IDAHO DEPARTMENT OF
HEALTH & WELFARE

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July 3, 2017

John Williams, Administrator
Oneida County Hospital & Long Term Care Facility
Po Box 126
Malad, ID 83252-0126

Provider #: 135062

Dear Mr. Williams:

On **June 16, 2017**, a survey was conducted at Oneida County Hospital & Long Term Care Facility by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 14, 2017**. Failure to submit an acceptable PoC by **July 14, 2017**, may result in the imposition of penalties by **August 5, 2017**.

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

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

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

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

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

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

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

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

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

We are recommending that The Centers for Medicare & Medicaid Services (CMS) RegionX impose the following remedy:

Civil Monetary Penalty

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.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 16, 2017** includes the following:

Denial of payment for new admissions effective **September 16, 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 16, 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

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 14, 2017**. If your request for informal dispute resolution is received after **July 14, 2017** the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135062		06/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL & LONG TERM CARE FACILITY	150 NORTH 200 WEST MALAD, ID 83252

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from June 12, 2017 through June 16, 2017. The surveyors conducting the survey were: Teresa Kobza, RDN/LD, Team Coordinator Linda Kelly, RN ABBREVIATIONS: ADL = Activities of Daily Living bpm = Beats per Minute CAA = Care Area Assessment cm = Centimeter CNA = Certified Nursing Assistant DNS = Director of Nursing Services HS = Hours of Sleep HTN = Hypertension L = Liter LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set mg = Milligram mL = milliliter mm = millimeter mmHg = millimeters of mercury; unit of pressure measurement PRN = as needed PU = Pressure Ulcer PVD = Peripheral Vascular Disease RD = Registered Dietitian RN = Registered Nurse TAR = Treatment Administration Record	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/14/2017

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

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F 000	Continued From page 1 UTI = Urinary Tract Infection x = by % = Percent	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 157		8/2/17

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F 157	Continued From page 2 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, review of Incident and Accident Reports, and review of resident records, it was determined the facility failed to ensure residents' physicians and family were promptly notified of significant changes in their conditions and/or a need to alter treatment. This was true for 2 of 9 sampled residents (#1 and #5) reviewed for notification and had the potential for harm if physicians and/or family were not provided with information necessary to initiate and/or alter interventions to meet residents' changing needs. Findings include: 1. Resident #1 was readmitted to the facility on 2/12/16 with multiple diagnoses, including multiple unstageable pressure ulcers (PU), peripheral arterial disease (PVD), and contractures of the left knee. Resident #1's 2/14/17 quarterly Minimum Data Set (MDS) assessment documented significant cognitive impairment and 5 PUs, three of which	F 157	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truths of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. F157□NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) Corrective Actions Taken: A root cause analysis completed on 7/10/2017 revealed that the facility□s incident reporting tool used in identifying and reporting resident changes of condition was not being appropriately utilized in the care process. The facility□s Incident Reporting Policy has been improved to help assure resident changes of condition are being accurately identified and	

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F 157	Continued From page 3 were present upon admission. A Wound Weekly Observation Tool, dated 2/3/17, documented Resident #1 "acquired" a Stage III PU, measuring 10 millimeters (mm) x 4 mm x 1 mm, to the posterior right hip, and a a Stage III PU, 10 mm x 10 mm x 1 mm, to the anterior right hip on 2/3/17. * A 2/4/17 Nurse's Note documented Resident #1 acquired two open wounds to the right hip. The Note documented the DNS was notified, but not the resident's physician or family. * A Facility Incident Report, dated 2/6/17, documented staff discovered two stage III PUs to Resident #1's right hip, measuring 1 cm x 1 cm x 0.1 cm, and 1 cm x 0.4 cm x 0.1 cm. The Incident Report documented the resident's physician and family was notified on 2/6/17. On 6/16/17 at 10:50 am, the Director of Nursing Services (DNS) stated she measured Resident #1's PUs that were present on admission to the facility on 2/3/17, but did not document the results before leaving for the weekend. The DNS stated she was notified of two new PUs to Resident #1's right hip, discovered by a night shift nurse on 2/4/17, and completed both the Incident and Accident Report and Wound Weekly Observation Tool for all wounds on 2/6/17, which she then back-dated to 2/3/17. The Wound Weekly Observation Tool documented the physician and family were notified of the new PUs on 2/3/17, although the two new wounds were not discovered until 2/4/17 and the DNS stated she called the family and physician when she completed the Incident Report on 2/6/17.	F 157	recorded. This was done by implementing the Interact Communication Tool to notify physicians and resident families regarding resident changes of condition and changes in resident treatment plans. This tool will also be used to immediately notify physicians of resident assessment abnormalities. Nurses will be expected to document Interact Communications in the progress notes. Staff will be educated on its usage by 7/19/2017. Identification Process: All residents have the potential to be affected. Monitoring Performance and Effectiveness: A sweep of all LTC incident reports was conducted on 7/7/2017 and the DON was made aware of the deficiencies found. To assure compliance, the DON or designee will audit facility incident reports and the facility progress notes/Interact Communications for accuracy and completeness five days a week for two weeks, then three days per week for two weeks, then weekly for one month. These audits will be reviewed at the facility□s monthly QAPI meeting. Progress and trending related to this deficiency will be monitored by the QAPI Team. If the QAPI Team determines that further monitoring is necessary, audits will continue per the QAPI Team□s recommendations. Two sets of the QAPI minutes related to this deficiency will be retained by the Nursing Home	

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F 157	Continued From page 4 2. Resident #5 was admitted to the facility on 4/4/16 with multiple diagnoses, including dementia, heart failure, hypertension, orthostatic hypotension, and coronary artery disease. According to the 2017 Nursing Drug Handbook, Metoprolol should not be administered without first assessing the apical pulse rate. If the apical heart rate is less than 60 beats per minute (bpm), the medication should be held and the physician contacted "immediately." Resident #5's June 2017 Physician Orders documented staff was to provide Metoprolol 25 mg twice daily for hypertension, initiated 1/5/17. An Altered Cardiovascular Status Care Plan, revised 4/15/16, documented staff were to assess Resident #5 weekly and as needed, and to notify the physician of "abnormalities." The care plan documented staff was not to administer Metoprolol if the resident's systolic blood pressure was less than 100 mmHg or the heart rate (HR) was less than 60 bpm. The Pulse Vitals Summary Report from 4/1/17 to 6/14/17 documented Resident #5's HR was less than 60 bpm on 34 of 42 (81%) assessments. The clinical record did not contain documentation the physician was notified of Resident #5's low HR's. On 6/15/17 at 9:05 am, the DNS stated staff were to notify the physician if a resident's HR was consistently below 60 bpm.	F 157	Administrator (NHA), or designee. Responsible Party: NHA or designee Completion Date: Compliance will be established by 8/2/2017. Auditing will continue as indicated to assure ongoing compliance.	
F 246	483.10(e)(3) REASONABLE ACCOMMODATION	F 246		8/2/17

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F 246 SS=D	Continued From page 5 OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and resident and staff interviews, it was determined the facility failed to ensure residents' call lights were accessible for use when needed. This was true for 1 of 11 (#1) residents reviewed for call light accessibility and created the potential for harm if residents could not summon staff for assistance when needed. Findings include: Resident #1 was readmitted to the facility on 2/12/16 with multiple diagnoses, including multiple unstageable PUs, Peripheral Artery Disease (PVD), and contractures of the left knee. A 6/6/17 significant change Minimum Data Set (MDS) assessment documented significant cognitive impairment, contractures and/or range of motion impairments with one upper- and one lower extremity (arm/leg), and total dependence or extensive assistance required from staff for all cares except eating. On 6/14/17 at 7:26 pm, Licensed Practical Nurse [LPN] #1 assisted Resident #1 into a wheelchair	F 246	F246 REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES Corrective Actions Taken: Resident #1 is able to appropriately use call light and demonstrated ability to clip call light to bed spread and chair. The NHA or designee will educate facility staff regarding: Identification of residents individual needs with regards to call light placement and assuring that assistive devices are in place and that they are accessible and in good repair. Education of facility staff will be completed by 7/19/2017. Facility orientation will be adapted to include education regarding these education items. Identification Process: All residents have the potential to be affected. Monitoring Performance and Effectiveness: NHA or designee will conduct audits to ensure resident call bells are placed within reach. These	

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F 246	Continued From page 6 positioned at the foot of his bed near a radio/stereo. LPN #1 turned the radio/stereo on and left the room without first placing the resident's call light within his reach. On 6/14/17 from 8:20 pm to 9:04 pm, Resident #1 was observed in his room with the call light not within his reach. On 6/14/17 at 8:45 pm, Resident #1 stated he was waiting for staff to assist him into bed for the night. On 6/16/17 at 10:50 am, the Director of Nursing Services stated residents should have access to call lights while in their rooms.	F 246	audits will be conducted three times per week for two weeks, then weekly for six weeks. An Angel Care Rounds Checklist will be conducted and staff will be educated regarding the appropriate use of this checklist as a quality assurance monitoring tool. This Angel Care Rounds Checklist contains tasks specifically related to ensuring that all residents□ call lights are within reach. The Angel Care Rounds Checklist process will be placed in facility□s Quality Assurance/Performance Improvement (QAPI) program and will be reviewed weekly by a PI subcommittee to ensure completion. This PI subcommittee will report findings directly to the NHA weekly for three months. The PI subcommittee□s findings will also be reviewed monthly by the PI committee for a minimum of three months. The NHA will be responsible for continued compliance. Responsible Party: NHA or designee Completion Date: Compliance will be established by 8/2/2017. Auditing will continue as indicated to assure ongoing compliance.	
F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe	F 252		8/2/17

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F 252	Continued From page 7 upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure residents were provided with a homelike environment. This was true for 2 doors in the dining room, a wall in the private dining room, floor tiles in one of 3 hallways and in the nurses' station, and walls in the rooms of 2 of 9 sample residents (#'s 1 & 8). The failure created the potential for Resident #1 and #8 and all other residents who utilized the dining room, the private dining room and the hallway between rooms 101 and 107, and the hallways by the nurses' station, to experience a negative effect on their sense of comfort and self-esteem. Findings include:	F 252	F252 SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT Corrective Actions Taken: The Maintenance Supervisor and NHA confirmed the findings included in the facility s 2567. These findings included: " Eight cracked floor tiles between rooms 101 and 133 " A hole in one wall in the private dining room " A scrape across one of the double doors in the dining room by the kitchen " A scrape across the door into the kitchen from the dining room	

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F 252	Continued From page 8 1. The following environmental issues were observed during each day of the 5-day survey: a. A line of eight floor tiles across the hallway between rooms 101 and 133 were cracked. Neither of the rooms were occupied. b. A 1 1/4 inch long by 1/2 inch wide hole in one wall in the private dining room. c. A 1/2 inch wide scrape across one of the double doors in the dining room by the kitchen and a 2-inch wide deep scrape across the door into the kitchen from the dining room. d. Black paint over-spray on 10 floor tiles in the nurses' station that were visible from 2 resident hallways. e. A 6-foot long by 6-inch wide scrape on the longest wall in Resident #1's room. 2. On 6/15/17 at 9:25 am, the wall corner molding was observed to be broken or missing by Resident #8's sink, the baseboard under the sink was dingy, and the corners of 3 floor tiles were curled. On 6/15/17 at 4:30 pm, the Plant Operations Manager said that over time he had replaced many floor tiles throughout the facility. He stated the cracked tiles in the hallway and those in the nurses' station also needed to be replaced. The Plant Operations Manager said he would repair the hole in the private dining room, the sink area in Resident #8's room, the scrape on the double door, as well as replace the door into the kitchen, and paint Resident #1's damaged wall.	F 252	" 10 damaged tiles in the nurses station " A scrape on one of the walls in Resident #1s room The Maintenance Supervisor and NHA then conducted a facility wide sweep of all resident rooms and common areas on 7/10/2017 to determine if other similar environmental issues existed. Three other areas were identified as having wall damage requiring putty/paint repair. The Maintenance Supervisor initiated immediate repairs of the hole in the wall in the dining room, the tiles in the hallway between rooms 101 and 133, and the scrape on the wall in Resident #1s room. New doors were ordered to replace the damaged doors identified. Carpeting was ordered to repair the nursing station floor. Identification Process: All residents have a potential to be affected. Monitoring Performance and Effectiveness: The Housekeeping Supervisor, or designee, will educate facility staff regarding appropriate way to move beds and other furniture without scarring walls. The Maintenance Supervisor and NHA will conduct daily/weekly environmental audits in an effort to identify new issues as they arise. To assure compliance, the NHA, or designee, will conduct these environmental audits daily for two weeks, then three times per week for two weeks, then weekly for one month. The audits	

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F 252	Continued From page 9	F 252	will be reviewed at the facility□s monthly QAPI meeting. Progress and trending related to this deficiency will be monitored by the QAPI Team. If the QAPI Team determines that further monitoring is necessary, audits will continue per the QAPI Team□s recommendations. Two sets of the QAPI minutes related to this deficiency will be retained by the NHA, or designee. Responsible Party: NHA or designee. Completion Date: Compliance will be established by 8/2/2017. Auditing will continue as indicated to assure ongoing compliance.	
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, staff interview, and clinical record review, it was determined the facility failed to ensure physician orders were implemented for 1 of 9 residents (#5) reviewed for medication management. This deficient practice had the potential to cause more than minimal harm to Resident #5, who was not administered antihypertensive medications as ordered. Findings include:	F 281	F281□SERVICES PROVIDED MEET PROFESSIONAL STANDARDS Corrective Actions Taken: A root cause analysis completed on 7/10/2017 revealed that the facility nurses did not follow physician orders related to cardiac orders for Resident #5 regarding resident assessment outcomes prior to	8/2/17

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F 281	Continued From page 10 According to the 2017 Nursing Drug Handbook, Metoprolol, an antihypertensive, should not be administered without first assessing the apical pulse rate. If the apical heart rate is less than 60 beats per minute (bpm), the medication should be held and the physician contacted "immediately." The Handbook documented Cardizem should be held and the physician notified when the heart rate is less than 60 bpm or systolic pressure less than 90 mmHg (millimeters pressure of mercury). The Handbook also documented Clonidine required frequent blood pressure and heart rate assessments and the elderly may be more sensitive to the hypotensive effect of the medication. Resident #5 was admitted to the facility on 4/4/16 with multiple diagnoses, including dementia, heart failure, hypertension, orthostatic hypotension, and coronary artery disease. An Altered Cardiovascular Status Care Plan, revised 4/15/16, documented staff was to assess Resident #5 weekly and PRN (as needed). Staff was also directed to notify the physician of "abnormalities," and withhold Metoprolol when the resident's systolic blood pressure (BP) was less than 100 mmHg or her heart rate (HR) was less than 60 bpm. Resident #5's June 2017 Physicians Orders documented: * Cardizem 120 milligrams [mg] once daily for hypertension, ordered 4/24/17. * Metoprolol 25 mg twice daily for hypertension, ordered 1/5/17.	F 281	administration of cardiac medications. The resident□s electronic MAR was immediately updated to include addressing parameters established by the physician regarding assessment prior to and following cardiac medication administration. Nurses will be expected to document corresponding physician notifications in the resident□s progress notes. Staff will be educated on this process by 7/19/2017. Identification Process: All residents have the potential to be affected. Monitoring Performance and Effectiveness: A sweep of all LTC electronic MAR□s and care plans were reviewed and updated to reflect current physician orders. To assure compliance with physician orders, the DON or designee will audit facility electronic MAR and resident assessments for accuracy and completeness five days a week for two weeks, then three days per week for two weeks, then weekly for one month. These audits will be reviewed at the facility□s monthly QAPI meeting. Progress and trending related to this deficiency will be monitored by the QAPI Team. If the QAPI Team determines that further monitoring is necessary, audits will continue per the QAPI Team□s recommendations. Two sets of the QAPI minutes related to this deficiency will be retained by the Nursing Home Administrator (NHA), or designee.	

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F 281	Continued From page 11 * Clonidine 0.1 mg PRN when systolic blood pressure exceeded 180 millimeters of mercury (unit of pressure measurement - mmHg) or when diastolic blood pressure exceeded 110 mmHg. Pulse Vitals Summary Reports for 4/1/17 to 6/14/17 documented Resident #5's HR was assessed on 42 occasions, 34 of which (81%) the resident's HR was recorded at less than 60 bpm, ranging from 48 to 56 bpm. Resident #5's HR should have been assessed a minimum of 150 times between these dates before the medication was administered. a. Medication Administration Records (MAR) from 4/1/17 through 6/14/17 did not document the Cardizem and Metoprolol were held when Resident #5's HR was less than 60 bpm. Resident #5's clinical record did not document Resident #5's HR was reassessed when less than 60 bpm on 30 occasions, or 88% of those times the HR was less than 60 bpm. On 6/15/17 at 9:05 the Director of Nursing Services (DNS) stated staff were to withhold Resident #5's antihypertensive medications, document the medication was held, and notify the physician when the HR was less than 60 bpm. b. A Physician's Order, dated 1/2/17, documented Resident #5 was to receive Clonidine 0.1 mg PRN when systolic blood pressure exceeded 180 mmHg or when diastolic blood pressure exceeded 110 mmHg. The medication was not to exceed 4 tablets within 24 hours.	F 281	Responsible Party: NHA or designee Completion Date: Compliance will be established by 8/2/2017. Auditing will continue as indicated to assure ongoing compliance.	

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F 281	Continued From page 12 BP Vitals Summary Reports from 5/1/17 to 6/14/17 documented Resident #5's systolic BP was greater than 180 mmHg on 36 occasions. Resident #5 received PRN Clonidine on 6 of those occasions, or 17% of the time when her systolic BP was greater than 180 mmHg. Resident #5's clinical record did not document staff consistently reassessed blood pressures after the resident experienced elevated systolic BP greater than 180 mmHg. The facility failed to ensure her BP was rechecked in a timely manner on 21 of 36 (58%) such occasions. On 6/15/17 at 9:05 the DNS stated staff were to administer PRN BP medications when the resident's BP exceeded parameters and should have reassessed the systolic BP for efficacy.	F 281		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 314		8/2/17

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F 314	Continued From page 13 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and resident interview, and record review, it was determined the facility failed to prevent the development of avoidable pressure ulcers (PUs.) This was true for 1 of 1 residents (#1) reviewed for PUs and resulted in harm when Resident #1 developed two Stage III PUs on the right hip. Findings include: Resident #1 was readmitted to the facility on 2/12/16 with multiple diagnoses, including multiple unstageable PU's, peripheral arterial disease (PVD), malnutrition, and contractures of the left knee. Resident #1's 11/15/16 quarterly Minimum Data Set (MDS) assessment documented significant cognitive impairment, 3 Stage III PUs present on admission, repositioning schedule in place, and extensive assistance of two or more staff required for transfers and bed mobility. Resident #1's 2/14/17 quarterly- and 6/6/17 significant change MDS assessments documented: * 5 PUs, 3 of which were present upon admission * Repositioning schedule in place * Extensive assistance of two or more staff required for transfers and bed mobility (quarterly only) The 6/6/17 significant change MDS assessment also documented: * 5 Stage III PUs, 3 of which were present on admission * Total dependence on staff for bed mobility	F 314	F314 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Corrective Actions Taken: A root cause analysis related to wound prevention and identifying residents at high risk for developing pressure sores was conducted on 7/7/2017. This root cause analysis demonstrated the need for updated policies and procedures related to routinely turning and repositioning the resident at risk of skin breakdown. On 7/10/2017 facility staff was educated related to providing cares for a resident with the potential for skin breakdown with emphasis on turning and repositioning residents and how to appropriately document that the resident was repositioned. Also on 7/10/2017, the facility DON initiated Q shift monitoring of CNA documentation regarding the turning and repositioning of residents at high risk of skin breakdown who are unable to turn and reposition themselves. For residents who require assistance with turning and repositioning, CNA s documentation of assistance in repositioning residents was added to the Point Click Care task list. Licensed nursing staff and CNA s were educated at staff meeting regarding the importance of weekly skin assessments and turning and repositioning. A skin assessment sweep was conducted involving all residents, and the care plans for residents found to be at risk for skin	

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F 314	Continued From page 14 A PU Care Plan, dated 11/24/16, documented Resident #1 was provided a pressure reducing mattress to protect his skin, and staff were directed to turn and reposition the resident at least every two hours and as needed (PRN), encourage Resident #1 to change positions while in a wheelchair, and document non-adherence to interventions. A Skilled Charting Assessment, dated 1/28/17, documented Resident #1's skin was "warm, pink, and dry." The assessment did not document concerns with Resident #1 refusing to reposition either in bed or while sitting in a chair/wheelchair. The facility's Hourly Rounding form instructed staff to monitor Resident #1's positioning by identifying current positioning, position changes with new position noted, and amount of assistance required with repositioning. The Hourly Rounding did not provide space to document whether Resident #1 was repositioned every two hours and/or whether the resident refused. Examples included: * The Hourly Rounding form, dated 2/1/17 from 3:00 pm to 10:59 pm, documented Resident #1 was in a wheelchair from 3:00 pm to 8:00 pm with no documentation of encouragement or refusals to reposition. The Hourly Rounding documented from 9:00 pm to 10:59 pm documented Resident #1 was in bed; it did not document Resident #1's position while in bed, whether there was a position change, or the level of assistance Resident #1 required. * The Hourly Rounding form, dated 2/1/17 11:00	F 314	breakdown were updated to assure that all diagnoses that might contribute to skin breakdown or place skin integrity at risk were clearly identified on the resident care plan along with appropriate interventions for the prevention of skin breakdown. Identification Process: All residents have the potential to be affected. Monitoring Performance and Effectiveness: The DON or designee, accompanied by the Wound Care Nurse, will review skin assessments and CNA documentation regarding turning and repositioning weekly. The wound Care Nurse will work with the DON to develop a treatment plan that will be subsequently reviewed by the physician and Interdisciplinary Team (IDT) weekly. The DON/designee and Wound Care Nurse will document applicable interventions and resident responses to those interventions on the EMR. Resident care plans will then be updated weekly or as needed. The weekly skin assessments and CNA turning and repositioning documentation will be reviewed by the DON five times a week for two weeks, then three times a week for two weeks, then weekly to assure that the skin assessments and turning and repositioning documentation are being completed and appropriate interventions are being implemented. Findings will be reported to the QAPI Team monthly and will continue as long as the QAPI deems	

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F 314	Continued From page 15 pm to 6:59 am and 2/2/17 from 11 pm to 6:59 am, documented Resident #1 was in bed from 11:00 pm to 6:59 am with no documentation of encouragement or refusals to reposition. The Hourly Rounding for did not document Resident #1's position while in bed, whether there was a position change, or the level of assistance Resident #1 required. * The Hourly Rounding form, dated 2/3/17 from 11:00 pm to 6:59 am, documented Resident #1 was in bed on his right side from 11:00 pm to 3:59 am with no documentation of encouragement or refusals to reposition. From 4:00 am to 5:00 am, Resident #1 was documented as being on his back, and from 5:00 am to 6:59 am, the form documented Resident #1 was on his right side. The Hourly Rounding form did not consistently document whether the resident's position was changed, new positioning, or the level of assistance Resident #1 required if he was repositioned. * The Hourly Rounding form, dated 2/4/17 from 7:00 am to 2:59 pm, documented Resident #1 was in bed from 7:00 am to 11:59 am with one documented refusal to get out of bed, and no documented encouragement or refusals to reposition. From 12:00 pm to 2:59 pm, the form documented Resident #1 was in a wheelchair with no documentation that staff encouraged repositioning. The Hourly Rounding form did not document Resident #1's positioning, whether positioning was changed, or the level of assistance Resident #1 required. * The Hourly Rounding form, dated 2/4/17 from 3:00 pm to 10:59 pm, documented Resident #1	F 314	it necessary. Responsible Party: DON or designee Completion Date: Compliance will be established by 8/2/2017. Auditing will continue as indicated to assure ongoing compliance.	

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F 314	Continued From page 16 was in bed with a one hour exception from 5:00 pm to 6:00 pm. The Hourly Rounding form documented an "R" without specifying whether the resident refused to get out of bed, repositioning, or if he was positioned on his right side. * The Hourly Rounding form, dated 2/4/17 from 11:00 pm to 6:59 am, documented Resident #1 was in bed on his right side from 11:00 pm to 3:59 am with no documentation of encouragement or refusals to reposition. From 4:00 am to 5:00 am, the form documented Resident #1 was on his left side, and on his right side from 5:00 am to 6:59 am. The Hourly Rounding form did not consistently document Resident #1's position, position changes, or the level of assistance Resident #1 required. Wound documentation was as follows: * A Wound Weekly Observation Tool, dated 2/3/17, documented Resident #1 "acquired" a Stage III PU (measuring 10 millimeters (mm) by 4 mm by 1 mm) to his posterior right hip on 2/3/17. The observation tool documented Resident #1 was on a pressure reducing mattress, as well as a turning and repositioning schedule of "at least" every two hours. * A Wound Weekly Observation Tool, dated 2/3/17, documented Resident #1 "acquired" a Stage III PU (10 mm by 10 mm by 1 mm) to his anterior right hip on 2/3/17. The observation tool documented Resident #1 was on a pressure reducing mattress, as well as a turning and repositioning schedule of "at least" every two hours.	F 314		

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F 314	Continued From page 17 On 6/16/17 at 10:50 am, the Director of Nursing Services (DNS) stated the two hip PUs were discovered on 2/4/17 by a night nurse and not on 2/3/17 as documented on the Wound Observation Tools. The DNS stated on 2/3/17 she measured other PU's that were present upon the resident's admission to the facility, however she did not chart the results before leaving for the weekend. She stated she was notified on 2/4/17 about an additional two new PUs to Resident #1's right hip. The DNS stated the Incident and Accident report was completed on 2/6/17 and she completed the Wound Weekly Observation Tool for all wounds and back-dated those measurements to 2/3/17. * A Skilled Charting Assessment, dated 2/4/17, documented Resident #1's skin was "warm, pink, dry, and intact." The assessment did not document concerns with Resident #1 refusing to reposition in bed and chairs. * A Nurse's Note, dated 2/4/17 at 5:49 am, documented Resident #1 was incontinent and that "... two open wounds: one (3 x 3 cm) and the second (1.5 cm) were noted on right hip." The Note documented the RN notified the DNS, but did not document Resident #1's physician or family was notified of the newly discovered pressure ulcers. * A Facility Incident Report, dated 2/6/17, documented staff discovered two Stage III PUs to Resident #1's right hip measuring 1 cm by 1 cm by 0.1 cm, and 1 cm by 0.4 cm by 0.1 cm. The Incident Report documented the PUs to the right hip were caused by decreased circulation,	F 314		

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F 314	Continued From page 18 smoking, decreased mobility, and weight loss. The Incident Report documented staff were to reposition Resident #1 to his back and left side "only" every two hours and PRN. The Incident report documented Resident #1's mattress was changed to a Low Air Loss Mattress on 2/7/16. The Incident report documented the physician and family was notified of the newly discovered pressure ulcers on 2/6/17. * A PU Care Plan revision, dated 2/7/17, documented Resident #1 used a low loss air mattress to protect his skin. The care plan documented staff was to turn and reposition at least every two hours and PRN, encourage Resident #1 to change positions while in his wheelchair, and to document non-adherence to interventions. A Skilled Charting Assessment, dated 2/11/17, documented Resident #1's had multiple open wounds to the right hip, and was swearing during bed checks, repositioning, catheter/peri care and wound care. The assessment documented Resident #1 experienced increased pain with movement and repositioned himself back onto his right side. On 6/13/17 from 2:31 pm to 4:23 pm, Resident #1 was observed in a wheelchair in a common area near his room. There were no staff offers to reposition during the nearly two-hour observation despite interaction with two staff during this time. On 6/15/17 at 9:05 am, the DNS stated Certified Nursing Assistants should reposition residents every two hours when care planned.	F 314		

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F 314	Continued From page 19 The documentation prior to the discovery of the two Stage III PU wounds did not record he was consistently repositioned every two hours or that he refused to reposition. On 6/15/17 at 9:05 am, the DNS stated Resident #1 had three different mattresses and when the hip PUs were discovered she "thinks" he was placed on an air mattress (ArroAIR MAX Pump & Premier Air Mattress System). She stated when the hip PU worsened the facility purchased a "True Low Loss Air Mattress" (Moxi Fusion 2K Convertible Air Mattress) and placed it on his bed. The DNS stated another resident who tried the first ArroAIR MAX Mattress told her it was not comfortable. The DNS was not "exactly sure" when the first air mattress was placed on Resident #1's bed. A PU Care Plan version, dated 6/16/16, 8/9/16, 11/24/16, and 2/2/17, documented Resident #1 used a "pressure reducing mattress" to protect his skin. An Invoice from a supplier, dated 7/19/16, documented an "ArroAIR MAX Pump & Premier Air Mattress System" was ordered for the facility. The invoice did not document which resident received the air mattress or when it was initiated. A Wound Weekly Observation Tool, dated 2/3/17, documented Resident #1's Stage III PU measured 10 mm x 10 mm x 1 mm to his anterior right hip. The Observation Tool documented Resident #1 was on a "pressure reducing mattress." A Wound Weekly Observation Tool, dated 2/3/17,	F 314		

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F 314	Continued From page 20 documented Resident #1's Stage III PU was 10 mm x 4 mm x 1 mm to his posterior right hip. The Observation Tool documented Resident #1 was on a "pressure reducing mattress." A Facility Incident Report, dated 2/6/17, documented staff discovered two Stage III PU's to Resident #1's right hip. The Incident report documented Resident #1's mattress was changed to a low air loss mattress. A PU Care Plan version, revised 2/7/17, documented Resident #1 used a "low loss air mattress" to protect his skin. Wound Weekly Observation Tools documented the following: * 2/10/17 - Resident #1's Stage III PU measured 10 mm x 16 mm x 1 mm to his anterior right hip. A Stage III PU on the posterior hip measured 10 mm x 4 mm x 1 mm. The observation tool documented Resident #1 slept on a "low air loss mattress." * 2/17/17 - Resident #1's Stage III PU measured 5 mm x 13 mm x 1 mm to his anterior right hip and slept on a "pressure reducing mattress." A Stage III PU to the posterior right hip measured 3 mm x 3 mm x 1 mm, and the resident slept on a "low air loss mattress." * 2/20/17 - Resident #1's Stage III PU measured 10 mm x 14 mm x 1 mm to his anterior right hip, and the resident slept on a "pressure reducing mattress." A Stage III PU to the posterior right hip measured 5 mm x 5 mm x 1 mm, and Resident #1 slept on a "low air loss mattress."	F 314		

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F 314	Continued From page 21 An invoice from a supplier, dated 3/1/17, documented a "Moxi Fusion 2K Convertible Air Mattress" was delivered to the facility. A Wound Weekly Observation Tool, dated 3/2/17, documented Resident #1's Stage III PU was 5 mm x 10 mm x 1 mm to his anterior right hip. The Observation Tool documented Resident #1 was on a "True Low Loss Air Mattress." A Wound Weekly Observation Tool, dated 3/2/17, documented Resident #1's Stage III PU healed to his posterior right hip. The observation tool documented Resident #1 was on a "low air loss mattress." A Wound Weekly Observation Tool, dated 3/10/17, documented Resident #1's Stage III PU was 10 mm x 10 mm x 1 mm to his anterior right hip. The Observation Tool documented Resident #1 was on a "True Low Loss Air Mattress." A Wound Weekly Observation Tool, dated 3/17/17, documented Resident #1's Stage III PU was 10 mm x 15 mm x 1 mm to his anterior right hip. The Observation Tool documented Resident #1 was on a "True Low Loss Air Mattress." Resident #1's clinical records included other Wound Weekly Observation Tool between 3/23/17 and 6/13/17 for the anterior right hip wound which documented he was on a "True Low Loss Air Mattress" and the PU wound size worsened to 15 mm x 15 mm x 1 mm on 4/21/17 and then improved. The facility failed to ensure protective interventions were implemented prior to the	F 314		

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F 314	Continued From page 22 discovery of two new PUs involving a resident who had other PUs and disease factors which placed him at higher risk for skin impairment.	F 314		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of records and facility policies, it was determined the facility failed to ensure 1 of 1 (#1) sampled residents who smoked was provided with a safe smoking area	F 323	F323 FREE OF ACCIDENT/ HAZARDS/SUPERVISION/DEVICES Corrective Actions Taken: During annual survey process, one resident was	8/2/17

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F 323	Continued From page 23 and safe smoking practices were enforced. * A resident's nasal cannula was left in place while he smoked with staff assistance. * A resident smoked in non-designated smoking areas. This deficient practices created the potential for more than minimal harm if the resident's oxygen ignited and staff could not respond with timely emergency procedures. Findings include: The Facility's Companion Liquid Oxygen System Manufacture's guide, dated 2009, documented a warning that smoking near the equipment was not safe. A Resident Smoking Policy, dated 7/31/13, documented the facility would establish and maintain safe resident smoking practices. The policy documented: * Residents would be informed of any limitations on smoking, including designated smoking areas. * Residents were to smoke in the "designated/approved smoking areas only." Residents were not to use oxygen in the smoking area. * Smoking restrictions would be "strictly enforced in all nonsmoking areas." Resident #1 was readmitted to the facility on 2/12/16 with multiple diagnoses, including multiple unstageable pressure ulcers, peripheral arterial disease [PVD], and contractures of the left knee. The significant change Minimum Data Set (MDS)	F 323	observed smoking while wearing his oxygen canister and tubing in a non-designated smoking area. The oxygen was turned off but the resident was still wearing the nasal cannula and tubing. A root cause analysis related to smoking safety was conducted on 6/13/2017. As part of the root cause analysis, facility administration reviewed the IDAPA and NFPA guidelines as well as Norco guidelines for patient safety related to the use of liquid oxygen canisters. NFPA and IDAPA regulations call for personal oxygen tanks and tubing to be removed and stored at least twenty feet from designated smoking areas. The NHA determined that, in order to fully meet these regulations, the facility needed to provide a space or receptacle bin where residents who use oxygen and also smoke could store their oxygen tank and tubing within the building while they smoked outside. A storage area was immediately created next to the ER entrance where resident personal oxygen equipment could be stored while the resident smoked. Facility staff was educated on 6/13/2017 regarding the removal of resident personal oxygen equipment prior to taking residents out to smoke. Although the area in which the resident was smoking was initially a non-designated smoking area, it is an entrance to the facility and as such, the area contains a receptacle that visitors may use to extinguish cigarettes. A fire proof trash receptacle, fire blanket and fire extinguisher will be ordered and	

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F 323	Continued From page 24 assessment, dated 6/6/17, documented Resident #1 experienced significant cognitive impairment. A Physician's Order, dated 5/26/17, documented Resident #1 was to receive 2 liters (L) of oxygen continuously through a nasal cannula, which could be removed while the resident was smoking. The Smoking Care Plan, revised 5/10/17, documented Resident #1 could smoke with "supervision only." Interventions included: * Resident #1 could smoke with supervision and was aware of the correct smoking area. Nurses would store lighters and cigarettes. * Resident #1 was aware of the facility policy on smoking, including permissible locations, times, and relevant safety concerns. * Staff was to notify the Charge Nurse (RN) or the Social Worker (LSW) "immediately" if it was suspected Resident #1 was not following the facility smoking policy. * Staff was to observe Resident #1's skin and clothes for signs of cigarette burns. A Smoking Assessment, dated 6/1/17, documented Resident #1 smoked 5-10 cigarettes per day on average, and smoked in the morning, afternoon, and evening. The assessment documented the facility would store smoking materials, and that the resident required supervision while smoking. On 6/13/17 at 5:14 pm, Certified Nursing Assistant (CNA) #1 was observed outside the facility with Resident #1, who was smoking. The resident and CNA #1 were outside an adjoining	F 323	added to the area. A line will be painted that that will indicates where an individual must remain in order to be in compliance with NFPA and IDAPA regulations if smoking in this area. Identification Process: Residents who smoke and use personal oxygen equipment have the potential to be affected. Monitoring Performance and Effectiveness: The NHA or designee will audit all residents who smoke and utilize personal oxygen equipment daily for two weeks, then weekly for six weeks, to assure personal oxygen equipment is being removed and stored in the proper area prior to the resident going out to smoke and that individuals are smoking in the demarcated area. Smoking safety will be placed in the facility□s Quality Assurance/Performance Improvement (QAPI) program and will be reviewed weekly by a PI subcommittee to ensure facility practices are in accordance with professional standards of quality. This PI subcommittee will report findings directly to the NHA weekly for three months. The PI subcommittee□s findings will also be reviewed monthly by the PI committee for a minimum of three months. Responsible Party: Administrator or designee Completion Date: Compliance will be	

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F 323	Continued From page 25 Emergency Room entrance and under its covered area. The covered area had two signs posted on the side of the building near the emergency room entrance which read, "No Smoking." The Emergency Room entrance did not contain safety equipment such as smoke blankets, smoking aprons, or a fire extinguisher. Resident #1's wheelchair was under the covered area and near a cigarette receptacle approximately 15 feet from the emergency room entrance. Resident #1 had a nasal cannula in his nose and a portable oxygen tank attached to the back of his wheelchair. CNA #1 handed Resident #1 a cigarette, turned off his oxygen, left the nasal cannula in place on his face, and proceeded to light the cigarette. Resident #1 smoked the cigarette with CNA #1 present. On 6/13/17 at 7:17 pm, Licensed Practical Nurse (LPN) #1 was observed assisting Resident #1 outside to smoke. LPN #1 wheeled Resident #1 to the designated smoking area, where she turned off his oxygen and removed the nasal cannula. LPN #1 placed the nasal cannula on the back of the wheelchair next to the portable oxygen tank, handed Resident #1 a cigarette, and lit the cigarette. LPN #1 then sat down in a chair near Resident #1 and waited for him to finish his cigarette. On 6/13/17 at 7:20 pm, CNA #1 stated she would typically turned off Resident #1's oxygen, left the nasal cannula in place with the portable oxygen tank on the back of his wheelchair, provided the resident with a cigarette and lit it for him. CNA #1 stated she stays with the resident until his finishes the cigarette and then takes him to the covered area by the Emergency Room entrance	F 323	established by 8/2/2017. Auditing will continue as indicated to assure ongoing compliance.	

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F 323	Continued From page 26 because it is difficult for Resident #1 to travel the full distance to the designated smoking area. CNA #1 stated Resident #1 refused to smoke in the designated smoking area the previous week because the ground was rough and hurt his hips. On 6/13/17 at 7:26 pm, LPN #1 stated staff accompanies Resident #1 to smoke as often as he chooses, typically to the designated smoking area. LPN #1 stated she usually took Resident #1 to the designated smoking area, turned off the oxygen, removed the nasal cannula, and then gave him a cigarette. She stated she did not know if the oxygen tank needed to be removed from the back of the wheelchair while a resident smoked. On 6/13/17 at 7:25 pm, the Administrator stated Resident #1 was not compliant with the smoking policy and using only the designated smoking area to smoke. The Administrator stated Resident #1 went to the designated smoking area with another smoker, but not with a nonsmoker. The administrator did not know how far away an oxygen tank should be from a resident who is smoking. The Administrator stated the nasal cannula should be removed and oxygen turned off while a resident was smoking. On 6/14/17 at 4:45 pm, LPN #1 stated the facility was told by an oxygen supplier company that an oxygen tank should be kept at least 5 feet away from a smoking resident.	F 323		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility	F 328		8/2/17

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F 328	Continued From page 27 and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal	F 328		

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F 328	Continued From page 28 suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, it was determined the facility failed to ensure staff changed residents' oxygen tubing, humidifiers, and cannulas per resident care plans. This was true for 2 of 4 sampled residents (#1 and #5) receiving oxygen therapy and created the potential for harm from respiratory infections due to the growth of pathogens in oxygen tubing, humidifiers, and cannulas. Findings include: 1. Resident #1 was readmitted to the facility on 2/12/16 with multiple diagnoses, including Chronic Obstructive Pulmonary Disease, smoking, and pulmonary embolism. Resident #1's 6/6/17 significant change Minimum Data Set (MDS) assessment documented significant cognitive impairment and oxygen therapy required. A Shortness of Breath Care Plan, revised 5/27/17, documented staff was to change	F 328	F328 TREATMENT/CARE FOR SPECIAL NEEDS Corrective Actions Taken: A root cause analysis conducted on 7/7/2017 revealed that the nursing staff failed to follow the proper procedure for replacing and changing oxygen tubing and cannula. On 7/10/2017, the facility DON initiated a facility wide sweep wherein all residents utilizing oxygen tubing cannulas had new oxygen tubing and cannulas placed. For residents who require oxygen tubing, changing out resident oxygen tubing and cannulas on the fifteenth of every month was added to the Point Click Care CNA task list. Identification Process: All residents have the potential to be affected. Monitoring Performance and Effectiveness: Facility staff has been educated regarding checking oxygen	

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F 328	Continued From page 29 Resident #1's oxygen tubing and humidifier each month and as needed (PRN). A 5/26/17 Physician's Order directed staff to provide Resident #1 with 2 liters (L) of oxygen continuously through a nasal cannula. Medication Administration Records and Treatment Administration Records [MARs/TARs] between 5/26/17 and 6/13/17 did not specify when the resident's oxygen tubing, humidifier and nasal cannula was to be changed. On 6/15/17 at 12:05 pm, Resident #1 was observed in his wheelchair with oxygen. The oxygen tubing connected to the portable oxygen concentrator was not dated. The Director of Nursing Services (DNS), who was present at the time of the observation, stated the oxygen tubing was not dated. The DNS stated the resident's tubing was usually changed on the 15th of each month. 2. Resident #5 was admitted to the facility on 4/4/16 with multiple diagnoses including, atherosclerosis heart disease, coronary arterial disease, and angina. A quarterly MDS assessment, dated 4/18/17, documented Resident #5 was cognitively intact and required oxygen therapy. An Oxygen Therapy Care Plan, revised 5/6/16, documented Resident #5 required oxygen related to insomnia and sleep apnea. The care plan documented staff was to change Resident #5's oxygen tubing and humidifier monthly and PRN.	F 328	tubing and cannula for tags dated within the past 30 days on the fifteenth of every month. Also, the competency checklist has been updated to include checking oxygen tubing and cannula for tags dated within the past 30 days. To assure compliance, the DON or designee will monitor the administration of oxygen and oxygen delivery equipment. Monitoring will be conducted five days a week for two weeks, then three days per week for two weeks, then weekly for one month. These audits will be reviewed at the facility□s monthly QAPI meeting. Progress and trending related to this deficiency will be monitored by the QAPI Team. If the QAPI Team determines that further monitoring is necessary, audits will continue per the QAPI Team recommendations. Two sets of the QAPI minutes related to this deficiency will be retained by the NHA or designee Responsible Party: NHA or designee Completion Date: Compliance will be established by 8/2/2017. Auditing will continue as indicated to assure ongoing compliance.	

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F 328	Continued From page 30 A Physician's Order, dated 4/19/16, directed staff to provide Resident #5 with 2 L of oxygen continuously through a nasal cannula. MARs/TARs from 4/1/17 to 6/13/17 did not specify when the tubing, humidifier and nasal cannula was to be changed. The resident's clinical record did not include documentation that the facility had changed Resident #5's oxygen tubing, humidifier, and/or cannula. On 6/14/17 at 3:25 pm, Resident #5 was observed in the activities room wearing oxygen. The resident's oxygen tubing connected to the portable oxygen concentrator was not dated. On 6/15/17 at 9:05 am, the DNS stated the oxygen tubing, nasal cannula, and humidifiers were changed on the 15th of the month and PRN.	F 328		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or	F 329		8/2/17

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F 329	Continued From page 31 (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure psychotropic medications were monitored for adverse reactions and that medications ordered for insomnia were monitored. This was true for 7 of 10 residents (#s 1, 2, 4, 5, 6, 8 and 9) reviewed for medications. The failure created the potential for harm if treatments and interventions were inappropriate because adverse reactions to psychotropic medications were undetected. Findings include:	F 329	F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Corrective Actions Taken: On 6/16/2017, a root cause analysis was conducted regarding the administration of psychoactive and hypnotic medications revealed that the facility failed to provide staff with adequate tools to identify and monitor side effects of psychoactive medications and hypnotic medications to include hours of sleep. Also, it was	

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F 329	Continued From page 32 1. Resident #4 was admitted to the facility in 2014, and readmitted on 2/17/17, with multiple diagnoses, including Parkinson's disease, dementia with behavioral disturbance, bipolar disorder, major depressive disorder, anxiety, and chronic pain. Resident #4's Psychotropic Medication Care Plan, initiated 2/27/14, documented staff were to monitor, document, and report any adverse reactions to psychotropic medications. Resident #4's Physician's Orders for 5/1/16 to 6/30/17 documented: * Clonazepam and Doxepin were ordered for bipolar disorder on 2/17/17. * Depakote was ordered for major depressive disorder on 2/17/17. * Cymbalta was ordered for chronic pain and major depressive disorder on 3/3/17 and increased on 5/6/17. Resident #4's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for June 2017 did not contain documentation the facility monitored for potential adverse reactions to psychotropic medications. Resident #4's Behavior/Intervention Monthly Flow Records for May 2017 and 6/1/17 through 6/14/17 did not contain documentation that adverse reactions to the psychotropic medications was monitored.	F 329	identified that Resident 2 had a diagnosis of Anxiety but specific behaviors related to the diagnosis were not addressed on the care plan nor were they addressed in the resident's behavior monitoring. The DON conducted a facility wide sweep of all residents receiving hypnotic medications to assure that they are being monitored every shift for hours of sleep. The DON also updated both the care plan and behavior monitoring documentation for Resident 2 to address Anxiety. Identification Process: All residents have the potential to be affected. Monitoring Performance and Effectiveness: DON or designee will monitor all residents with prescribed psychoactive medications and hypnotic medications for potential side effect and adverse reactions. A new form monitoring the side effect of psychoactive medications and hypnotic medications was created, and facility staff was educated regarding the use of this new form on 7/19/2017. The DON or designee will review these forms for accurate nursing documentation and sleep pattern documentation. These audits will be conducted five days a week for two weeks, then three days per week for two weeks, then weekly for one month. These audits will be reviewed at the facility□s monthly QAPI meeting. Progress and trending related to this deficiency will be monitored by the QAPI Team. If the QAPI Team determines that	

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F 329	Continued From page 33 On 6/15/17 at 9:05 am, the Director of Nursing Services (DNS) said the facility should monitor for adverse reactions of psychotropic medications and the issue would be corrected. 2. Resident #6 was admitted to the facility in 2015 and readmitted on 12/1/16 with multiple diagnoses including dementia with behavioral disturbance, psychotic disorder with delusions, major depressive disorder, and chronic pain. Resident #6's Physician's Orders for 5/1/16 to 6/30/17 documented: * Antipsychotic medication - Staff were to monitor for dry mouth, constipation, blurred vision, disorientation/confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea/vomiting, lethargy, drooling, tremors, disturbed gait, increased agitation, restlessness, involuntary movement of mouth or tongue. Document a "Y" if monitored and none observed; document an "N" if monitored and any were observed and chart a progress note of the findings. Ordered 3/20/17. * Seroquel was ordered on 3/20/17 for psychotic disorder with delusions. * Zoloft was ordered on 1/6/17 for major depressive disorder. Resident #6's June 2017 MAR contained the order to monitor for adverse reactions of antipsychotic medications, instructions for "Y" or "N," and spaces for documentation on the day, evening and night shift for each day of the month. A check mark and an undetermined staff	F 329	further monitoring is necessary, audits will continue per the QAPI Team□s recommendations. Two sets of the QAPI minutes related to this deficiency will be retained by the NHA or designee. Responsible Party: NHA or designee Completion Date: Compliance will be established by 8/2/2017. Auditing will continue as indicated to assure ongoing compliance.	

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F 329	Continued From page 34 member's initials were documented in all spaces from 6/1/17 through 6/13/17 day shift. On 6/14/17 at 5:25 pm, the DNS said she did not know what the check marks meant. 3. Resident #8 was admitted to the facility in 2013 with multiple diagnoses including major depressive disorder. Resident #8's antidepressant use for neuralgia care plan and a care plan for depression with anxiety, both initiated in 2013, documented the facility was to monitor for side effects and adverse reactions to the antidepressants. Resident #8's Physician's Orders for 5/1/16 to 6/30/17 documented buspirone was ordered 8/1/16 for anxiety disorder and Cymbalta was ordered 9/4/13 for neuralgia neuritis and radiculitis. Resident #8's June 2017 MAR and TAR and the Behavior/Intervention Monthly Flow Records for May and June 2017 did not contain documentation that the facility monitored for potential adverse reactions to the psychotropic medications. On 6/15/17 at 9:05 am, the DNS said the facility should monitor for side effects and adverse reactions of psychotropic medications and that the issue would be corrected. 4. Resident #1 was readmitted to the facility on 2/12/16 with multiple diagnoses, including a single episode of major depression and anxiety.	F 329		

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F 329	Continued From page 35 Resident #1's 6/6/17 significant change Minimum Data Set (MDS) assessment documented significant cognitively impairment with minimal signs of depression. The MDS documented Resident #1 did not experience hallucinations or delusions. The Psychotropic Medication Care Plan, revised 3/12/14, documented staff was to monitor Resident #1 for adverse side effects of medications with medication pass. Resident #1's June 2017 Physician's Orders included: * Ativan 0.5 milliliter (mL) every hour as needed for anxiety, ordered 5/25/17. * Remeron 30 mg by mouth at bedtime for major depression single episode, ordered 3/21/16. * Staff were to monitor for side effects from antianxiety medication, including drowsiness, slurred speech, dizziness, nausea, aggressive/impulsive behavior, ordered 2/12/16. The order gave instructions for staff to monitor and document a "Y" if side effects to the antianxiety medication were not observed and an "N" if side effects were detected. Staff were directed to chart a progress note describing any side effect that Resident #1 displayed. The MAR/TARs from 2/1/17 to 6/13/17 did not contain documentation that the facility monitored the resident for potential side effects to the antianxiety medication.	F 329		

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F 329	Continued From page 36 Behavior Monitors from 5/1/17 to 6/14/17 did not contain documentation that the facility monitored for potential side effects to the anti-anxiety medication. On 6/15/17 at 9:05 am, the DNS stated the facility should have monitored for side effects of the psychotropic medications, which was completed for some other residents, but not for Resident #1. The DNS stated the issue would be corrected. 5. Resident #2 was admitted to the facility on 12/11/15 with multiple diagnoses, including anxiety. A quarterly MDS assessment, dated 4/19/17, documented Resident #2 was cognitively intact and exhibited no signs and/or symptoms of depression. An Anxiety Side Effects Care Plan, revised 12/29/15, documented staff was to monitor Resident #2 for adverse side effects of Clonazepam. Resident #2's care plan did not identify resident-specific behaviors associated with anxiety for staff to monitor. Resident #2's June 2017 Physician's Orders included: * Clonazepam 0.25 mg every evening for anxiety, ordered 6/2/17. * Staff was to monitor for side effects from antianxiety medication, including drowsiness,	F 329		

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F 329	Continued From page 37 slurred speech, dizziness, nausea, aggressive/impulsive behavior, ordered 12/11/15. The order directed staff to monitor and document a "Y" if side effects to the antianxiety medication were not observed and an "N" if side effects were observed. Staff were directed to chart a progress note with any side effect that Resident #2 displayed. The MAR/TAR from 6/2/17 to 6/12/17 did not contain documentation that the facility monitored for side effects to the anti-anxiety medication. Behavior Monitors from 5/1/17 to 6/14/17 did not contain documentation that the facility monitored for side effects to the anti-anxiety medication. On 6/15/17 at 9:05 am, the DNS stated the facility should monitor for side effects of the psychotropic medications and it was on the MAR with some residents, but not Resident #2. The DNS stated the issue would be corrected. 6. Resident #5 was admitted to the facility on 4/4/16 with multiple diagnoses, including Dementia and insomnia. A quarterly MDS assessment, dated 4/18/17, documented Resident #5 was cognitively intact and exhibited no signs of depression. An Oxygen Therapy Care Plan, revised 5/6/16, documented Resident #5 required oxygen therapy related to insomnia and sleep apnea. Staff was to administer Melatonin as ordered. The care plan did not include directions for staff to monitor Resident #5's hours of sleep.	F 329		

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F 329	Continued From page 38 A Physician's Order, dated 4/4/16, documented Resident #5 was to receive one tablet of Melatonin/Magnesium/Zinc/L-trip 5/250/10/160 mg per day related to insomnia. The clinical record did not contain an order for staff to monitor Resident #5's hours of sleep. The MAR/TAR from 4/1/17 to 6/13/17 did not contain documentation that Resident #5's hours of sleep were monitored by staff. On 6/15/17 at 9:05 am, the DNS stated the facility should have monitored the number of sleeping hours for those residents receiving related medications to determine their efficacy. 7. Resident #9 was admitted to the facility on 4/7/10 with multiple diagnoses, including dementia, insomnia, sleep apnea, anxiety, and dysthymic disorder [chronic depression]. A quarterly MDS assessment, dated 4/18/17, documented Resident #9 was cognitively intact and exhibited no signs of depression. A Psychotropic Medication Care Plan, revised 3/12/14, documented staff was to monitor Resident #9 for adverse side effects of medications. Resident #9's June 2017 Physician's Orders included: * Buspar 5 mg two times daily related to anxiety, ordered 9/23/16. * Staff was to monitor for side effects from	F 329		

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F 329	Continued From page 39 antianxiety medication, including drowsiness, slurred speech, dizziness, nausea, aggressive/impulsive behavior, ordered 7/8/15. The order directed staff to monitor and document a "Y" if no side effects to the antianxiety were observed and an "N" if side effects were observed. Staff was to chart a progress note if any side effects to antianxiety medications were observed. The MAR/TAR from 6/1/17 to 6/15/17 contained the order for the antianxiety medication side effects monitors, however the boxes contained a check mark rather than a "Y" or "N" as ordered to indicate if Resident #9 experienced any side effects to the medication. On 6/15/17 at 2:45 pm, the DNS stated the facility should have monitored for side effects of psychotropic medications, and space was provided as part of Resident #9's MARs, however the documentation did not follow physician orders and it was difficult to determine if the resident experienced any adverse side effects from the medication.	F 329		
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, staff interview and record review, it was determined the facility failed to	F 333	F333 RESIDENTS FREE OF SIGNIFICANT MED ERRORS	8/2/17

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F 333	Continued From page 40 ensure residents were free of significant medication errors. This was true for 1 of 9 residents (#3) observed during medication administration and 2 blood glucose (BG) assessments, and created the potential for Resident #3 to experience hypoglycemia when facility staff administered an excessive dose of fast-acting insulin. Findings include: Resident #3 was admitted to the facility on 2/15/17 with multiple diagnoses, including Type II diabetes mellitus, diabetic neuropathy and dementia. On 6/13/17 at 12:15 pm, the Assistant Director of Nursing (ADON) was observed assessing Resident #3's BG, which was 243. Then, the resident walked out of the room to the dining room. When asked whether insulin per sliding scale was required, the ADON said that it was not as Resident #3 was not ordered to receive insulin. Resident #3's care plan for diabetes, revised 3/3/17, included interventions for BG checks before meals and at bedtime, diabetic medications as ordered, and directives for the resident to eat within 15 minutes of receiving fast-acting insulin per sliding scale. Resident #3's Physician Orders and June 2017 MAR documented a 2/15/17 order for BG checks before meals and bedtime and a 4/25/17 order for Novolog insulin by subcutaneous injection per sliding scale as follows: * 70 - 149 = no units of insulin; * Below 80 notify physician;	F 333	Corrective Actions Taken: A root cause analysis completed on 7/10/2017 revealed that the facility nurse was given the accurate blood glucose result but entered it incorrectly in the electronic MAR. Facility Assistant Director of Nursing (ADON) immediately notified the resident□s physician and informed him of the med error. One-on-one education was conducted immediately with the resident□s nurse and a facility incident report was completed. Staff will be educated regarding the proper Insulin administration and documentation by 7/19/2017. Identification Process: All residents have the potential to be affected. Monitoring Performance and Effectiveness: A sweep of all residents receiving Insulin was conducted to make sure that the sliding scale dosage was given as ordered. To assure compliance, the DON or designee will conduct med pass audits and insulin documentation reviews for accuracy and completeness five days a week for two weeks, then three days per week for two weeks, then weekly for one month. These audits will be reviewed at the facility□s monthly QAPI meeting. Progress and trending related to this deficiency will be monitored by the QAPI Team. If the QAPI Team determines that further monitoring is necessary, audits will continue per the QAPI Team□s recommendations. Two	

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F 333	Continued From page 41 * 150 - 200 = 2 units; * 201 - 250 = 4 units; * 251 - 300 = 6 units; * 301 - 350 = 8 units; * 351 - 400 = 10 units; * Greater than 400 notify physician. Resident #3's June 2017 MAR contained areas to document BG results (before meals and at bedtime) and corresponding Novolog insulin administrations per sliding scale. In the BG results space for 6/13/17 at 11:30 am, the BG was documented as 243. In the Novolog insulin per sliding scale space for 6/13/17 at 11:30 am, a BG of "253" was documented and administration of 6 units of Novolog insulin was also documented. On 6/13/16 at 3:20 pm, the ADON said she was mistaken when she said Resident #3 did not receive insulin per sliding scale. The ADON said she reported the resident's BG of 243 to LPN (Licensed Practical Nurse) #1 and that LPN #1 administered sliding scale insulin to the resident. On 6/13/17 at 3:30 pm with the ADON present, LPN #1 said she documented Resident #3's BG was 253 in one place and 243 in another place. The LPN said she administered 6 units of Novolog insulin, rather than 4 units per sliding scale orders, to the resident by mistake. LPN #1 stated the excessive insulin administration qualified as a medication error.	F 333	sets of the QAPI minutes related to this deficiency will be retained by the Nursing Home Administrator (NHA), or designee. Responsible Party: NHA or designee Completion Date: Compliance will be established by 8/2/2017. Auditing will continue as indicated to assure ongoing compliance.	
F 368 SS=E	483.60(f)(1)-(3) FREQUENCY OF MEALS/SNACKS AT BEDTIME (f) Frequency of Meals	F 368		8/2/17

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F 368	Continued From page 42 (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 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. (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. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, it was determined the facility failed to ensure bedtime (HS) snacks were offered to all residents. This was true for 3 of 12 residents in a Resident Group interview and 5 of 11 residents (#1, #4, #7, #9 and #11) reviewed for nutritional status. The failure created the potential for more than minimal harm if residents experienced hunger between dinner and breakfast and/or did not receive adequate nutrition to support healing or prevent weight loss. Findings include: The facility's Snacks Policy and Procedure, dated 6/14/17, documented HS snacks would be provided to all residents unless contraindicated by the physician.	F 368	F368 FREQUENCY OF MEALS/SNACKS AT BEDTIME Corrective Actions Taken: A root cause analysis completed on 7/10/2017 revealed that the facility failed to ensure that all residents were receiving HS snack. It was also discovered that certain residents were regularly removing multiple snacks from the facility fridge in the day room that were supposed to be available for all residents. A new locking refrigerator was procured and placed in the nurses station where snacks could be secured until time of delivery. HS Snack delivery and percent consumed by the resident have been added to the Point Click Care CNA task list. Facility staff	

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F 368	Continued From page 43 On 6/13/17 at 8:45 pm, Certified Nursing Assistant (CNA #1) stated she and all other night shift CNAs delivered HS snacks from 7:30 to 8:00 pm throughout the facility rather than only to selected residents. On 6/13/17 at 8:56 pm, CNA #2 stated she and other CNAs helped pass snacks at night. CNA #2 stated all residents were offered an HS snack, which CNAs documented as either accepted or refused. On 6/14/17 at 5:00 pm, The Registered Dietitian (RD) stated all residents should receive an HS snack. The RD stated dietary staff members prepared snacks three times daily, which were then delivered to residents at 10:00 am, 3:00 pm, and 7:00 pm. On 6/15/17 at 9:05 am, the Director of Nursing Services (DNS) stated CNAs should document HS snacks as either accepted or refused in each resident's clinical record. a. On 6/13/17 at 10:00 am, 3 of 12 residents attending a group interview stated said they were not consistently offered bedtime snacks. b. Resident #1 was readmitted to the facility on 2/12/16 with multiple diagnoses, including multiple unstageable pressure ulcers and malnutrition. Resident #1's May 2017 HS snack record documented he did not receive an HS snack on 16 of 31 opportunities, or 52% of the time. Resident #1's 6/1/17 through 6/13/17 HS snacks	F 368	was educated regarding the delivery and documentation of HS Snack on 6/15/2017. Identification Process: All residents have the potential to be affected. Monitoring Performance and Effectiveness: To assure that residents are receiving HS Snacks and that this is being documented, the DON or designee will audit Point Click Care CNA task lists for accuracy and completeness related to HS Snacks. Also, the DON or designee will conduct audits with facility residents to make sure that they are receiving their evening snacks. These audits will conducted five days a week for two weeks, then three days per week for two weeks, then weekly for one month. These audits will be reviewed at the facility□s monthly QAPI meeting. Progress and trending related to this deficiency will be monitored by the QAPI Team. If the QAPI Team determines that further monitoring is necessary, audits will continue per the QAPI Team□s recommendations. Two sets of the QAPI minutes related to this deficiency will be retained by the Nursing Home Administrator (NHA), or designee. Responsible Party: NHA or designee Completion Date: Compliance will be established by 8/2/2017. Auditing will continue as indicated to assure ongoing compliance	

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	135062		06/16/2017

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F 368	Continued From page 44 record documented he did not receive an HS snack 7 of 13 opportunities, or 54% of the time. On 6/14/17 at 3:42 pm, Resident #1 stated he normally received a snack a couple times each day, but that there were days when he did not receive an HS snack. c. Resident #7 was admitted to the facility on 4/6/11 with multiple diagnoses, including dysphagia. Resident #7's May 2017 HS snack record documented he did not receive an HS snack 18 of 31 opportunities, or 58% of the time. Resident #7's 6/1/17 through 6/13/17 HS snacks record documented he did not receive an HS snack 4 of 13 opportunities, or 31% of the time. On 6/14/17 at 6:20 pm, Resident #7 stated he sometimes did not receive an HS snack. d. Resident #9 was admitted to the facility on 4/7/10 with multiple diagnoses, including protein malnutrition. Resident #9's May 2017 HS snack record documented she did not receive an HS snack 14 of 31 opportunities, or 45% of the time. Resident #9's 6/1/17 through 6/14/17 HS snacks record documented she did not receive an HS snack 5 of 14 opportunities, or 36% of the time. On 6/15/17 at 8:55 am Resident #9 stated the facility offered a snack once or twice each day. She stated she did not recall specific times of day	F 368		

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F 368	Continued From page 45 that snacks were offered, but knew staff did not offer HS snacks each night. e. Resident #11 was admitted to the facility on 1/16/17 with multiple diagnoses, including diabetes mellitus. Resident #11's May 2017 HS snack record documented she did not receive an HS snack 17 of 31 opportunities, or 55% of the time. Resident #11's 6/1/17 through 6/15/17 HS snacks record documented she did not receive an HS snack 8 of 15 opportunities, or 53% of the time. On 6/14/17 at 3:54 pm, Resident #11 stated she was not "routinely" offered a snack before bedtime and normally received her last snack of the day between 3pm and 4 pm. 4. Resident #4 was admitted to the facility in 2014 and readmitted on 2/17/17 with multiple diagnoses, including upper respiratory infection and chronic respiratory failure, with a history of Parkinson's disease, heart failure, and anxiety disorder. On 6/13/17 at 9:00 pm, Resident #4 said she was not offered a snack at bedtime that night and that it was "hit and miss" with staff offering bedtime snacks. Resident #4's documentation of Nutrition - Snacks for 5/1/17 through 6/14/17 at 9:29 am documented a snack at bedtime was offered 14 of 31 nights in May and 4 of 13 nights in June.	F 368		
F 431	483.45(b)(2)(3)(g)(h) DRUG RECORDS,	F 431		8/2/17

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F 431 SS=E	Continued From page 46 LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws,	F 431		

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F 431	Continued From page 47 the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure pharmacy medication labels were consistent with physician orders and that expired insulin was not available for administration to residents. This was true for 3 sample residents (#2, #3 and #5) and one random resident (#11) observed during medication pass. These deficient practices created the potential for medication errors when Random Resident #11's warfarin (blood thinner) pharmacy label was incorrect; Resident #5's Combigan pharmacy label omitted the left eye that was to receive the medication and an acetaminophen label was different from what the physician ordered; and the potential for more than minimal harm when Humalog insulin for Residents #2, #3, and #11 was in use for more than 28 days after they were opened. Findings include: 1. On 6/13/17 (a Tuesday) at 4:00 pm, Registered Nurse (RN) #1 was observed as she	F 431	F431 DRUG RECORDS, LABEL/STORAGE DRUGS & BIOLOGICALS Corrective Actions Taken: A root cause analysis conducted on 7/7/2017 revealed that two medications received from the pharmacy did not have the appropriate labeling. Also, the nursing staff was not following facility policy related to removing and replacing expired Insulin from the medication cart. The mislabeled medications were corrected immediately and the insulins were removed from the cart and replaced immediately. Idnetification Process: All residents have the potential to be affected. Monitoring Performance and Effectiveness: A sweep of all resident medications was initiated immediately	

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F 431	Continued From page 48 prepared 4 oral medications, including warfarin, and a nebulizer medication for RR #11. The warfarin pharmacy label documented warfarin 4 milligrams (mg) daily except Tuesday and Thursday. RN #1 took the oral medications and nebulizer medication to RR #11's room. Before entering the resident's room, RN #1 was asked the day of the week. She said it was Tuesday. At that time, the RN was asked to reread the warfarin pharmacy label and compare it to the physician's order for warfarin. RN #1 immediately returned to the medication cart by the nurses' station and reread the warfarin pharmacy label. She said she did not notice "except Tuesday and Thursday" when she initially read the label. The RN then read the physician's order which documented warfarin 4 mg was ordered for every day. RN #1 said she would notify the pharmacy of the issue. 2. On 6/14/17 4:45 pm, Licensed Practical Nurse (LPN) #2 was observed removing a bottle of Combigan eye drops (medication to treat glaucoma medication) from the medication cart and preparing 6 oral medications, including acetaminophen 500 mg 1 tablet, for Resident #5. The Combigan pharmacy label documented, "Instill 1 drop two times a day." The acetaminophen pharmacy label documented, "Take one tablet by mouth two times a day." LPN #2 took the medications to Resident #5's room and administered all of them, including 1 acetaminophen tablet and 1 drop of Combigan in the resident's left eye only. Immediately afterward, when asked how she knew which eye to instill the Combigan, LPN #2	F 431	and completed on 7/6/2017. No other expired or mislabeled medications were found. All nurses were educated regarding recommended replacement of Insulin within every 28 days. Insulin will be dated when opened and replaced in 28 days. All nurses were also educated to verify that medication labels match the electronic MAR. The DON or designee will monitor Insulin administration. Monitoring will be conducted five days a week for two weeks, then three days per week for two weeks, then weekly for one month. These audits will be reviewed at the facility□s monthly QAPI meeting. Progress and trending related to this deficiency will be monitored by the QAPI Team. If the QAPI Team determines that further monitoring is necessary, audits will continue per the QAPI Team□s recommendations. Two sets of the QAPI minutes related to this deficiency will be retained by the DON, or designee. Responsible Party: DON or designee. Completion Date: Compliance will be established by 8/2/2017. Auditing will continue as indicated to assure ongoing compliance	

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F 431	Continued From page 49 said the eMAR (electronic Medication Administration Record) documented Combigan 1 drop in the left eye only. LPN #2 then reviewed the physician's order for Combigan which documented 1 drop in the left eye two times a day. The LPN stated she would notify the pharmacy of the issue and request a new label. Resident #5's Physician's Orders directed staff to provide acetaminophen, 500 mg, every 12 hours as needed for breakthrough pain. When asked about the discrepancy between the acetaminophen pharmacy label and the physician's order, the Assistant Director of Nursing (ADON) said the pharmacy label for Resident #5's acetaminophen was incorrect and that the pharmacy would be notified promptly. 3. According to the Nursing 2017 Drug Handbook, Humalog insulin should be used within 28 days after being opened. a. On 6/13/17 at 12:00 pm, LPN #1 was observed filling a syringe with 2 units of Humalog insulin for Resident #11. The insulin bottle was marked as opened on 5/6/17. As the LPN was about to enter the resident's room with the insulin syringe in hand, she was asked about the open date of insulin. LPN #1 returned to the medication cart where she checked the open date and said the Humalog was expired. LPN #1 retrieved a new bottle of Humalog then administered 2 units to Resident #11. Resident #11's Humalog insulin was in use 10 days longer than recommended. b. On 6/13/17 at 12:00 pm, LPN #1 removed 2	F 431		

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F 431	Continued From page 50 opened bottles of Humalog insulin from the medication cart and said they were expired. One vial was for Resident #2 and the other was for Resident #3. Both Humalog vials had an open date of 5/5/17, indicating each was in use 11 days longer than recommended. LPN #1 discarded all of the expired Humalog insulin vials with the DNS present.	F 431		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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July 19, 2017

John Williams, Administrator
Oneida County Hospital & Long Term Care Facility
150 North 200 West, Po Box 126
Malad, ID 83252-0126

Provider #: 135062

Dear Mr. Williams:

On **June 16, 2017**, an unannounced on-site complaint survey was conducted at Oneida County Hospital & Long Term Care Facility. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007545

The complaint was investigated during a Complaint and Federal Recertification Survey conducted June 12, 2017 to June 16, 2017.

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

The clinical records of the identified resident and eight other residents were reviewed for quality of life and quality of care issues, including abuse prevention and investigation. The facility's grievance files and Incident and Accident reports were reviewed.

Interviews were conducted with multiple individual residents and the identified resident. Several direct care staff, including nurses and nursing aides, were also interviewed as well as the Director of Nursing Services, Social Worker, and the Administrator. The interviews included questions about abuse prevention, reporting, investigating, and protecting residents.

Allegation #1: The facility failed to protect the identified resident from abuse.

Findings #1: Based on interviews with residents and staff members, and record reviews, there were no concerns with the facility's abuse investigation findings.

The identified resident spoke with an outside agency, the Bureau of Facility Standards, and the facility about an abuse-related concern. The identified resident outlined different versions of the alleged abuse with the different entities. Based on observation, interviews, and record review, the allegation could not be substantiated due to lack of sufficient evidence.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The facility failed to protect the identified resident from a staff member whom allegedly threatened the resident.

Findings #2: Based on observations and interviews with staff and residents, there were no concerns identified with residents feeling or being threatened by staff. The identified resident spoke with an outside agency, the Bureau of Facility Standards, and the facility about an abuse-related concern. The identified resident outlined different versions of the alleged abuse with the different entities. Based on observation, interviews, and record review, the allegation could not be substantiated due to lack of sufficient evidence.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt