licensed Nurses #1 and #4 will have medication pass education and a medication pass competency completed	8/10/17	

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F 333	<p>Continued From page 36</p> <p>discrepancy between what the physician/mid-level provider ordered and what the patient received. Types of errors include; medication omission; wrong patient, dose, route, rate, or time; incorrect preparation; and incorrect administration technique." The policy stated medication errors would be investigated and appropriate interventions would be implemented. A medication administration error was noted during the following medication pass observation:</p> <p>1. LN #1 was observed as she prepared medications for Resident #16 on 6/13/17 beginning at 9:30 am.</p> <p>Resident #16 physician orders for the morning administration included:</p> <p>*Potassium Chloride ER tablet Extended Release 20 meq one table by mouth in the morning.</p> <p>The MAR included KCL ER [Extended Release] 20 mEq tablet, 1 tablet every morning.</p> <p>The medication was dispensed from a bubble pack that included a label which stated "Not to be crushed, avoid lying down for 10 minutes after administration, take with plenty of water."</p> <p>- LN #1 dispensed 1 tablet from the bubble pack, placed it in a plastic bag, and crushed the tablet. She poured the crushed tablet fragments into a dispenser cup with the other medications and added approximately 2 teaspoons of applesauce to the mixture.</p> <p>- The medications were presented to Resident</p>	F 333	<p>by the Center Nurse Executive or designee completed on or before 07/31/2017, licensed nurses #1 and #4 will completed a posttest to validate competency.</p> <p>Potential Residents Affected: A comprehensive MAR to cart audit will be completed by the CNE or designee on or before 07/26/2017 to identify any potential discrepancies between physician's orders and the medications available in the medication carts. Any variances will be reported to the resident's physician and pharmacy.</p> <p>Licensed Nurses will be observed completing a resident medication pass to validate competency by the Center Nurse Executive or designee on or before 07/31/2017. Follow-up including education and training will be completed as indicated.</p> <p>Systematic Change/Education: Licensed Nurses will be re-educated and had a medication pass competency completed on medication administration by the Practice Development Manager (NPE or designee on or before 07/26/2017. Licensed Nurses will complete a written posttest to validate competency on or before 07/31/2017.</p> <p>Monitors: Beginning the week of 07/31/2017 the CNE or designee will complete observed medication administration competencies</p>		

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F 333	Continued From page 37 #16, who was lying in bed. LN #1 repositioned the bed to a more upright position, and fed the spoonfuls of applesauce/medications to Resident #16.  - The LN offered Resident #16 a sip of water from a mug and returned her bed back to the lying down position.  Upon return to the medication cart, LN #1 was questioned about crushing the KCL ER tablet. She stated that it was a huge tablet and too big for Resident #16 to swallow. She stated that she should probably order another form of the medication, or a liquid that would be easier to administer. LN #1 was asked to review the bubble pack for the KCL ER and explain why the label stated "Do not crush." She appeared surprised to read the label, and confirmed the medication was crushed, that Resident #16 was not offered 4-8 ounces of water or juice and she was returned to the lying down position after taking the medication.	F 333	for 4 LN staff to validate competency and to ensure that the medication available matches the physician order. These audits will be completed weekly times 4 weeks, monthly times 2 months, quarterly and with any change of condition. The CNE or designee will compile the results of the audits and report to the QAPI committee for review monthly times 3 months or until substantial compliance is achieved. The CNE is responsible for monitoring and oversight.		
F 368 SS=E	483.60(f)(1)-(3) FREQUENCY OF MEALS/SNACKS AT BEDTIME  (f) Frequency of Meals  (f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.  (f)(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16	F 368		8/10/17	

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F 368	<p>Continued From page 38</p> <p>hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.</p> <p>(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, Resident Council Minutes, Resident Group Interview, Interested Party Interview and resident and staff interview, it was determined the facility did not offer a bedtime snack, allowed residents to go more than 14 hours between meals and received meals later than expected. This was true for 8 of 8 residents in the Resident Group interview, 8 of 17 (#s 2, 3, 5, 6, 7, 9, 11, 13, 16 &amp; 17) sampled residents and 7 (#s 22, 24, 26, 29, 30, 31 &amp; 32) random residents. This failure had the potential to impact most residents in the facility who wanted a bedtime snack or who were at risk for nutritional compromise and had the potential to harm residents if they experienced hunger, low blood sugar levels or did not receive adequate nutritional support for healing or weight loss.</p> <p>Findings include:</p> <p>1. HS Snacks The 3/14/17 Resident Council Meeting Minutes documented residents were not offered a bedtime snack. The minutes documented the DON [Director of Nursing] was to address the concern.</p> <p>On 6/13/17 at 2:00 pm, during the Resident</p>	F 368	<p>Residents Affected: Residents <input type="checkbox"/> #2,3,5,6,7,9,11,13,16,17,22,24,26,29,30,31,&amp; 32 were assessed by Center Dietitian for any adverse side effects related to not be offered a bedtime snack on or before 07/31/2017. No adverse side effects noted.</p> <p>Residents <input type="checkbox"/> 22, 24, &amp; 9 were interviewed by LSW for any adverse effects from waiting in the dining room for food to be served on or before 07/21/2017. Any issues will be followed up on as indicted.</p> <p>Potential Residents Affected: A review/ round of the HS snack pass was completed by the CED on or before 07/31/2017 to ensure that HS snacks were offered to center residents, any identified concerns were addressed immediately by the CED.</p> <p>A review of meal and snack administration was completed by the CED on or before 07/21/2017 to ensure that residents that residents did not wait</p>		

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F 368	<p>Continued From page 39</p> <p>Group Interview, 6 of 8 residents said they were still not being offered a bedtime snack.</p> <p>On 6/12/17 the facility's entrance conference request for information, documented bedtime snack pass began at 7:00 pm.</p> <p>The facility's Resident Question Report from 6/9/17 through 6/14/17, documented residents had not been offered a bedtime snack: Resident #2- 4 out of 6 times, Resident #3- 5 out of 6 times, Resident #5- 5 out of 6 times, Resident #6- 5 out of 6 times, Resident #13- 3 out of 6 times, and Similar results for Resident #s 16, 17, 26, 29, and 30.</p> <p>On 6/14/17 from 7:30 pm to 8:45 pm, the 100, 200 and 300 hallways were observed. During the observation, several residents with labeled snacks received snacks and a few other residents were offered a snack. Several other residents in the hallways were not offered a bedtime snack.</p> <p>On 6/14/17 at 8:24 pm, Resident #26, who had diabetes, was observed in his bed and did not have a snack. He said he had not been offered a snack that evening and was not offered a snack at night. He said he thought the facility no longer made them in the evening.</p> <p>On 6/14/17 at 8:28 pm, Resident #16, who had diabetes, was observed in her bed and did not have a snack. She said she had not been offered a snack that evening, but wanted some pudding. She said sometimes staff offered a bedtime</p>	F 368	<p>longer than 14 hours between a substantial evening meal and breakfast, and to validate that meals were served on time. Any issues will be followed up on as indicted.</p> <p>Systematic Change/Education: Beginning the week of 07/24/2017, a snack cart will be provided by the dietary department between the hours of 7:00-7:30 to facilitate delivery of HS snacks</p> <p>Beginning 07/21/2017, Licensed Nurses will validate the offering of HS snacks on their assigned hall(s) and report completion of validation to Center Nurse Executive for review on utilizing shift assignment sheet.</p> <p>On or before 07/21/2017, The Dietary Manager will change the Dining Room signage will be to Dining Room Opens and Dining Service Begins so that residents have the option of coming to the dining room closer to the time service begins.</p> <p>On 07/18/2017, Resident Council will be informed by Administrator of the dining service changes. Any concerns or issues will be addressed and changed per resident council approval.</p> <p>On or before 07/21/2017, Genesis Meridian Center staff will be educated by CED or designee on insuring bedtime snacks are offered and passed and</p>		

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F 368	<p>Continued From page 40 snack.</p> <p>On 6/14/17 at 8:34 pm, Resident #29, who had diabetes, was observed in her bed and did not have a snack. She said she had not been offered a snack that evening.</p> <p>On 6/13/17 at 4:00 pm, Resident #6 said staff did not offer bedtime snacks.</p> <p>On 6/16/17 at 3:15 pm, a refrigerator was observed in Resident #6's room and the resident's Interested Party said the family had brought in a personal fridge for Resident #6 and would stock it with snacks because the facility did not offer snacks at bedtime.</p> <p>On 6/14/17 at 7:52 pm, CNA #11 said snacks were passed when they had time, usually between 8:30 pm to 9:00 pm.</p> <p>On 6/14/17 at 8:05 pm, CNA #12 said she did not normally work evenings and was not sure when snacks were to be passed out.</p> <p>On 6/14/17 at 8:20 pm, LN #7 said the CNAs were responsible to offer snacks to the residents.</p> <p>On 6/15/17 at 2:20 pm, the DON said staff should offer bedtime snacks, especially to those with diabetes.</p> <p>On 6/15/17 at 3:20 pm, the CDM [Certified Dietary Manager] said several residents in the facility had a specific bedtime snack which were labeled and passed out at night. She said bedtime snacks were placed in the hallway pantries and fridges in late afternoon for the</p>	F 368	<p>starting meal service must begin at time indicated on dining room signage.</p> <p>Beginning the week of 07/24/2017, resident meal tickets will be placed on ticket holder on individual tables. This will allow the turn in of 1 set of tickets per table to insure all residents at the table will be served together.</p> <p>Monitors: Beginning the week of 07/24/2017, an audit of HS Snacks will be conducted by CED or designee to insure bedtime snacks are being passed and offered. These audits will conducted weekly x4 weeks and then monthly x2 months.</p> <p>Beginning the week of 07/24/2017, an audit of dining room service will be conducted by the CED or designee to insure meal service starts at time posted. These audits will be conducted weekly x4 weeks and then monthly x2 months.</p> <p>The results of these audits will be reviewed by the IDT in monthly QAPI.</p>		

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F 368	<p>Continued From page 41</p> <p>nursing staff to distribute. The CDM said bedtime snacks were passed out about 7:30 pm every night. She said residents with diabetes used to have specific snacks, but due to a lot of refusals of those snacks, the facility began to make sure the pantries were stocked with more generic snacks for the nursing staff to offer residents.</p> <p>On 6/15/17 at 5:15 pm, the DON said according to the snack documentation, snacks were not being offered consistently. He said bedtime snacks should be offered to all residents between 7:00 pm to 8:00 pm every night.</p> <p>2. Late meals.</p> <p>On 6/12/17 the facility's entrance conference request for information documented lunch began at 12:00 pm and dinner began at 5:00 pm.</p> <p>On 6/12/17 at 5:20 pm, a posted meal time sign was observed outside of the main dining room and documented lunch began at 12:30 pm and dinner began at 5:00 pm.</p> <p>On 6/12/17 at 4:55 pm, 22 residents were observed seated in the main dining room with 12 of those seated in the assisted area of the dining room. At 5:20 pm, the first meal tray was served to the assisted area of the dining room.</p> <p>On 6/13/17 at 12:05 pm, Resident #22 was observed in the main dining room with liquids on the table in front of her and was by herself at the table. At 1:05 pm, Resident #22 was still at the table by herself when her lunch tray was delivered to her. Resident #22 said meals are always late and said, "We wait and wait and</p>	F 368			

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

PRINTED: 07/26/2017  
FORM APPROVED  
OMB NO. 0938-0391

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F 368	<p>Continued From page 42</p> <p>wait...I forget sometimes why I am even here because of the wait."</p> <p>On 6/13/17 at 12:15 pm, Resident #24 was observed in the main dining room with liquids on the table in front of her. At 12:43 pm, Resident #24 called out to the facility staff in the dining room, "Hurry up, I'm Hungry." At 12:46 pm, her lunch tray was delivered to her.</p> <p>On 6/13/17 at 12:18 pm, 40 residents were observed in the main dining room. At 12:30 pm, 44 residents were observed in the main dining room. At 12:40 pm, the first three meal trays were served to residents who had family members with them.</p> <p>On 6/13/17 at 12:35 pm, Resident #9's Interested Party said he came for lunch every other day and lunch was supposed to start at 12:00 pm, but the meals were always late and the residents sit for a long time waiting for their meals.</p> <p>On 6/13/17 at 2:00 pm, during the Resident Group Interview, 8 of 8 residents said lunch should start at 12:30 pm, but sometimes trays did not come out until 12:45 pm or 1:00 pm and dinner should start at 5:30 pm, but sometimes trays did not come out until 5:45 pm or 6:00 pm.</p> <p>On 6/15/17 at 1:22 pm, CNA #13 said she and the other staff waited until most of the residents were in the dining room before residents' meal tickets were turned into the kitchen and tickets for those who needed assistance with their meal were turned in first. CNA #13 said if a resident had a guest with them, then those tickets were the first ones turned in.</p>	F 368			

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F 368	Continued From page 43  On 6/15/17 at 1:35 pm, CNA #14 said tickets for those who needed assistance with their meal were turned in first. CNA #14 said if a resident had a guest with them, then those tickets were the first ones turned in. CNA #14 said tables with more residents at them had their tickets given to the kitchen ahead of those tables were there were less residents.  On 6/15/17 at 3:20 pm, the CDM said the kitchen relied on nursing staff in the dining room to turn in meal tickets and were supposed to be served on a first come, first served basis to minimize the wait time.  On 6/15/17 at 5:00 pm, the DON said nursing staff are supposed to turn in meal tickets on a first come, first served basis. He said hall trays were supposed to be delivered to residents eating in their rooms within 20 minutes of the hall cart being delivered.	F 368			
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS  (a) Infection prevention and control program.  The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 441		8/10/17	

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F 441	<p>Continued From page 44</p> <p>accepted national standards (facility assessment implementation is Phase 2);</p> <p>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p>	F 441			

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F 441	<p>Continued From page 45</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review and staff interview, it was determined the facility failed to ensure a resident was tested for tuberculosis [a communicable disease] upon admission to the facility. This was true for 1 of 17 (#6) sampled residents and had the potential to spread infectious disease to other residents in the facility. Findings include:  The facility's revised Tuberculosis Screening policy, dated 3/21/13, documented residents without a history of a positive TB [Tuberculosis] test should receive a two step PPD [Purified Protein Derivative] test upon admission and those with a history of a positive TB test should receive a chest x-ray, if not already completed.</p> <p>Resident #6 was admitted on 4/9/13 and readmitted on 2/2/17 with multiple diagnoses, including heart failure.</p> <p>Resident #6's local hospital discharge summary, dated 2/2/17, documented, "Patient is free of signs and symptoms of TB."</p>	F 441	<p>Residents Affected: Resident #6 received TB test on 06/19/2017, with a clear result on 06/21/2017.</p> <p>Potential Residents Affected: All current residents were reviewed by CNE or designee on or before 07/31/2017 for TB screening (TST or Chest X-ray per policy) with 48 hours of admission. Follow-up screening will be completed by a licensed nurse on or before 07/31/2017 as indicated</p> <p>Systematic Change/Education: Beginning the week of 07/24/2017, new admissions will be reviewed in morning clinical meeting to ensure that TB screening is completed.</p> <p>Licensed Nurse Staff will be educated on or before 07/21/2017 by Practice Development Manager (NPE) or Designee on performing Tuberculin Skin</p>		

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F 441	Continued From page 46  Resident #6's Immunization Report for TB PPD skin test, dated 6/16/17 documented, "No data found."  On 6/16/17 at 9:30 am, the Director of Nursing said he could not find information that the resident received a TB test in the hospital or at the facility. He said chest x-rays prior to and after the resident was readmitted were taken for the resident's heart failure and were not a screen for TB.	F 441	Test (TST)/Mantoux Skin Test upon admission for all new admissions and any re-admission whom has been out of the facility less than one year. Any admission with a history of TB must have chest x-ray or documentation of previous chest x-ray and treatment or preventive therapy. Licensed nurses will complete a post-test to validate competency on or before 07/31/2017.  Monitors: Beginning the week of 07/24/2017, an audit of all new and re-admissions will be completed by CNE or designee to insure TB tests were administered within 48 hours of admission. These audits will occur weekly x4 weeks and monthly x2 months.  The results of these audits will be reviewed by the IDT in monthly QAPI.		
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-  (i) Complete;  (ii) Accurately documented;  (iii) Readily accessible; and	F 514		8/10/17	

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F 514	<p>Continued From page 47</p> <p>(iv) Systematically organized</p> <p>(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure the clinical records for 3 of 20 sample residents (#1, #6 and #18) were accurate and complete. This deficient practice placed residents at risk of medical complications due to inaccurate and/or incomplete medical records. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 8/14/16 with multiple diagnoses which included dementia with behavioral disturbances, stage 4 pressure ulcer, Alzheimer's disease, and anxiety.</p> <p>Resident #1's record included monthly recapitulated orders for weekly skin checks. The</p>	F 514	<p>Residents Affected: Resident #1 had a skin assessment and treatment completed by the licensed nurse per MD order on 07/17/2017. The Medical record was updated to reflect the resident's current condition and completion of treatment.</p> <p>Resident 18 discharged from Meridian Center on 06/06/2017.</p> <p>Resident #6 was assessed by the dietitian on 07/18/2017 related to supplement documented as given, that had been discontinued with no concerns identified.</p>		

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F 514	<p>Continued From page 48</p> <p>order was written 8/4/16, and stated "Weekly skin check Thursday day shift. See new Skin Integrity Report." The Skin Integrity Report was reviewed from 3/14/17 to 6/14/17. The report identified Resident #1's wound as a stage IV Pressure Ulcer on her coccyx. The 3 month period included on the Skin Integrity Report, if monitored weekly as ordered, should have had 14 weekly entries. However, there were 7 entries, assessments were not documented for the weeks of 3/27/17, 4/17/17, 5/1/17, 5/15/17, 5/22/17, 6/5/17 and 6/12/17.</p> <p>On 6/14/17 at 2:55 pm, LN #4 stated the assessments were not documented as done. She stated the dressing for Pressure Ulcer on Resident #1's coccyx was changed daily. She stated she was only responsible for her own documentation, and was not able to explain why documentation was not completed by other staff.</p> <p>2. Resident #18 was admitted to the facility on 5/12/17, following a fall at her home which resulted in multiple fractures. Resident #18's diagnoses included End Stage Renal Disease [ESRD] for which she required dialysis 3 times weekly, anemia, osteoporosis, HTN, chronic pain and weakness.</p> <p>Resident #18's June 2017 MAR included Calcium Carbonate tablet 500 mg, two tablets before meals. The MAR did not have LN initials that documented the medication was administered on 6/3/17, 11:30 am, 4:30 pm and 6/4/17, 4:30 pm.</p> <p>On 6/16/17 at 9:40 am, the RN UM stated the MAR most likely did not have initials of an LN</p>	F 514	<p>Potential Residents Affected: A review of resident skin checks, MARS, and TARS for the last 30 days will be completed by the Center Nurse Executive or designee on or before 07/31/2017 for any incomplete documentation. Follow-up will be completed as indicated by the Center Nurse Executive or designee on or before 07/31/2017.</p> <p>Systematic Change/Education: Licensed nurses will be re-educated on documentation requirements for assessments, medication, treatment and supplement administration by the Practice Development Manager (NPE) on or before 07/21/2017. Licensed Nurses will complete a post-test on or before 07/31/2017 to validate competency.</p> <p>Monitors: Beginning the week of 07/24/2017 the Center Nurse Executive or designee will audit 5 resident MARs, TARs, or skin checks to ensure that documentation is accurate and complete and that it reflects the care and services provided. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be compiled by the Center Nurse Executive and reported to the center QAPI committee for review monthly X 3 months or until substantial compliance is maintained. The Center Nurse Executive is responsible for monitoring and follow-up.</p>		

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F 514	<p>Continued From page 49</p> <p>during the times Resident #18 was out for dialysis. She stated the LN should have indicated a "hold" for the medications that were timed during the dialysis. She stated she did not know why the assessments and medications were not documented on Resident #18's MAR.</p> <p>3. Resident #6 was readmitted to the facility on 2/2/17 with multiple diagnoses, including heart failure.</p> <p>Resident #6's Physician's order, dated 5/8/17, documented an order for a house supplement once a day.</p> <p>Resident #6's Nutrition progress note, dated 5/31/17, documented the resident no longer wanted the supplement.</p> <p>Resident #6's Diet Order and Communication Form, dated 5/31/17, documented to discontinue the supplement.</p> <p>Resident #6's current tray card did not indicate the resident received a house supplement.</p> <p>Resident #6's June 2017 Medication Review Report and MAR [Medication Administration Record] documented an order for a house supplement. The MAR documented the resident had received the supplement everyday from 6/1/17 through 6/13/17.</p> <p>On 6/13/17 at 8:20 am and 12:54 pm, on 6/14/17 at 1:10 pm, and on 6/15/17 at 9:05 am, Resident #6 was observed during the breakfast and lunch meals in the main dining room and the resident had not received a house supplement.</p>	F 514			

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

PRINTED: 07/26/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/16/2017</b>
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F 514	Continued From page 50  On 6/14/17 at 10:35 am, Resident #6 said she used to drink a supplement at lunch but she asked for it to be stopped a few weeks prior, because she was no longer concerned about her weight.  On 6/15/17 at 9:00 am, Licensed Nurse #6 reviewed Resident #6's MAR and said the resident received a house supplement at breakfast and nurses would have signed off on the MAR when the supplement was observed at the resident's table.  On 6/15/17 at 9:10 am, the Certified Dietary Manager said Resident #6 did not receive a house supplement.  On 6/15/17 at 2:30 pm, the Director of Nursing said the house supplement order should have been discontinued and nurses should have visualized the supplement prior to signing and said the MAR was inaccurate.	F 514			
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS  The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to have an Emergency Preparedness Program in place to ensure all shifts of staff had received training, and ensure 8 of 28 employees (CNA #1, CNA #2, CNA #4,	F 518	Residents Affected: No residents identified.  Potential Residents Affected: No residents identified. Center Executive	8/10/17	

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F 518	<p>Continued From page 51</p> <p>CNA #5, CNA #6, NA, and two Housekeepers received emergency preparedness training.</p> <p>Findings include:</p> <p>Review of an "Emergency Preparedness Plan" dated 11/01/09 indicated on Section IX: Drills and Training: "Emergency Preparedness drills will be conducted and recorded by the Director of Maintenance. The Safety Committee will determine how to manage the deficiencies, i.e., education, corrective action plan, and/or revising the Emergency Preparedness Plan."</p> <p>On 6/14/17 at 7:34 pm during an interview regarding emergency preparedness training's, CNA #1 stated she had "Received training on Fire Drills, CPR (Cardiopulmonary Resuscitation), choking, and what to do in the event of a power outage." When asked if she had received emergency preparedness training's on inclement weather, bomb threats, or active shooter, CNA #1 stated, "I don't know if I received any other training's for Emergency Preparedness."</p> <p>On 6/14/17 at 7:41 pm during an interview regarding emergency preparedness training's, NA #1 stated, "I know I received an orientation that covered some training's such as fire, and elopements, but I'm not really sure about inclement weather training's, bomb threats, or active shooter training. I'm not really sure what the process is."</p> <p>On 6/14/17 at 8:25 pm during an interview regarding emergency preparedness training's, CNA #2 stated, "I know we get fire drills every</p>	F 518	<p>Director reviewed Emergency Preparation Manual and training calendar for any needed updates on or before 07/21/2017 Calendar was updated to include additional training.</p> <p>Systematic Change/Education: On or before 07/21/2017, staff employed with or contracted with Genesis Healthcare Meridian Center will be educated by Director of Maintenance or Designee on Emergency Preparedness. These educations will include, but not limited to; inclement weather, active shooter, bomb threat, fire, and elopement.</p> <p>Beginning the week of 07/24/2017, facility emergency drills will begin to be conducted under the direction of the Administrator or designee. Education and training will be provided immediately for any staff that cannot demonstrate or verbalize correct procedures. These drills will continue bi-weekly x2 months until all shifts have had emergency preparedness drills.</p> <p>Beginning the week of 07/24/2017, General Orientation Schedule will be revised to allow time for Director of Maintenance to review all Emergency Preparedness plans and procedures.</p> <p>Beginning the week of 07/24/2017, a 2018 Emergency Preparedness Drill calendar will be updated by Administrator of designee to insure all Emergency Preparedness training will be covered</p>	

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F 518	<p>Continued From page 52</p> <p>month on all shifts, but as far as bomb threats, I would have to speak to my supervisor about that. Since I do both central supply and work the floor as a CNA, I really don't know. I'm really not sure."</p> <p>On 6/15/17 at 9:00 am during an interview regarding emergency preparedness training's, the Maintenance Supervisor was asked how often disaster drills were conducted, he stated, "We just had one for the 3rd shift (referring to the graveyard shift from 10 pm-6 am), but the first and second shift (referring to the day and evening staff), I don't remember." When the Maintenance Supervisor was asked if there had been any training's on bomb threats, he stated, "We have not had one this year." When asked about active shooter training's, he stated, "I think four months ago we had a training on the third shift, but nothing this year for the first or second shift. We only talked about it, but we have not had a formal training." When asked about inclement weather training's, the Maintenance Supervisor stated, "We've talked about them, but to be honest, I'm not sure when I'm supposed to have these training's. I've only been here a little over a year."</p> <p>Review of a "Record of Drill Log" dated 2017 revealed the log was checked "Disaster." It further indicated on March 15, 2017, "Elopement Training" was conducted with the first and second shift only (referring to day and evening shift) however, there was no documentation that the third shift (graveyard shift) had received training. Further review of the log indicated on April 16, 2017 a disaster drill was conducted on first shift (day shift). There was no documentation found that showed the evening or graveyard shift</p>	F 518	<p>with all shifts. The dates and shifts of the drills will not be announced to any staff other than; Administrator, Director of Nurses, and Director of Maintenance.</p> <p>Monitors: Beginning the week of 07/24/2017, a random audit of 5 staff members will be conducted by Administrator or designee on emergency preparedness procedures and knowledge. These audits will be conducted weekly x4 weeks and then monthly x2 months.</p> <p>The results of these audits will be reviewed by the IDT in monthly QAPI.</p>		

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F 518	<p>Continued From page 53 had received disaster drill training."</p> <p>On 6/15/17 at 9:05 am during an interview the Maintenance Supervisor stated, "We had an elopement drill on March 15, 2017, on the first and second shift, but the third shift (graveyard shift) were not trained. We did a natural disaster drill on March 16, 2017 on the first shift." When the Maintenance Supervisor was asked if the second or third shift had received the natural disaster training, he stated, "I didn't record it for the second and third shift." He then stated, "On April 26, 2017, I had an active shooter drill on the third shift (referring to graveyard shift), but we didn't have one on the first or second shift."</p> <p>On 6/15/17 at 10:17 am during an interview regarding emergency preparedness training's, Housekeeper #1 stated, "I know we received training on fire drills, but bomb threats no. Probably because I'm new I guess. We have not received any active shooter training's that I know of. I guess if something happened, I guess I would hide."</p> <p>On 6/15/17 at 10:20 am during an interview regarding emergency preparedness training's, the Housekeeping Supervisor stated, "We do a general safety training like fire safety but as far as active shooter training's, we do not have those. I don't know if this building does those specifically or not. As far as training's on bomb threats, we have not had anything specific to that."</p> <p>On 6/15/17 at 1:00 pm during an interview regarding emergency preparedness training's, CNA #4 stated, "For emergency preparedness,</p>	F 518			

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F 518	<p>Continued From page 54</p> <p>there is a book at the nurse's station that gives us different scenarios of what to do." When CNA #4 was asked if he had received any training's on active shooter or bomb threats, he stated, "We talked about it, but we didn't have an actual drill. With the bomb threats, I think we had a meeting."</p> <p>On 6/15/17 at 1:10 pm during an interview regarding emergency preparedness training's, CNA #5 stated, "I think we've had meetings on where to find the book at the nurse's station. As far as bomb threats, I don't recall that very well. Regarding active shooter training, I really don't recall getting any training on that."</p> <p>On 6/15/17 at 1:15 pm during an interview regarding emergency preparedness training's, CNA #6 stated, "We have not had any training's on bomb threats or active shooter."</p> <p>On 6/15/17 at 1:22 pm during an interview regarding emergency preparedness training's, Housekeeper #2 stated, "we have plenty of fire drills, regarding natural disasters, bomb threats, and active shooter training, we have not had any training. I guess if something happened, I would find a safe place to hide."</p> <p>On 6/13/17 at 8:25 am during an interview regarding emergency preparedness training's, Housekeeper #3 stated, she had only been working at this facility about one month and had not been trained on disaster or the disaster policy, which included the fire procedure. Housekeeper #3 stated, she knew the fire doors would shut, and assumed the residents should be in their rooms and a headcount completed.</p>	F 518			

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F 518	<p>Continued From page 55</p> <p>On 6/15/17 at 1:34 p.m. during an interview regarding emergency preparedness training's, the Director of Nursing (DON) stated, "We have fire drill training every month on all three shifts, days, evenings, and nights. We did an armed intruder training recently. All employees have on the back of their badges a list of codes that says what each code is for. For example, code 10 is weather, code 20 bomb, etc. I know employees get training's when they are hired, but the number of "No's" you are getting from our employees is surprising. There should be no excuses as to not knowing all the emergency preparedness training's. We are quite disappointed that our staff is not more aware. This is an issue for us."</p> <p>On 6/15/17 at 1:51 p.m. during an interview regarding emergency preparedness training's the Administrator stated, "I believe we had an active intruder training, we only did one. With bomb threats, we have not done a drill, we only talked about it. With natural disaster, we are not in a flood place and we don't have tornadoes or hurricanes."</p> <p>On 6/16/17 at 9:55 a.m. during an interview regarding emergency preparedness, the Housekeeping Supervisor was asked how do you ensure your staff has received training's on emergency preparedness. He stated "I have only been here a short time. I would imagine the facility would have a stand up meeting to let our staff know. It is my expectation that all staff receive general training's such as fire and emergency preparedness."</p>	F 518			