



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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July 14, 2017

Dawn Meyer, Administrator
Lincoln County Care Center
511 East Fourth Street, Po Box 830
Shoshone, ID 83352-1502

Provider #: 135056

Dear Ms. Meyer:

On **June 30, 2017**, a survey was conducted at Lincoln County Care Center 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 immediate jeopardy to resident health or safety, as documented on the enclosed CMS-2567, whereby significant corrections are required.** You were informed of the immediate jeopardy situation(s) verbally in writing on **June 28, 2017**.

On **June 29, 2017**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your allegation, it was determined that the immediate jeopardy to the residents had been removed. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 24, 2017**.

Failure to submit an acceptable PoC by **July 24, 2017**, may result in the imposition of additional civil monetary penalties by **August 18, 2017**.

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

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

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

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

Dawn Meyer, Administrator
July 14, 2017
Page 3

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

Based on the immediate jeopardy cited during this survey:

F0309 -- S/S: J -- 483.24, 483.25(k)(1) -- Provide Care/services For Highest Well Being
F0323 -- S/S: J -- 483.25(d)(1)(2)(n)(1)-(3) -- Free Of Accident Hazards/supervision/devices

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

Civil money penalty

Denial of Payment for New Admission effective **September 30, 2017**.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 30, 2017**, if substantial compliance is not achieved by that time.

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

Your facility's noncompliance with the following:

F0309 -- S/S: J -- 483.24, 483.25(k)(1) -- Provide Care/services For Highest Well Being; F0323 -- S/S: J -- 483.25(d)(1)(2)(n)(1)-(3) -- Free Of Accident Hazards/supervision/devices

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

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

Dawn Meyer, Administrator
July 14, 2017
Page 4

Residents # **#8** as identified on the enclosed Resident Identifier List.

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

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

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **July 24, 2017**. If your request for informal dispute resolution is received after **July 24, 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,

Dawn Meyer, Administrator
July 14, 2017
Page 5

A handwritten signature in black ink that reads "D. Scott". The "D" is stylized with a vertical line through it, and "Scott" is written in a cursive-like font.

David Scott, RN, Supervisor
Long Term Care

ds/dr
Enclosures

cc: Chairman, Board of Examiners - Nursing Home Administrators

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

PRINTED: 08/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/30/2017
NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST FOURTH STREET SHOSHONE, ID 83352		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility June 26, 2017 to June 30, 2017. The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator Marcia Mital, RN Abbreviations: CNA = Certified Nursing Assistant DNS = Director of Nursing Services GERD = Gastroesophageal Reflux Disease GI = Gastrointestinal LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set mcg/hr = Microgram(s) per hour mg = Milligram(s) mL = MiliLiters(s) PRN = As needed RCD = Regional Clinical Director W/C = Wheelchair	F 000			
F 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.	F 156		7/21/17	

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

TITLE

(X6) DATE

Electronically Signed

07/21/2017

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 156	Continued From page 1 (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect,	F 156			

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F 156	<p>Continued From page 2</p> <p>exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.</p> <p>(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(vi) Information and contact information for filing grievances or complaints concerning any</p>	F 156			

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F 156	<p>Continued From page 3</p> <p>suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.</p> <p>(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:</p> <p>(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and</p> <p>(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.</p> <p>(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written</p>	F 156			

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F 156	<p>Continued From page 4</p> <p>information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.</p> <p>(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.</p> <p>(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.</p> <p>(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;</p> <p>(g)(17) The facility must--</p> <p>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-</p> <p>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;</p> <p>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and</p>	F 156		

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F 156	Continued From page 5 (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's	F 156			

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F 156	<p>Continued From page 6 date of discharge from the facility.</p> <p>v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to publicly post a current list of residents' rights. This had the potential to adversely affect 33 of 33 residents in the facility who may not have been aware of those rights or how to exercise those rights. Findings include:</p> <p>On 6/27/17 at 2:30 pm, the facility's posted resident rights, dated 2002, were observed not to include updated changes from November 2016.</p> <p>On 6/27/17 at 2:30 pm, the Administrator stated the resident rights posting had not been updated with the 2016 changes.</p> <p>On 6/28/17 at 10:20 am, the Administrator stated the facility's residents had not been informed of changes to the resident rights, but that a new poster with the updated information had been ordered.</p>	F 156	<p>F156 Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes. The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.</p> <p>The facility will ensure that each resident will be informed of their rights on admission and will publicly post any and all changes to the rights and information related to resident rights</p> <ol style="list-style-type: none"> 1. All current residents were affected by the deficient practice. 2. This has the potential affect all new admissions. 3. We provided all current residents and family/legal representative with an updated copy of resident' Rights, along with a statement letting them know of the changes. <p>We posted the new and current Resident rights Poster in common area for all residents to read and observe.</p> <p>The new Resident rights was placed in all admission packets.</p>		

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F 156	Continued From page 7	F 156	All staff in-serviced on Federal Citations and deficient practice. Social services and admission staff in-serviced on Federal citations and deficient practice. 4. Audits will be performed (see attached audit tool) 1x weekly for 4 weeks, then monthly x3 to ensure a) Current Resident Rights poster is present in common area. b) that all admission packets contain current Resident Rights information. All audits to be brought to QA/QI meeting monthly.		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual	F 167		7/21/17	

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F 167	<p>Continued From page 8 to review upon request; and</p> <p>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.</p> <p>(iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interview, it was determined the facility failed to ensure posted survey results were identifiable and notice was posted that the three preceding years of survey results were available for review. This deficient practice had the potential to affect sample residents (#s 1-9) and all others residents in the facility, their representatives, and visitors who may have wanted to review information about the facility's survey history. Findings include:</p> <p>Each day from 6/26/17 to 6/28/17, an unmarked plastic wall pocket was observed in the hallway to the dining room. A binder, labeled "survey results," was in the wall pocket, however, the binder's label was below the top of the wall pocket and the label was not legible through the dark colored plastic. In addition, notice of availability of survey results for the preceding 3 years was not found in the facility during survey.</p> <p>On 6/27/17, during a Group Interview with 7 residents, none of the residents knew where the survey results were located. One of the 7 residents said s/he knew s/he could ask to see the survey results.</p>	F 167	<p>F 167 The resident has the right to examine the results of the most recent survey of the facility conducted by Federal and State surveyors, and any plan of correction.</p> <p>Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.</p> <p>Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the three preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and</p> <p>Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.</p> <ol style="list-style-type: none"> 1. All current residents were affected by the deficient practice. 2. All new admissions have the potential to be affected by the deficient practice. 3. The most recent three years of survey results were printed and placed in a binder, and placed on wall at eye level for 		

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F 167	Continued From page 9 On 6/28/17 at 10:50 am, the Administrator said the wall pocket with the survey results binder had a sign on it but a resident kept pulling the sign off and it was not replaced. The Administrator said notice that previous survey results were available for review was not posted in the facility.	F 167	wheel chair residents. A sign was posted just above stating that there was three years of survey results, and the frame was attached so it could not be removed by residents. The plastic wall sleeve was also labeled with statement of survey results in binder. The label was placed so it could not be easily removed. All staff in-serviced on Federal citations and deficient practice.		
F 247 SS=D	483.10(e)(6) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide written notice prior to a room change. This was true for 1 of 10 residents sampled for facility practices (#2) and 1 random resident (#17) and had the potential to adversely affect the sense of self-determination and dignity of any resident	F 247	4.Audits 1x weekly for 4 weeks, then monthly x 3 to ensure that three years of survey and findings are available to family/residents/ and legal representatives. All audits to be reviewed in QA/QI monthly F247 Respect and Dignity. The resident has a right to be treated with respect and dignity, including: The right to receive written notice, including the reason for the change, before the resident's room or roommate	7/21/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/30/2017
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F 247	Continued From page 10 assigned to a new room without prior input or notification. Findings include: During an initial tour of the facility on 6/26/17 at 10:30 am, Licensed Practical Nurse (LPN) #1 stated Resident #17 had moved into a room with Resident #2 on 6/22/17. The clinical records of both Resident #2 and Resident #17 did not include documentation that written notice was provided to either resident prior to the move. On 6/27/17 at 2:44 pm, the Resident Service Director stated she was not able to locate a written notice regarding the move for either resident.	F 247	in the facility is changed. 1. This affected 2 of 33 residents. 2. This has the potential to affect all resident who may have room changes. 3. All staffed in-serviced on Residents Rights to be given notice of change of room or roommate with reason for such change. Social services was in-serviced on documentation of room changes. A form was formatted to assist with notifications. Resident #2 and #17. Both resident were interviewed about current placement, no concerns were expressed. 4. Audits will be performed 1x weekly for 4 weeks than monthly x 3 to ensure all residents that will have a possible room change or room mate are notified of event. All audits to be brought to QA/QI monthly.		
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 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-	F 252		7/21/17	

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F 252	<p>Continued From page 11</p> <p>(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>(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.</p> <p>(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 baseboards and a cabinet door in the dining room and a wall in the telephone room on the west hallway. The failure created the potential for sample residents (#s 1-9) and all other residents living in the facility to experience a negative effect on their sense of comfort and self-esteem. Findings include:</p> <p>1. a. On 6/26/17 at 11:50 am, and daily from 6/26/17 through 6/30/17, ten white spots of missing paint 1-2 inches long were observed on 2 olive green colored baseboards in the dining room. The baseboards with missing paint were located between the window into the kitchen and the kitchen door, as well as between the kitchen door and the Linen Room door.</p> <p>b. On 6/29/17 at 8:40 am, the left door of the dining room cabinet with the emergency "crash" cart in it was observed in disrepair. The left lower corner of the cabinet door was coming apart and</p>	F 252	<p>F 252 The resident has the right to a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. 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.</p> <p>1.All current residents were affected by the deficient practice. 2.All new admits have the potential to be affected by the deficient practice. 3.All baseboards in the building was audit for chips, all chips painted. The cabinet door to crash cart area in dining room was repaired and assessed for any nail or screws to be protruding. The pitted area to Phone booth was filled and area to phone booth was painted. All staff in-serviced for monitoring for paint chips or areas in environment that</p>		

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F 252	Continued From page 12 an exposed nail was parallel to the door panel at the unattached joint. During all days of the survey, all residents were observed dining, observing/participating in activities in the dining room, or going through the dining room to get to the Therapy Room, the Sun Room, or the back yard. 2. On 6/28/17 at 11:30 am, five pitted and torn areas were observed on three 12 inch by 12 inch wall tiles by the light switch in the telephone room on the west hallway. On 6/29/17 at 2:15 pm, during a tour of the facility, the Maintenance Supervisor said he would attend to the identified areas in need of repair as soon as possible.	F 252	may need repair. These issues are to be brought to Maintenance director attention, and repaired timely. 4. Audits will be performed 1x weekly for 4 weeks, then monthly for 3 months to ensure a) walls and baseboards have no chips or missing paint. b) That phone booth has no pitted areas around light switch. c) and that cabinet door has no nails or areas of concern. All audits to be brought to QA/QI monthly.		
F 309 SS=J	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 309		7/21/17	

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F 309	<p>Continued From page 13</p> <p>practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:</p> <p>(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure staff recognized and reported the need for suctioning to licensed nurses for 1 of 1 sample residents (#8) with orders and care plan interventions for oral suctioning as needed. The failure placed the health and safety of Resident #8 in immediate jeopardy of serious harm, impairment, or death from choking and/or aspiration. In addition, the facility failed to ensure pain medications were administered per physician orders for 2 of 3 residents (#2 and #6) with orders for Fentanyl patches. The failure created the potential for harm if residents' pain was not controlled. Findings include:</p> <p>1. Resident #8 was admitted to the facility in 2013 with multiple diagnoses, including</p>	F 309	<p>F309</p> <p>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:</p> <p>Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the</p>		

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F 309	<p>Continued From page 14</p> <p>intracranial injury, convulsions, salivary secretion disturbances, gastroesophageal reflux disease (GERD), nausea, and history of recurrent pneumonia.</p> <p>Resident #8's most recent quarterly Minimum Data Set (MDS) assessment, dated 5/30/17, documented persistent vegetative state/no discernable consciousness; total assistance of 2 or more staff required for bed mobility and transfers; total assistance of 1 staff required for eating; 51% or more caloric intake and daily fluids received via enteral route; functional limitation in range of motion in both upper and both lower extremities; and wheelchair (W/C) use.</p> <p>Resident #8's care plan documented:</p> <ul style="list-style-type: none"> * GI (gastrointestinal) upset related to GERD - Place on side if emesis, initiated 12/17/13. * History of recurrent pneumonia, wheezing and cough - Orders for oral suctioning by licensed nurses if needed, initiated 3/18/14. * Persistent vegetative state, dependent for all cares - "special" W/C when up, initiated 12/8/15. * Nutrition/feeding tube - History of recurrent upper respiratory infections "(aspiration pneumonia)." If symptoms of aspiration (fever, moist cough, choking, watery eyes, nasal discharge, increased respirations, or audible breathing) notify nurse, initiated 11/30/16. <p>Resident #8's Total Plan of Patient Care directions for Certified Nursing Assistants (CNAs) contained an undated Additional Comments section which documented, "Notify nurse if resident has excessive oral salivation - suctioning PRN (as needed)."</p>	F 309	<p>comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>1) This affected 2 of three residents. 2) This has the potential to affect all current residents with orders for pain patches. 3) Orders were changed to reflect set times on electronic MARS. All License staff in-serviced to the change in practice. 4) Audits will be performed 1x weekly x 4 weeks, then monthly x3 to ensure patches are being changed in parameters of order. All audits to be reviewed monthly in QA/QI process. Quality of Life: 1) This affected one of 33 residents. 2) All residents with Dysphasia diet or swallowing issues has the potential to require PRN suctioning.</p> <p>3) Facility will review and audit Mars for signatures to show License staff are monitoring for placement of Yaunker and tubing to suction machine in room.</p> <p>CNAs were in-serviced on elevating head-of-bed and reporting to licensed staff if the resident exhibited signs and/or symptoms of saliva around the mouth or choking.</p> <p>The Maintenance Supervisor was to place a mark on the wall to assist in properly elevating the resident's</p>		

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F 309	<p>Continued From page 15</p> <p>Resident #8's Order Summary Report for 12/28/16 - 6/30/17 documented:</p> <ul style="list-style-type: none"> * Change suction canister, tubing and Yankeur (brand of suction tip) every week as needed "upon usage," dated 1/11/17; * Jevity 1.0 at 100 ml/hour (miliLiters per hour) from 5:00 pm to 8:00 am, dated 3/3/16; * Glycopyrrolate 1 milligram (mg) via feeding tube 3 times a day for excessive salivation, dated 2/13/16. <p>On 6/28/17 at 5:40 pm, Resident #8 was observed laying on his back in a geriatric chair next to his bed. The resident's head was elevated 30 degrees and Jevity 1.0 was infusing at 100 ml/hour via feeding tube. Occasional gurgling sounds were heard coming from the resident's mouth. There was a suction machine on the resident's bedside table, but no suction tubing or suction tip device.</p> <p>On 6/28/17 at 5:45 pm, CNA #2 entered the room and began assisting Resident #8's roommate. When asked about suction tubing and a suction tip for Resident #8, CNA #2 said she had seen them earlier, "but not now." CNA #2 looked in Resident #8's bedside table drawers but did not find suction tubing or a suction tip. The CNA resumed assisting the roommate, but stopped a few moments later and looked briefly at Resident #8 when he made a loud gurgling sound. CNA #2 said she would "get a nurse" then left the room.</p> <p>On 6/28/17 at 5:46 pm, CNA #2 returned to Resident #8's room and said a nurse was coming. CNA #2 resumed assisting the roommate and during this time, Resident #8</p>	F 309	<p>head-of-bed.</p> <p>Resident #8 Physician was made aware of IJ F323 and IJ F309, by phone and letter.</p> <p>Any resident noted to have concerns with swallowing will have a referral to Speech therapy for evaluation.</p> <p>When residents are in dining room, staff to monitor and watch for signs of possible choking, or aspiration, and to alert License staff.</p> <p>Crash cart in dining room, audited by License staff on duty on night shift for proper set up and functioning.</p> <p>4)Audits will be performed 1x weekly for 3 months and then monthly.</p> <p>a) To ensure placement of suctioning machine tubing.</p> <p>b)To ensure License staff are monitoring for any signs of aspiration or choking from resident #8, or other with potential of choking.</p> <p>All audits will be reviewed in QA/QI monthly</p>		

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F 309	<p>Continued From page 16</p> <p>made more loud gurgling sounds and saliva/phlegm was observed bubbling up in his mouth. CNA #2 continued assisting the roommate then took the roommate out of the room and toward the restrooms.</p> <p>On 6/28/17 at 5:48 pm, while enroute to take Resident #8's roommate to the restroom, CNA #2 motioned toward Licensed Practical Nurse (LPN) #3 who was preparing medications at a medication cart several rooms away. At 5:49 am, LPN #3 walked to and stopped briefly in the doorway to Room #17 with a medication cup in hand, then walked toward the dining room.</p> <p>On 6/28/17 at 5:50 pm, when LPN #3 did not come to Resident #8's room, the surveyor left the room to find a nurse. The Director of Nursing Services (DNS) was in the hallway to the dining room and she accompanied the surveyor to Resident #8's room. When asked about suction tubing and a suction tip, the DNS looked, but did not find suction tubing or a suction tip. The DNS said that suction tubing and a Yankeur tip "should be" in the resident's room. She said the resident "rarely" needed to be suctioned and that staff "hook" up the suction equipment when they need to suction the resident. At that point, loud gurgling sounds were heard and bubbling phlegm was observed in Resident #8's mouth; the DNS said, "He needs suctioning now." The DNS left the room to get suction tubing and a suction tip.</p> <p>On 6/28/17 at 5:56 pm, the DNS and the MDS nurse entered Resident #8's room with suction tubing and a suction tip. They connected the tubing and suction tip to the suction machine and began suctioning the resident, who was gurgling</p>	F 309			

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F 309	<p>Continued From page 17 and observed with phlegm bubbling in his mouth.</p> <p>On 6/28/17 at 6:15 pm, the DNS and MDS nurse were observed in Resident #8's room. The suction canister at the bedside contained 50 miliLiters (ml) of clear, frothy liquid. The MDS nurse stated, "He needed to be suctioned" and that the mucus was "thick." The MDS nurse said she used 30 ml of water to flush the suction tip and tubing and the rest of the canister's contents was mucus/phlegm. The DNS and MDS nurse both said the resident could have aspirated or choked on 20 mls of mucus/phlegm.</p> <p>On 6/28/17 at 7:10 pm, CNA #2 said she had heard "a little gurgling" from Resident #8 while in the room assisting his roommate. The CNA said, "But usually he'll have a little cough. He does that. Like a little cough." CNA #2 said she told LPN #3 that the surveyor was asking about suction tubing. The CNA said "No" when asked if she told the LPN that the resident was gurgling.</p> <p>On 6/28/17 at 7:12 pm, LPN #3 said CNA #2 told her a surveyor wanted to know about suction tubing but the CNA did not say anything else. The LPN said she told the CNA she would go to Resident #8's room as soon as she finished her current task.</p> <p>On 6/28/17 at 8:00 pm, the facility's Administrator was informed verbally and in writing of the Immediate Jeopardy situation regarding Resident #8 and of the need to develop and implement a plan to remove the immediacy.</p> <p>On 6/29/17 at 11:30 am, the facility provided evidence that an acceptable plan to remove the</p>	F 309			

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F 309	<p>Continued From page 18 immediacy had been developed and implemented. The plan documened:</p> <ul style="list-style-type: none"> * All licensed staff were to be inserviced before working with residents related to aspiration prevention and having functional suctioning equipment present. * Head-of-bed elevation levels were to be monitored every hour during the enteral feeding process, and at least one hour after feeding is completed, order written. * Licensed staff were to assess for signs of aspiration/need for suction every hour and PRN, order written. * DNS or designee was to audit MARs for compliance with above orders weekly for 3 months then monthly, starting 6/29/17. * Resident #8's care plan was updated to reflect changes in care, 6/28/17 revised 6/29/17. * CNAs were to be inserviced on elevating head-of-bed and reporting to licensed staff if the resident exhibited signs and/or symptoms of saliva around the mouth or choking. * The Maintenance Supervisor was to place a mark on the wall to assist in properly elevating the resident's head-of-bed. * No other resident at risk at this time, due to no other feeding tube/PRN suction machine orders. * Systemic changes: Enteral Feedings - Safety Precautions policy updated 6/28/17 to include 	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/30/2017
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F 309	<p>Continued From page 19</p> <p>suctioning: 1. Obtain order for suctioning, as appropriate 2. If order present, ensure suction machine is readily available and functioning 3. Recognize the need to suction 4. Suction as appropriate, document in eMAR (electronic MAR).</p> <p>* All employees were to receive inservice to monitor for coughing, choking noises, excessive saliva, and when performing room rounds to assess for placement of tubing to suction machine, starting 6/28/17.</p> <p>* All licensed staff were to complete inservice training by 7/5/17.</p> <p>2. Resident #6 was admitted to the facility on 2/3/17 with diagnoses that included left knee pain and lower back pain.</p> <p>Physician's Orders, dated 3/9/17, documented Resident #6 was to receive a 12 mcg Fentanyl transdermal patch every 72 hours for pain.</p> <p>The April 2017 MAR documented the resident's Fentanyl patch had been removed on 4/17/17 at 12:13 am, but not replaced by staff until 4:00 pm.</p> <p>On 6/29/17 at 2:52 pm, the DNS stated the Fentanyl patch was not applied as ordered by the physician.</p> <p>Resident #6's April 2017 MAR documented a Fentanyl patch was removed on 4/21/17 at 1:33 am, and a new patch was applied at 1:34 a.m. However, a Progress Note, dated 4/21/17 at 1:34 am, documented Resident #6 was not provided</p>	F 309			

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F 309	<p>Continued From page 20 with a Fentanyl patch that day because the pharmacy had not delivered the medication to the facility.</p> <p>The Controlled or Antibiotic Drug Record documented the Fentanyl patch was not applied until 4/23/17 at 11:30 pm, 3 days after the patch was removed on 4/20/17.</p> <p>On 6/29/17 at 1:35 pm, the DNS and the Regional Clinical Director stated the Fentanyl patches had not been reordered because when the physician came into the facility staff did not realize there were no more Fentanyl patches on hand and did not ask the physician to order more.</p> <p>On 6/29/17 at 3:00 pm, the DNS stated a Fentanyl patch was not applied until 4/23/17, but should have been provided to Resident #6 on 4/21/17.</p> <p>Resident #6 was at increased risk for increased pain when the Fentanyl patch for treatment of pain was not available as ordered.</p> <p>3. Resident #2 was admitted to the facility with diagnoses that included chronic pain and a pressure ulcer to the right buttock.</p> <p>A 5/20/17 physician order documented staff were to provide Resident #2 with a 50 mcg Fentanyl patch every 72 hours for pain.</p> <p>The June 2017 MAR documented Resident #2's Fentanyl patch was to be applied/changed at "night" without providing a specific time for staff to apply/change the patch.</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/30/2017
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F 309	Continued From page 21	F 309			
F 323 SS=J	<p>The Controlled or Antibiotic Drug Record documented Resident #2's Fentanyl patch was applied on 6/12/17 at 10:00 pm, and on 6/15/17 at 1:14 am.</p> <p>483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>(d) Accidents. The facility must ensure that -</p> <p>(1) The resident environment remains as free from accident hazards as is possible; and</p> <p>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure bedside suctioning equipment was</p>	F 323	F323 The facility must ensure that -	7/21/17	

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F 323	<p>Continued From page 22</p> <p>operational for 1 of 1 sampled residents (#8) with orders and care plan interventions for suctioning as needed. The failure placed Resident #8 in immediate jeopardy for choking, aspiration, and death when excessive oral secretions were in his mouth and the suctioning equipment was incomplete, and therefore not operational.</p> <p>The facility also failed to ensure: * Cigarette lighters for 1 of 2 residents (#2) who smoked tobacco products were secured; * One of 2 staff restrooms without a call system or safety bars was secured; * Lawn sprinklers did not leak; and *A stove drawer in the Therapy Room closed completely.</p> <p>The failures created the potential for harm if independently mobile and cognitively impaired residents (#s 15-18) were to start a fire using an unsecured lighter and/or were unable to summon help in the unsecured Staff Restroom. Residents were also at risk for injury from the broken and protruding stove drawer in the Therapy Room, and for falls if they slipped on wet, slick spots on the sidewalk. Findings include:</p> <p>1. Resident #8 was admitted to the facility in 2013 with multiple diagnoses, including intracranial injury related to a motor-vehicle accident, convulsions, disturbances of salivary secretion, gastroesophageal reflux disease (GERD), nausea, and history of recurrent pneumonia.</p> <p>Resident #8's most recent quarterly Minimum Data Set (MDS) assessment, dated 5/30/17, documented persistent vegetative state/no</p>	F 323	<p>The resident environment remains as free from accident hazards as is possible; and</p> <p>Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>1) One of 33 residents were affected by this deficient practice. 2) All resident with dysphasia diet or swallowing issues have the potential to require PRN suctioning. 3)All licensed staff were to be in-serviced that a complete and functioning suction system must be present for immediate use before working with the resident.</p> <p>Staff were to monitor and assess for placement of suction tubing to suction machine every shift and PRN, order written.</p> <p>Licensed staff were to assess for any signs of aspiration/need for suctioning Q hour and PRN. Monitor and assess for placement of suction tubing to suction machine Q shift and PRN. Care Plan updated to reflect change in care.</p> <p>When residents are in the dining room staff to monitor and watch for signs of possible choking or aspiration, and to alert License staff. If resident is noted to have concerns with swallowing, License staff to make</p>		

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F 323	<p>Continued From page 23</p> <p>discernable consciousness, total assistance of 2 or more staff for bed mobility and transfers, 51% or more calories and daily fluids received via the enteral route, functional limitation in range of motion in both upper and both lower extremities, and wheelchair (W/C) use.</p> <p>Resident #8's care plan documented: * GI (gastrointestinal) upset related to GERD - Place on side for emesis, initiated 12/17/13. * History of recurrent pneumonia, wheezing and cough - Orders for oral suctioning by licensed nurses if needed, initiated 3/18/14. * Persistent vegetative state, dependent for all cares - "Special" W/C when up, initiated 12/8/15. * Nutrition/feeding tube - History of recurring upper respiratory infections "(aspiration pneumonia)." If symptoms of aspiration (fever, moist cough, choking, watery eyes, nasal discharge, increased respirations, or audible breathing) notify a nurse, initiated 11/30/16.</p> <p>Resident #8's Total Plan of Patient Care directions for Certified Nursing Assistants (CNAs) contained an undated Additional Comments section which documented, "Notify nurse if resident has excessive oral salivation-suctioning PRN [as needed]."</p> <p>Resident #8's physician orders documented: * Change suction canister, tubing and Yankeur every week as needed upon usage, dated 1/11/17; * Jevity 1.0 at 100 ml/hour (miliLiters per hour) from 5:00 pm to 8:00 am, dated 3/3/16; * Glycopyrrolate 3 times daily for excessive salivation, dated 2/13/16.</p>	F 323	<p>referral to speech therapy.</p> <p>Crash cart is located in dining room/License staff on shift to monitor for set up and proper functioning.</p> <p>4) Audits to be performed 1x weekly for three months, then monthly.</p> <p>1)The door not closing tightly on bathroom in hallway had the potential to harm all residents that are independent in locomotion. 2) This has the potential to affect all independent in locomotion residents. 3) All doors with self closers to be monitored for function, and repaired or replaced if issue arises. New closer for bathroom door, ordered and installed. 4) Environmental audits to be done 1x weekly for 4 weeks then monthly. All audits to be reviewed in QA/QI monthly.</p> <p>Lawn sprinkler: 1) This affected all resident that were assisted outside for walks. 2)This has the potential to affect all residents and families who may go for walks outside of facility. 3) Valve to pump that is directly connected to sprinkler was replaced so when system is shut off no excess water can run back through sprinkler. All side walks were assessed for possible moss or slick area related to sprinklers. 4) Environmental audits to be done 1x weekly for 4 weeks then monthly</p>		

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F 323	<p>Continued From page 24</p> <p>On 6/28/17 at 5:40 pm, Resident #8 was observed laying on his back in a geriatric chair in his room. The resident's head was elevated 30 degrees and the Jevity enteral feeding was infusing at 100 ml/hour via feeding pump. The resident made occasional gurgling sounds. A suction machine was on the resident's bedside table, however the suction tubing and suction tip device was not visible.</p> <p>On 6/28/17 at 5:45 pm, CNA #2 entered the room and began assisting Resident #8's roommate. When asked about suction tubing and suction tip for Resident #8's suction machine, the CNA said she had seen them earlier, "but not now." CNA #2 looked in Resident #8's bedside table drawers, but did not find suction tubing or a suction tip. She resumed assisting the roommate a few more moments, but stopped when Resident #8 made a loud gurgling sound. CNA #2 said she would summon a nurse then left the room. CNA #2 returned to the room at 5:46 pm and said a nurse was coming. Resident #8 made more loud gurgling sounds and phlegm was visible bubbling in his mouth while CNA #2 continued assisting the roommate before taking her out of the room.</p> <p>On 6/28/17 by 5:50 pm, a nurse did not come to Resident #8's room. The surveyor left the room and found the Director of Nursing Services (DNS) in the hallway to the dining room. The DNS accompanied the surveyor to Resident #8's room. The DNS looked for, but did not find, suction tubing or a suction tip in the resident's room. The DNS said that suction tubing and a Yankeur tip "should be" in the resident's room. The DNS stated the resident "rarely" needed to</p>	F 323	<p>All audits to be brought to QA/QI monthly for review.</p> <p>Drawer to oven in therapy room was not closing properly.</p> <p>1)This had the potential but did not affect any resident at the time.</p> <p>2)This had the potential to affect all residents that were independent in locomotion.</p> <p>3)The drawer to the bottom of the oven was permanently secured to the stove so it could no longer open.</p> <p>4)Maintenance to monitor during rounds 1x weekly for 4 weeks and then monthly for 3 months.</p> <p>All audits to be reviewed by QA/QI monthly.</p> <p>Facility smoking Policy:</p> <p>1) This affected 1 of 33 residents.</p> <p>2) This has the potential to affect 2 of 33 residents.</p> <p>3) All residents that are smokers, will have smoking assessment done on admission, PRN and quarterly.</p> <p>All current smokers have had a new smoking assessment, with care plans updated.</p> <p>All lighters were removed from residents, and placed in drawer of locking medication cart.</p> <p>Smoking policy was updated to reflect these changes.</p> <p>All staff in-serviced on change in smoking policy.</p> <p>4) Audits to be performed 1x weekly for 4 weeks and then monthly for 3 months.</p> <p>All audits to be reviewed in QA/QI monthly.</p>		

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F 323	<p>Continued From page 25</p> <p>be suctioned and that staff "hook" up the suction equipment when they need to suction the resident. At that point, loud gurgling sounds were heard and bubbling phlegm was observed in Resident #8's mouth. The DNS said, "He needs suctioning now." The DNS left the room to get suction tubing and a suction tip.</p> <p>On 6/28/17 at 5:56 pm, the DNS and the MDS nurse entered Resident #8's room with suction tubing and a suction tip. The nurses connected the tubing to the suction machine and began suctioning the resident, who was gurgling with phlegm bubbling in his mouth.</p> <p>On 6/28/17 at 6:15 pm, the DNS and MDS nurse said that 20 mililiters (ml) of 50 ml of clear, frothy liquid in the suction canister was mucus/phlegm. The MDS nurse said, "He needed to be suctioned" and that the mucus was "thick." The DNS and MDS nurse both said the resident could have aspirated or choked on 20 mls of mucus/phlegm.</p> <p>On 6/28/17 at 8:00 pm, the facility's Administrator was informed verbally and in writing of the Immediate Jeopardy situation regarding Resident #8's incomplete, and therefore inoperable, suctioning equipment and of the need to develop and implement a plan to remove the immediacy.</p> <p>On 6/29/17 at 11:30 am, the facility provided evidence that an acceptable plan to remove the immediacy had been developed and implemented. The plan included:</p> <p>* All licensed staff were to be inserviced that a complete and functioning suction system must be</p>	F 323			

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F 323	<p>Continued From page 26</p> <p>present for immediate use before working with the resident.</p> <p>* Staff were to monitor and assess for placement of suction tubing to suction machine every shift and PRN, order written.</p> <p>* Licensed staff were to assess for any signs of aspiration/need for suctioning every hour and PRN, order written.</p> <p>* DNS or designee were to audit Medication Administration Records (MAR) for compliance with orders weekly for 3 months then monthly, starting 6/29/17.</p> <p>* Resident #8's care plan was updated to reflect change in care on 6/28/17 and 6/29/17.</p> <p>* Systemic changes: Enteral Feedings - Safety Precautions policy updated 6/28/17 to include suctioning: 1. Obtain order for suctioning, as appropriate 2. If order present, ensure suction machine is readily available and functioning 3. Recognize the need to suction 4. Suction as appropriate, document in eMAR (electronic MAR)."</p> <p>* Facility to review and audit MARs for signatures, weekly room rounds, monitoring of Yankeur (suction tip device), and tubing to suction machine.</p> <p>* All employee's - Housekeeping/Dietary/Activities/Nursing/Social Services/Business Office/Human Resources/Medical Records - inserviced to monitor for cough, choking noise, saliva, and</p>	F 323			

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F 323	<p>Continued From page 27</p> <p>when performing room rounds to assess for placement of tubing to suction machine, starting 6/28/17.</p> <p>* All licensed staff were to complete inservice by 7/5/17.</p> <p>2. One of two Staff Restrooms in the hallway to the dining room, which did not have a call system or safety bars, was observed unsecured. The door was either unlocked or not fully closed as follows:</p> <p>* 6/26/17 at 10:25 am - The door was closed, but not locked. * 6/27/17 at 10:38 am - The door was closed, but not locked. * 6/27/17 at 11:23 am - The door knob was locked, but the door was not closed completely. The Human Resource staff member was in the hallway at the time and said the door should be closed. She closed the door. * 6/27/17 at 1:30 pm - The door was closed, but not locked. * 6/27/17 at 2:10 pm - The door was closed, but not locked, when LPN #1 and LPN #2 went to the restroom to destroy a medication. One of the LPNs locked and closed the door.</p> <p>On 6/27/17 at 2:15 pm, the Administrator said the maintenance supervisor would fix the door.</p> <p>3. Facility lawn sprinklers by the sidewalk in front of the facility were observed leaking continuously in 4 places from 6/26/17 through 6/29/17. Water with a layer of silt underneath was pooled on the sidewalk by the 4 leaking sprinklers. The pools of water and slick pavement were 2 to 4 feet wide</p>	F 323			

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F 323	<p>Continued From page 28 and crossed the sidewalk.</p> <p>Residents were observed ambulating and moving about on the sidewalk in front of the facility during each day of the survey.</p> <p>A tour of the facility environment was conducted with the Maintenance Supervisor on 6/29/17. The Maintenance Supervisor said the lawn sprinklers were fed by water from a hose placed in a water canal receptacle on facility property. He said the lawn sprinklers were set to run every Monday, Wednesday and Friday and that the first staff member to arrive for work the next morning was supposed to remove the hose. He said the task was not assigned to any staff member in particular and it was not getting done. The Maintenance Supervisor removed the hose from the water canal receptacle.</p> <p>4. The drawer at the bottom of the stove in the Therapy Room was observed sticking out 2 inches on the left side as follows: * 6/26/17 at 12:25 am - one resident was in the room eating lunch and 1 staff was present; * 6/27/17 at 9:00 am - during a Group Interview with 7 residents present; * 6/28/17 at 10:00 am and 6/29/17 11:30 am - the drawer would not close.</p> <p>On 6/29/17 at 2:30 pm, during a tour of the facility environment, the Maintenance Supervisor said the stove drawer was broken and needed to be repaired.</p> <p>5. The facility's smoking policy, dated April 2012, documented, "This facility shall establish and</p>	F 323			

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

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F 323	<p>Continued From page 29</p> <p>maintain safe resident smoking practices... Resident [with independent smoking privileges] may keep disposable lighters. All other forms of lighters ... shall be prohibited ..."</p> <p>Resident #2 was readmitted to the facility on 3/9/17 with diagnoses that included quadriplegia, anxiety disorder, depression, and respiratory failure. Resident #2's roommate, Resident #17, was admitted to the facility on 2/28/17 with diagnoses of anxiety disorder and dementia.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 4/17/17, documented Resident #2 was cognitively intact.</p> <p>Resident #2's care plan, dated 4/2/17, documented she was safe to smoke independently, was not on a smoking schedule, but required staff assistance getting outside to smoke; occasionally required staff assistance lighting a cigarette; and was allowed to keep her cigarettes and lighter in her personal possession.</p> <p>A smoking assessment, dated 6/11/17, documented Resident #2 experienced intermittent confusion; had no visual deficits; experienced contractures to her fingers/hands; and that the physician, staff, and family were concerned about the resident's safety related to times that Resident #2 was sleepy but would stay outside for hours at a time. The smoking assessment documented there had not been any smoking related accidents; Resident #2 could flick ashes safely and extinguish cigarettes appropriately; an adaptive cigarette holder was required; and the resident required assistance getting into- and out from the designated</p>	F 323			

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F 323	<p>Continued From page 30 smoking area.</p> <p>On 6/26/17 at 2:20 pm, Resident #2 was observed sitting outside in a wheelchair with a cigarette holder containing an extinguished cigarette butt in her hand. The resident stated she did not require supervision to smoke and could keep her cigarettes and lighter. The resident's cigarettes and lighter were observed on her lap.</p> <p>On 6/26/17 at 3:48 pm, the door to Resident #2's room was observed open and 2 disposable lighters and a Zippo lighter could be seen on the resident's overbed table. Resident #2 was not in the room at the time of the observation, Resident #17 was observed lying in her bed.</p> <p>On 6/26/17 at 3:55 pm, CNA #1 stated Resident #2 leaves her lighters on the overbed table, which staff does not remove to a secure location because the resident would become "upset" if the lighters were moved. CNA #1 then lit each lighter to show they worked as intended.</p> <p>On 6/26/17 at 4:02 pm, the DNS stated Resident #2 could keep the cigarettes and lighters in her personal possession, although she was told they had to be in a secure location. The DNS stated Resident #2 was "very particular" about her personal possessions, but that she would speak to the resident about keeping her lighters in a secured location.</p> <p>On 6/26/17 at 4:52 pm, the DNS stated Resident #2 agreed to relocate her disposable lighters to a secured medication cart, where they would remain when not in use, and the Zippo lighter</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/30/2017
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F 323	Continued From page 31	F 323			
F 431 SS=E	<p>was taken out of the facility by a family member.</p> <p>483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--</p> <p>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>(g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p>	F 431		7/31/17	

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F 431	<p>Continued From page 32</p> <p>(h) Storage of Drugs and Biologicals.</p> <p>(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and record and policy review, it was determined the facility failed to ensure medications were available for use according to accepted professional practice, opened Lantus insulin was not in use more than 28 days, 2 nurses witnessed disposal of controlled pain medication and the date of disposal was recorded, and controlled pain medication was accounted for upon admission and each shift thereafter. This was true for 4 of 4 sample residents (#1, #3, #4 and #6) and 4 random resident (#11-14). The deficient practice created the potential for medication errors when pharmacy labels did not include the dose for Resident #1's antiglaucoma eye drops and Residents #1, #4, #11 and #12's insulin medications; the potential for ineffective treatment if Resident #13 and #14's Lantus insulin were in use more than 28 days after opened; and, the potential for diversion of</p>	F 431	<p>F431</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in 483.70(g) of this part.</p> <p>Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>All medications need labels with dose, and direction of administration.</p> <p>1) This affected 4 of 33 residents. 2) This has the potential to affect all residents with medication orders for insulin/eye drops. 3) Facility policy updated to reflect</p>	

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F 431	<p>Continued From page 33</p> <p>Resident #3 and #6's controlled pain medications. It was also determined the facility did not have a sufficient pharmacy-provided inventory of Fentanyl duragesic patches to meet the pain-relief needs of 1 of 1 resident reviewed for duragesic pain relief patches (Resident #6). This failed practice had the potential for harm if residents experiencing moderate- to severe pain did not have access to physician-ordered medications for this purpose. Findings include:</p> <p>1. a. On 6/26/17 at 3:25 pm, Licensed Practical Nurse (LPN) #1 was observed preparing 12 medications, including Lumigan (antiglaucoma) eye drops, for Resident #1. The Lumigan pharmacy label documented, "Instill into left eye every day," but did not specify the number of drops to administer. LPN administered 1 drop of Lumigan into the resident's left eye.</p> <p>Immediately afterward, when asked how she knew how many drops of Lumigan to administer, LPN #1 said she had read the MAR instructions. The LPN said the pharmacy label did not include the number of drops to administer and that she would notify the pharmacy.</p> <p>Resident #1's Order Summary Report included a 12/17/16 order for bimatoprost solution (generic Lumigan) 1 drop in left eye one time a day for glaucoma.</p> <p>b. On 6/27/17 at 11:10 am, LPN #2 was observed preparing and administering 32 units of insulin in a Novolog Flexpen to Resident #1. The pharmacy label on the Novolog Flexpen did not include the dose of insulin to be administered.</p>	F 431	<p>changes.</p> <p>Pharmacy was consulted and Pharmacy will provide medication labels with directions.</p> <p>a. License staff in-serviced on calling Pharmacy with new orders.</p> <p>b. Medication will be first dosed from Omni-cell.</p> <p>4) Audits to be performed 1x weekly for 4 weeks, then monthly for 3 months. All audits to be reviewed in monthly QA/QI</p> <p>Insulin boxes opened and not dated:</p> <p>1) This affected 2 of 33 residents.</p> <p>2) All current residents who use insulin, have the potential to be affected.</p> <p>3) All medications on cart were audited for dates.</p> <p>All License staff was in-serviced on dating insulin.</p> <p>Medication cart to be audit weekly for 4 weeks then monthly for the next three months.</p> <p>4) All audits to be reviewed in QA/QI monthly.</p> <p>All narcotic medications must be destroyed by two License staff:</p> <p>1) This affected 1 of 33 residents.</p> <p>2) All current residents on narcotic medications have the potential to be affected by the deficient practice,</p> <p>3) The times that the patches were to be applied was changed to format for two nurses to be present in the building for destruction, of patches.</p> <p>All License staff were in-serviced on this</p>		

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F 431	<p>Continued From page 34</p> <p>Immediately afterward, when asked how she knew the number of units of Novolog insulin to administer for Resident #1, LPN #2 said she had read the MAR instructions. The LPN said the pharmacy label on the Novolog Flexpen did not include the number of units to be administered.</p> <p>Resident #1's Order Summary Report included a 1/2/17 order for Novolog 32 units by subcutaneous injection 3 times a day prior to meals.</p> <p>c. On 6/27/17 at 11:20 am, LPN #2 removed 4 insulin pens from the medication cart. The 4 pharmacy labels on the insulin pens did not include the number of units to be administered for Resident #1's Toujeo SoloStar, Resident #4's Toujeo SoloStar, Resident #11's Lantus SoloStar and Resident #12's Toujeo SoloStar. LPN #2 said she would notify the pharmacy.</p> <p>The facility's policy for Labeling of Medication Containers, revised September 2014, documented that labels for individual drug containers "shall" include "Directions for use."</p> <p>2. On 6/27/17 at 11:30 am, during observations of medication pass by LPN #2, opened vials of Lantus insulin for Residents #13 and #14 were found without an open date. The LPN said she did not know how long the insulin vials had been in use. Resident #14's pharmacy label documented that the unused medication should be discarded after 28 days. The LPN discarded the 2 undated, opened vials and said she would obtain new vials for both residents.</p> <p>3. Resident #3 was admitted to the facility</p>	F 431	<p>practice.</p> <p>a. License staff will have 2 nurses present for destruction of medication.</p> <p>b. Two nurses present for signature for the process of destruction.</p> <p>4)Audits 1x weekly for 4 weeks than monthly for 3 months.</p> <p>All controlled substances must be counted on delivery. A controlled substance record must be made for each resident who will be receiving a controlled substance. Nursing staff must count controlled substance at end of shift and report discrepancies.</p> <p>1) This affected 1 of 33 residents.</p> <p>2) All residents with controlled substance orders have the potential to be affected by deficient practice.</p> <p>3) Audit all controlled substance sheets, assess proper documentation. All narc sheets to be turned into DNS or designee.</p> <p>4) Audits 1x weekly for 4 weeks and then 1x monthly for three months.</p>		

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F 431	<p>Continued From page 35 8/17/16 with multiple diagnoses, including chronic pain.</p> <p>Resident #3's care plan documented, "I have a pain patch. I need the licensed nurse to apply it as ordered..."</p> <p>Resident #3's Order Summary Report documented a 4/22/17 order for Duragesic (brand name for Fentanyl) 50 microgram (mcg) patch transdermally every 3 days for chronic pain.</p> <p>The June 2017 Medication Administration Record (MAR) documented the pain patch was changed every 3 days through 6/27/17. However, the resident Controlled or Antibiotic Drug Record for Fentanyl 50 mcg patches documented the used pain patch was destroyed by 1 nurse, rather than 2 nurses, when the patch was changed on 6/18/17.</p> <p>On 6/29/17 at 1:35 pm, the DNS and Regional Clinical Director (RCD) said narcotic medications must be destroyed by two nurses; she stated a second nurse should have witnessed the destruction of Resident #3's used Duragesic (Fentanyl) pain patch on 6/18/17.</p> <p>4. a. Resident #6 was admitted to the facility on 2/3/17 with diagnoses that included left knee pain and lower back pain.</p> <p>Resident #6's Controlled or Antibiotic Drug Record, dated 4/6/17, documented a 25 mcg Fentanyl analgesic patch had been destroyed by one nurse on an unspecified date.</p>	F 431			

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

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F 431	<p>Continued From page 36</p> <p>On 6/29/17 at 1:35 pm, the DNS and RCD, stated that narcotic medications must be destroyed by two nurses.</p> <p>The facility's Discarding and Destroying Medications policy, dated September 2014, documented, "After the removal of a Fentanyl patch from a resident, its disposal must be witnessed by two licensed nurses. Both nurses must sign the narcotic control sheet ..."</p> <p>b. Physician's Orders, dated 3/9/17, documented Resident #6 was to receive a 12 mcg Fentanyl transdermal patch every 72 hours for pain.</p> <p>Resident #6's April 2017 MAR documented a Fentanyl patch was removed on 4/21/17 at 1:33 am, and a new patch was applied at 1:34 a.m. However, a Progress Note, dated 4/21/17 at 1:34 am, documented Resident #6 was not provided with a Fentanyl patch that day because the pharmacy had not delivered the medication to the facility.</p> <p>The Controlled or Antibiotic Drug Record documented the Fentanyl patch was not applied until 4/23/17 at 11:30 pm, 3 days after the patch was removed on 4/20/17.</p> <p>On 6/29/17 at 1:35 pm, the DNS and the Regional Clinical Director stated the Fentanyl patches had not been reordered because staff did not realize there were no more Fentanyl patches on hand and did not ask the physician to order more.</p> <p>On 6/29/17 at 3:00 pm, the DNS stated a</p>	F 431		

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F 431	<p>Continued From page 37</p> <p>Fentanyl patch was not applied until 4/23/17, but should have been provided to Resident #6 on 4/21/17.</p> <p>Resident #6 was at increased risk for increased pain when the Fentanyl patch for treatment of pain was not available as ordered.</p> <p>c. Resident #6's physician orders, dated 3/2/17, documented staff were to provide Oxycodone-Acetaminophen 5-325 mg (milligrams) every 8 hours as needed for pain.</p> <p>Resident #6's clinical record did not include documentation of the narcotic count for the Oxycodone-Acetaminophen.</p> <p>On 6/29/17 at 4:24 pm, the DNS stated she was unable to find Resident #6's narcotic count record for Oxycodone-Acetaminophen.</p> <p>On 6/30/17 at 12:28 pm, the Administrator stated the facility could not locate a narcotic count sheet for Resident #6's Oxycodone-Acetaminophen. She stated Resident #6 was admitted from another facility with an unknown quantity of Oxycodone-Acetaminophen. She stated the facility did not know the number of Oxycodone-Acetaminophen tablets that accompanied the resident at the time of admission to the facility.</p> <p>The facility's Controlled Substances policy, dated September 2014, documented, "Controlled substances must be counted on delivery ... an individual resident controlled substance record must be made for each resident who will be receiving a controlled substance ... Nursing staff</p>	F 431			

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F 431	Continued From page 38 must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report discrepancies..."	F 431			