



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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E-mail: fsb@dhw.idaho.gov

July 21, 2017

Joan Martellucci, Administrator
Life Care Center of Coeur d'Alene
500 West Aqua Avenue
Coeur d'Alene, ID 83815-7764

Provider #: 135122

Dear Ms.. Martellucci:

On **July 6, 2017**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **May 30, 2017**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- **F0279 -- S/S: E -- 483.20(d);483.21(b)(1) -- Develop Comprehensive Care Plans**
- **F0314 -- S/S: D -- 483.25(b)(1) -- Treatment/svcs To Prevent/heal Pressure Sores**
- **F0329 -- S/S: D -- 483.45(d)(e)(1)-(2) -- Drug Regimen Is Free From Unnecessary Drugs**
- **F0514 -- S/S: D -- 483.70(i)(1)(5) -- Res Records-Complete/accurate/accessible**
- **F0157 -- S/S: D -- 483.10(g)(14) -- Notify Of Changes (injury/decline/room, Etc)**
- **F0280 -- S/S: D -- 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) -- Right To Participate Planning Care-Revise Cp**
- **F0281 -- S/S: D -- 483.21(b)(3)(i) -- Services Provided Meet Professional Standards**
- **F0309 -- S/S: D -- 483.24, 483.25(k)(l) -- Provide Care/services For Highest Well Being**

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

Joan Martellucci, Administrator
July 21, 2017
Page 2 of 4

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 31, 2017**.

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

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

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

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

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

As noted in the Bureau of Facility Standards' letter of **May 12, 2017**, following the survey of **May 12, 2017**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions effective July 20, 2017

Joan Martellucci, Administrator
July 21, 2017
Page 3 of 4

and termination of the provider agreement on **October 20, 2017**, if substantial compliance is not achieved by that time. The findings of non-compliance on **July 6, 2017**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On , CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **July 19, 2017**
- Civil money penalty

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, it will provide you with a separate formal notification of that determination.

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, 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 31, 2017**. If your request for informal dispute resolution is received after **July 31, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Joan Martellucci, Administrator
July 21, 2017
Page 4 of 4

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

Sincerely,

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

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

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

PRINTED: 08/14/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/06/2017
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COEUR D'ALENE			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST AQUA AVENUE COEUR D ALENE, ID 83815		
(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 An on-site revisit survey was conducted at the facility from July 5, 2017 to July 6, 2017. The surveyors conducting the survey were: Teresa Kobza, RDN, LD, Team Coordinator Susan Costa, RN Definitions Include: BG - Blood Glucose CHF - Congestive Heart Failure COPD - chronic obstructive pulmonary disease DM Type II - Diabetes Mellitus Adult Onset GDR - Gradual Dose Reduction HS - Hours of Sleep or bedtime I&A - Incident Report IV - Intravenous LN - Licensed Nurse LTC - Long Term Care MAR - Medication Administration Record MDS - Minimum Data Set mEq - milliEquivalent mg - Milligram mg/dl - milligram per deciliter PICC - Percutaneous Inserted Central Catheter PRN - as needed Pt - patient PU - pressure ulcers R - right RCM - Resident Care Manager Rx - prescription TAR - Treatment Administration Record x - by > - less than	{F 000}			
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157		7/26/17	

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

TITLE

(X6) DATE

Electronically Signed

07/27/2017

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 157	Continued From page 1 (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. (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	F 157			

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F 157	<p>Continued From page 2 as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, facility policy, and staff and physician interview, it was determined the facility failed to ensure physicians were notified when residents' blood glucose values were not within normal limits. This was true for 1 of 5 (#4) residents reviewed for diabetic management and had the potential for harm if those values would have prompted new orders by the physician. Findings include:</p> <p>Resident #4 was admitted to the facility on 5/30/17 with diagnoses of dementia, Type II diabetes mellitus (DM) and Congestive Heart Failure (CHF).</p> <p>Resident #4's Diabetic Administration Record documented a BG (Blood Glucose) level of 59 milligrams per deciliter (mg/dl) at 8:00 am on 7/4/17. The record documented an untimed follow-up BG of 82 mg/dl . The record did not document whether Resident #4's physician was notified of the initial BG result of 59 mg/dl.</p> <p>The facility's Diabetic Care policy, undated, documented normal BG levels as 60-115 mg/dl and that staff should know residents' specific parameters. The policy stated all changes in a</p>	F 157	<p>Resident #4: Physician was notified of identified blood sugar. Resident #19: No longer resides in the facility.</p> <p>Residents were reviewed in the last 7 days for any noted change in condition including blood glucose levels out of range per current protocol. Any noted changes identified were reported to the physician for appropriate follow up and care plans updated as needed. Facility's current diabetic protocol does include when to notify the physician.</p> <p>Licensed nurses have been educated on identifying a change of condition, diabetic protocol, and timely notification to the physician as well as appropriate documentation.</p> <p>The DNS/designee will identify residents through the 24 hour report/grand rounds and review of daily notes and audit residents with a noted change in condition for appropriate notification, Monday through Friday, for 4 weeks and then</p>		

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F 157	Continued From page 3 diabetic residents condition should be reported to the charge nurse "immediately." The policy did not include direction to staff for physician notification of abnormal values. On 7/6/17 at 12:10 pm, the RCM stated the LN caring for Resident on 7/4/17 did not document the interventions she performed in response to the BG of 59 mg/dl. The RCM stated she could not locate documentation that Resident #4's physician was notified of the low BG. On 7/6/17 at 3:15 pm, Resident #4's physician stated he was not informed of the low BG result, but that he expected notification of any BG result out of established facility parameters.	F 157	monthly for 3 months. Findings will be reviewed by the Director of Nursing and forwarded to the Quality Assurance/Performance Committee for ongoing review and recommendations.		
{F 279} SS=E	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the	{F 279}		7/26/17	

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{F 279}	Continued From page 4 comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	{F 279}			

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{F 279}	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure resident-specific care plans were developed and implemented for 3 of 10 residents (#7, #18, #20) reviewed for initial care plans. This failed practice created the potential for harm if residents did not receive appropriate or adequate care. Findings include:</p> <p>1. Resident #20 was admitted to the facility on 5/13/17 with diagnoses that included COPD (chronic obstructive pulmonary disease), dementia, weakness, and irregular heartbeat.</p> <p>a. Physician Orders, dated 5/13/17, documented Resident #20 was to receive oxygen via nasal cannula as needed for shortness of breath, and staff were to monitor blood-oxygen saturation levels, as well as shortness of breath episodes, signs of edema, and oxygen liter flow rates twice daily. Resident #20's clinical record did not include an oxygen therapy care plan.</p> <p>b. Physician Orders, dated 6/27/17, directed staff to provide wound care and a dressing to Resident #20's sacral wound every three days. Resident #20's clinical record did not include a care plan for the sacral wound.</p> <p>On 7/6/17 at 4:20 pm, the RCM (Resident Care Manager) stated care plans for Resident #20's oxygen needs and wound care were not developed.</p> <p>2. Resident #18 was admitted to the facility on 6/13/17 with diagnoses that included weakness</p>	{F 279}	<p>Resident #7: Care Plan reviewed and updated to reflect current needs. Resident #18: Care Plan reviewed and updated to reflect current needs. Resident #19: No longer resides in the facility. Resident #20 Care Plan reviewed and updated to reflect current needs.</p> <p>Resident Care Plans were reviewed and updated to reflect currents needs.</p> <p>Licensed Nurses were educated regarding initiation of care plan for residents diagnosis, change of condition, or end of treatment.</p> <p>DNS or Designee will audit 15 residents weekly for care plan updates as indicated by telephone orders and 24 hour reports for 4 weeks then monthly for 3 months. Care Plans will be reviewed for accuracy with their MDS schedule.</p> <p>Results will be reported to the Quality Assurance/Performance Improvement Committee for ongoing review and recommendations.</p>		

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{F 279}	<p>Continued From page 6 and difficulty swallowing.</p> <p>Resident #18 was admitted to the facility from a recent hospitalization with a percutaneous inserted central catheter (PICC) to the left arm and an IV Therapy Administration Record directing staff to flush the PICC and provide dressing changes. Resident #18's clinical record at the facility did not include a care plan for the PICC.</p> <p>On 7/6/17 at 4:00 pm, the RCM stated there was not a care plan in Resident #18's clinical record for PICC management, but that a PICC care plan should have been initiated upon his admission to the facility.</p> <p>3. Resident #7 was readmitted to the facility on 2/22/17 with diagnoses which included Type II diabetes mellitus, epilepsy, anxiety, bipolar disorder, and respiratory failure.</p> <p>A Behavior Management Care Plan, dated 2/27/17, documented Resident #7 experienced depression and received an appetite stimulant.</p> <p>Behavior Monitoring Flow Reports for June and July 2017 documented Resident #7 received a medication for insomnia, however the resident was not diagnosed with insomnia and the clinical record did not include a care plan related to insomnia.</p> <p>On 7/5/17 at 4:45 pm, the Social Services Assistant stated an insomnia care plan should have been developed if Resident #7 was diagnosed with and experienced insomnia.</p>	{F 279}			

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{F 279}	Continued From page 7 On 7/6/17 at 3:40 pm, the Medical Director stated Resident #7 received a medication to treat insomnia.	{F 279}			
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative.	F 280		7/26/17	

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F 280	<p>Continued From page 8</p> <p>(ii) Include an assessment of the resident's strengths and needs.</p> <p>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.</p> <p>483.21</p> <p>(b) Comprehensive Care Plans</p> <p>(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p>	F 280		

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F 280	<p>Continued From page 9</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents' care plans were revised to reflect current fall prevention interventions and diabetic management. This was true for 1 of 10 residents (#19) reviewed for care plan revision and had the potential to cause harm if residents did not receive appropriate care and interventions due to outdated and/or incomplete care plan information. Findings include:</p> <p>Resident #19 was admitted to the facility on 6/14/17 with diagnoses that included respiratory failure, Type II diabetes mellitus, and Stage V chronic kidney disease.</p> <p>a. A Hyper/hypoglycemic Care Plan, dated 6/14/17, directed staff to report to the physician when Resident #19 experienced signs and symptoms (s/s) of labile BG levels. The care plan documented staff was to check BG levels as ordered, but did not include BG parameters or instruction for staff to notify the physician when BG levels were outside of physician-established parameters; when to administer insulin; and when to follow hyper/hypoglycemic protocols.</p> <p>On 7/6/17 at 4:54 pm, the RCM stated Resident #19's care plan should have been more specific.</p> <p>b. An Incident Report (I&A), dated 6/17/17 at 6:25</p>	F 280	<p>Resident #19: No longer resides in the facility.</p> <p>DNS/designee conducted audit of all current residents to assure care plans were current and accurate.</p> <p>Licensed Nurses were educated on requirements related to the development and updating of care plans.</p> <p>DNS or designee will audit 15 residents weekly for care plan updates as indicated by telephone orders and 24 hour reports for 4 weeks then monthly for 3 months.</p> <p>Results will be reported to the Quality Assurance/Performance Improvement Committee for review and recommendations.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/06/2017
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F 280	Continued From page 10 am, documented staff found Resident #19 unresponsive and on the floor of his room with the call light on. The report documented the resident was attempting to get out bed and his BG was 25 mg/dl at the time of the fall. Follow-up fall prevention interventions included resident education and blood glucose assessments before meals, before bed and at 2 am. A Falls Care Plan, dated 6/14/17, documented Resident #19 experienced a non-injury fall on 6/17/17, but did not include the new interventions listed on the 6/17/17 I&A report. On 7/6/17 at 4:54 pm, the RCM stated Resident #19's care plan should have included the interventions outlined on the 6/17/17 I&A report.	F 280			
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 record review and staff interview, it was determined the facility failed to follow physician orders relating to the administration of cardiac, anticoagulant, diuretic, and other medications. This was true for 1 of 10 residents (#20) reviewed for medication management and had the potential for harm if the residents's health conditions deteriorated as a result of not receiving pharmacological therapy per physician	F 281	Resident #20 was reviewed for negative outcomes related to the identified areas and none were found. Residents have the potential to be affected by this practice. Completed audit of medication administration records and treatment administration records for past 7 days and areas of concern were	7/26/17	

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F 281	<p>Continued From page 11 orders. Findings include:</p> <p>1. Resident #20 was admitted to the facility on 5/13/17 with diagnoses that included COPD (chronic obstructive pulmonary disease), dementia, weakness, and irregular heartbeat.</p> <p>a. Resident #20's June and July 2017 MARs (Medication Administration Record) documented staff was to provide the following:</p> <ul style="list-style-type: none"> * Norvasc 5 mg (milligrams) daily * Metoprolol 100 mg twice daily * Lasix 20 mg daily <p>The MARs included specific instructions not to administer these medications when Resident #20's systolic blood pressure was less than 100 mmHg (millimeters mercury pressure) or when the resident's heart rate was less than 50 beats per minute (bpm).</p> <p>The June and July 2017 MARs included LN initials that were circled to indicate medications were not administered, and did not include Resident #20's blood pressure and/or heart rate on the following dates:</p> <ul style="list-style-type: none"> * Metoprolol 100 mg twice daily <ul style="list-style-type: none"> - 6/2/17 at 8:00 am - 6/21/17 at 8:00 pm - 6/24/17 at 8:00 am - 7/5/17 at 8:00 am * Lasix 20 mg daily <ul style="list-style-type: none"> - 6/14/17 at 8:00 am - 6/21/17 at 8:00 am 	F 281	<p>addressed.</p> <p>Licensed Nurses were educated to professional standards which included but is not limited to, following physician orders, documentation requirements, and when to notify the physician. DNS/designee will conduct weekly medication and treatment administration records for 4 weeks then monthly for 3 months.</p> <p>Results will be reported to the Quality Assurance/Performance Improvement Committee for review and recommendations.</p>		

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F 281	<p>Continued From page 12</p> <p>Nurses Notes in the resident's clinical record also did not explain the reason staff did not administer Resident #20's Metoprolol and Lasix as physician-ordered for the above dates/times.</p> <p>b. The June 2017 MAR included empty spaces, indicating the medication was not provided, in which staff was to document administration of Resident #20's medications as follows:</p> <ul style="list-style-type: none"> * Metoprolol (antihypertensive) 100 mg daily <ul style="list-style-type: none"> - 6/13/17 at 8:00 pm * Omeprazole (reduce stomach acid production) 20 mg, twice daily <ul style="list-style-type: none"> - 6/16/17 at 8:00 am and 4:00 pm - 6/23/17 at 4:00 pm - 6/23/17 at 4:00 pm - 6/28/17 at 4:00 pm - 6/30/17 at 4:00 pm * Norvasc (antihypertensive) 5 mg, daily <ul style="list-style-type: none"> - 6/13/17 at 8:00 am - 6/18/17 at 8:00 am - 6/19/17 at 8:00 am * Lasix (diuretic) 20 mg, daily <ul style="list-style-type: none"> - 6/18/17 at 8:00 am - 6/19/17 at 8:00 am * Rivaroxaban (anticoagulant) 15 mg, twice daily <ul style="list-style-type: none"> - 6/13/17 at 8:00 pm - 6/29/17 at 8:00 am * Remeron (antidepressant used as appetite stimulant) 7.5 mg, daily <ul style="list-style-type: none"> - 6/13/17 at 8:00 pm 	F 281			

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

PRINTED: 08/14/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/06/2017
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F 281	Continued From page 13 * Optifiber (laxative) 3 scoops, daily - 6/4/17 at 8:00 am - 6/9/17 at 8:00 am - 6/28/17 at 8:00 am * KCL caps (potassium supplement) 10 mEq (milliEquivalent) 2 capsules, daily - 6/23/17 at 8:00 am - 6/26/17 at 8:00 am On 7/6/17 at 4:20 pm, the RCM (Resident Care Manager) stated the MAR included incomplete documentation and that it was unclear whether Resident #20 received medications as physician ordered. The RCM stated medications not administered due to abnormal vital signs as established by the physician should be documented clearly and thoroughly.	F 281			
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 309		7/26/17	

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F 309	<p>Continued From page 14</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 staff interview, policy review, and record review, it was determined the facility failed to ensure residents diagnosed with diabetes mellitus received care consistent with their needs, care plans, current standards of practice, and facility policy. This was true for 3 of 5 (#4, #7 and #19) residents reviewed for diabetic management. As a result:</p> <ul style="list-style-type: none"> * Residents' blood glucose (BG) levels were not monitored as ordered * Hypoglycemic BG levels were not reported to physicians * The facility's diabetes policy was not updated with current standards of practice * The facility's hypoglycemia policy was not followed * Insulin was administered inconsistent with 	F 309	<p>Resident #4: MD was notified of identified blood sugar. Resident#19: No longer resides in facility. Resident #7: MD notified of blood sugar levels.</p> <p>Residents were reviewed in the last 7 days for any noted changes in condition including blood glucose levels out of range per current protocol. Any noted changes identified were reported to the physician for appropriate follow up and care plans updated as needed. Facility's current diabetic care protocol does include when to notify the physician.</p> <p>Licensed Nurses have been educated on identifying a change of condition, diabetic</p>		

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F 309	<p>Continued From page 15</p> <p>physician orders. This deficient practice placed residents at risk of further health complications as a result of inadequate diabetic management. Findings include:</p> <p>The facility's undated Diabetic Care policy and procedure documented normal BG levels were 60-115 mg/dl (all measurements in milligrams/deciliters) and staff should know each resident's specific parameters. The policy documented all changes in a diabetic resident's condition should be reported to a charge nurse "immediately." The policy did not document or identify when staff was to notify the physician of BG levels outside of specified parameters.</p> <p>According to the American Diabetes Association, Standards of Medical Care in Diabetes - 2016, from the Diabetes Care Journal, Volume 39 Supplement 1, BG levels in the elderly who were "very complex" with "end stage chronic illnesses" and poor health should be 100-180 mg/dl before meals. The journal documented BG levels in the elderly who were "complex" with multiple comorbidities should have BG levels in the 90-150 mg/dl range. The journal documented older adults with diabetes in a long term care (LTC) facility were at higher risk of experiencing hypoglycemic episodes, and providers should be called "immediately" in case of hypoglycemic episodes or when BG levels were less than 70 mg/dl.</p> <p>A position statement from the American Diabetes Association documented LTC facilities should increase the frequency of glucose monitoring, call the practitioner, and confirm high glucose</p>	F 309	<p>protocol, and timely notification to the physician as well as appropriate documentation.</p> <p>The DNS/Designee will review residents daily M-F with a noted condition change for 4 weeks then monthly for 3 months. This review will include information from daily notes/MARS/TARS/24 reports and rounds and will have special focus on blood glucose results.</p> <p>Findings will be reviewed by the Director of Nursing and forwarded tot he Quality Assurance/Performance Committee for ongoing review and recommendations.</p>		

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

PRINTED: 08/14/2017
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/06/2017
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F 309	<p>Continued From page 16</p> <p>values by laboratory testing. These steps were to be completed if residents experienced BG's greater than 300 during all or part of 2 consecutive days. In addition, the position statement documented monitoring frequency should be based on complexity of residents and their risk for hypoglycemia. (Munshi, M. N., Florez, H., Huang, E. S., et al. "Management of Diabetes in Long-term Care and Skilled Nursing Facilities: A Position Statement of the American Diabetes Association." Diabetes Care, vol. 39, Feb. 2016, pp. 308-318.)</p> <p>1. Resident #19 was admitted to the facility on 6/14/17 with diagnoses that included respiratory failure, Type II diabetes mellitus, and Stage V chronic kidney disease.</p> <p>The admission Minimum Data Set (MDS) assessment, dated 6/21/17, documented Resident #19 was cognitively intact and required insulin 7 days a week.</p> <p>A Hyper/hypoglycemic Care Plan, dated 6/14/17, directed staff to report to the physician when Resident #19 experienced signs and symptoms of unstable BG levels. The care plan documented staff was to check BG levels as ordered, but did not include established BG level parameters and/or instruction for staff to notify the physician if BG levels were outside of physician-established parameters, when to administer insulin, or when to follow hyper/hypoglycemic protocols.</p> <p>Resident #19's June 2017 Physician's Orders, dated 6/14/17, documented:</p> <p>* HumaLOG (insulin) solution before meals and</p>	F 309			

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F 309	<p>Continued From page 17 at bedtime (HS) per sliding scale for BGs of:</p> <p>Less than 50 see hypoglycemic protocol units; 51-130 = 0 units; 131 - 150 = 3 units 151 - 200 = 4 units 201 - 250 = 6 units 251 - 300 = 8 units 301 - 350 = 10 units 351 - 400 = 12 units</p> <p>Staff were also to call the physician for BG levels greater than 400 mg/dl, and administer 10 units before meals in addition to the insulin administration specified by the sliding scale.</p> <p>The 6/14/17 Physician's Orders also documented the following:</p> <ul style="list-style-type: none"> * 75 units of Lantus solution at HS (bedtime) for diabetes mellitus. * Blood glucose finger sticks (BG assessment) before meals and at bedtime for diabetes mellitus. * Check BGs for signs and symptoms of hypo-/hyperglycemia and follow facility protocol. * Notify physician for BGs less than 60 mg/dl or greater than 400 mg/dl and follow facility clinical protocol. * When BGs were less than 80 mg/dl and Resident #19 could swallow, staff was to administer 15-20 g (grams) of fast acting glucose. 	F 309			

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

PRINTED: 08/14/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/06/2017
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F 309	<p>Continued From page 18</p> <p>* Staff was to repeat BG checks every 15 minutes as needed (PRN).</p> <p>Resident #19's Medication Administration Record (MAR) from 6/14/17 through 6/19/17 documented:</p> <p>* BG of 48 mg/dl on 6/15/17 at 7:30 am. Resident #19's clinical record did not document when the BG was reassessed or what, if any, interventions were implemented.</p> <p>* BG of 494 mg/dl on 6/18/17 at 8:00 pm. Resident #19's clinical record did not document when the BG was rechecked.</p> <p>* BG of 253 mg/dl on 6/19/17 at 7:30 am. The MAR did not document insulin (4 units) was administered per physician order.</p> <p>Resident #19's clinical record did not document BG reassessments were performed following hyperglycemic and hypoglycemic episodes; evidence the facility followed its hypoglycemic protocol for hypoglycemic BG levels; and the reason for not administering insulin on 6/19/17.</p> <p>A 6/17/17, 6:25 am, Incident Report (I&A) documented staff found Resident #19 on the floor of his room in an unresponsive condition and with the call light on. The report documented Resident #19 was attempting to get out bed at the time of the incident and that the BG was 25 mg/dl at the time of the fall. Post-fall interventions included educating Resident #19 and BG assessments before meals, before bed, and at 2 am.</p>	F 309			

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F 309	<p>Continued From page 19</p> <p>A 6/19/17 fax to the physician at 2:20 pm documented Resident #19 did not use insulin or assess BG levels at home and the nurse asked the physician if the insulin and BG checks could be discontinued. The physician discontinued Resident #19's insulin and BG checks.</p> <p>A Lab Report, dated 7/3/17, documented Resident #19's fasting glucose was 230 mg/dl.</p> <p>On 7/6/17 at 2:45 pm, Resident #19's stated he had diabetes, but was not monitoring BG levels or taking any kind of diabetic medication while at home prior to admission to the facility. The resident stated he received steroids at the hospital, which was why the insulin was initiated. He stated the facility stopped administering insulin and monitoring BG levels, but that he did not know why the facility stopped evaluating his BG levels.</p> <p>On 7/6/17 at 3:40 pm, the Medical Director stated he expected staff to monitor Resident #19's BG levels after the insulin was discontinued as it was not his intention for the BG assessments to be discontinued when the insulin was discontinued.</p> <p>On 7/6/17 at 4:54 pm, a Resident Care Manager (RCM) stated staff should have continued assessing Resident #19's BG until it was stable. The RCM stated staff should follow physician orders, administer correct insulin doses, and reassess BG levels outside Resident #19's established parameters.</p> <p>2. Resident #7 was readmitted to the facility on 2/22/17 with diagnoses that included Type II diabetes mellitus.</p>	F 309			

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

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F 309	Continued From page 20 Resident #7's June 2017 Physician's Orders, dated 2/22/17, documented: * HumaLOG (insulin) solution before meals per sliding scale for BGs of: Less than 120 = 0 units; 121 - 170 = 1 units 171 - 220 = 2 units 221 - 270 = 3 units 271 - 320 = 4 units 321 - 370 = 5 units * Staff were to call the physician for BG levels greater than 371 mg/dl * Blood glucose finger sticks before meals and at bedtime * Check BGs for signs and symptoms of hypo/hyperglycemia and follow facility protocol * Notify physician for BGs less than 60 mg/dl or greater than 400 mg/dl and follow facility clinical protocol * When BGs were less than 80 mg/dl and Resident #7 could swallow, staff was to administer 15-20 g of fast-acting glucose * Staff were to repeat BG assessments every 15 minutes PRN A Hyper/Hypoglycemia Care Plan, dated 3/1/17, documented staff was to administer insulin as ordered and notify the physician if Resident #7's BG levels were less than 60 mg/dl or greater than 400 mg/dl. The care plan documented staff	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/06/2017
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F 309	<p>Continued From page 21</p> <p>was to check BG levels as ordered. Resident #7's care plan was not consistent with physician orders.</p> <p>Resident #7's MAR from 6/1/17 through 6/30/17 documented the following:</p> <ul style="list-style-type: none"> * From 6/1/17 to 6/21/17, Resident #7's clinical record documented 24 BG results for which she was to receive 1 unit of insulin, however, insulin was provided on only 4 of those 24 opportunities. * On 6/5/17 at 11:00 am, Resident #7's BG was 211 mg/dl. Physician's Orders for that result directed staff to administer 2 units of insulin, however no insulin was administered. Resident #7's clinical record did not document the reason staff did not administer insulin at that time. * On 6/9/17 at 5:00 pm, Resident #7's BG was 245 mg/dl. Physician's Orders for that result directed staff to administer 3 units of insulin, however no insulin was administered. Resident #7's clinical record did not document the reason staff did not administer insulin at that time. * On 6/30/17 at 5:00 pm, Resident #7's BG was 280 mg/dl. Physician's Orders for that result directed staff to administer 4 units of insulin. The LN documented 3 units of insulin was administered and the clinical record did not document a reason the insulin dosage was inconsistent with physician's orders. * From 6/4/17 to 6/26/17, Resident #7's clinical record did not document BG assessments were performed on 5 of 66 opportunities. 	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/06/2017
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F 309	<p>Continued From page 22</p> <p>On 7/6/17 at 4:54 pm, the RCM stated Resident #7's MAR included documentation the insulin was not administered as ordered. She stated there was no evidence BG checks were performed.</p> <p>3. Resident #4 was admitted to the facility on 5/30/17 with diagnoses that included dementia, Type II diabetes mellitus, and CHF (Congestive Heart Failure).</p> <p>Resident #4's Diabetic Administration Record documented a BG level of 59 mg/dl at 8:00 am on 7/4/17, with a repeat BG of 82. The record did not indicate what time the repeat BG was performed, or if Resident #4's physician was notified of the initial BG result of 59.</p> <p>The facility's Diabetic Care policy, undated, documented normal BG levels were 60-115 mg/dl, staff should know residents' specific parameters, and that all changes in a diabetic residents' condition should be reported to a charge nurse "immediately." The policy did not include direction to staff for physician notification of abnormal values.</p> <p>On 7/6/17 at 12:10 pm, the RCM stated the LN caring for Resident #4 on 7/4/17 did not document what interventions she performed for the BG result of 59. The RCM stated she was unable to find documentation that Resident #4's physician was notified of the low BG.</p> <p>On 7/6/17 at 3:15 pm, Resident #4's physician stated he was not informed of the low BG result. He stated he would expect to be notified of any</p>	F 309			

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F 309 {F 314} SS=D	Continued From page 23 BG result out of established facility parameters. 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 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, observation, and record review, it was determined the facility failed to ensure services were provided to promote the healing of pressure ulcers (PU). This was true for 2 of 4 residents reviewed for pressure ulcers (#19 and #20) and had the potential to place residents at risk of harm if prompt and consistent treatment was not provided for newly discovered wounds. Findings include: 1. Resident #19 was admitted to the facility on 6/14/17 with diagnoses that included respiratory failure, Type II diabetes mellitus, and Stage V Chronic Kidney Disease.	F 309 {F 314}	Resident #19: No longer resides in the facility. Resident #20: Wound has resolved. Residents with pressure ulcers were reviewed for accurate and complete weekly assessments. Licensed Nurses were educated on accurate and timely completion of weekly skin assessments. DNS/ designee will complete weekly audits for 4 weeks and then monthly for 3 months of weekly skin assessments.	7/26/17	

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{F 314}	<p>Continued From page 24</p> <p>The Admission Braden Scale assessment, dated 6/14/17, documented Resident #19 was "at risk" for PUs.</p> <p>An undated Non-Pressure Skin Condition Record in Resident #19's clinical record was blank and contained no entries.</p> <p>Resident #19's Admission Skin Assessment, dated 6/14/17, documented a skin abrasion to the coccyx; measurements were not included.</p> <p>The Risk for Pressure Ulcers Care Plan, dated 6/14/17, instructed staff to complete weekly skin assessments and notify a nurse "immediately" of any new areas of skin breakdown, redness, blisters, bruises or discoloration. The care plan did not address the wound on Resident #19's coccyx, and was not updated to include an ordered treatment staff were to follow for the coccyx wound.</p> <p>A Weekly Skin Integrity Data Collection tool, dated 6/20/17, documented Resident #19 had an abrasion to the coccyx. There were no measurements provided for the wound.</p> <p>The admission Minimum Data Set (MDS) assessment, dated 6/21/17, documented Resident #19 had no PUs on admission.</p> <p>A Notification Fax to the physician, dated 6/22/17 at 8:00 am, documented a 2 cm x (by) 2 cm x 0.1 cm abrasion to the right buttock. with no "pressure/redness" noted.</p> <p>Nurses Notes from 6/14/17 through 7/5/17 did not contain documentation or measurements of</p>	{F 314}	<p>Regional Nurse will provide monthly oversight for 4 months to assure ongoing compliance.</p> <p>Findings will be reviewed by the Director of Nursing and forwarded to the Quality Assurance/Performance Committee for ongoing review and recommendations.</p>	

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{F 314}	<p>Continued From page 25 the wound to Resident #19's coccyx.</p> <p>A Weekly Skin Integrity Data Collection tool, dated 6/26/17, documented Resident #19 had an abrasion on the coccyx. There were no measurements provided for the wound.</p> <p>A Weekly Skin Integrity Data Collection tool, dated 7/2/17, documented Resident #19 had a "popped blister" to the "right buttock." There were no measurements provided for the wound.</p> <p>On 7/6/17 at 2:45 pm, Resident #19's wound was observed as a 0.7 x 0.7 round blister-like area on the right buttocks. The area appeared dry and was dark purple/gray.</p> <p>On 7/6/17 at 4:54 pm, the Resident Care Manager (RCM) stated the Non-Pressure Skin Condition Record should have been initiated upon discovery of the wound and the measurements documented. She stated staff were to continue documenting the progression of the wound until it resolved. The RCM stated Resident #19's wound record was not complete.</p> <p>On 7/6/17 at 5:52 pm, the RCM stated nursing staff completed a Non-Pressure Skin Condition Records for Resident #19. She stated Resident #19's coccyx wound was not related to pressure and would not be treated by the wound team. She stated she did not know why the 7/2/17 Weekly Skin Integrity Data Collection sheet documented the coccyx "abrasion" was a "popped blister," and stated it was "never" a "blister."</p>	{F 314}			

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

PRINTED: 08/14/2017
FORM APPROVED
OMB NO. 0938-0391

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{F 314}	<p>Continued From page 26</p> <p>2. Resident #20 was admitted to the facility on 5/13/17 with diagnoses that included COPD (chronic obstructive pulmonary disease), dementia, weakness, and irregular heartbeat.</p> <p>Physician Orders, dated 6/27/17, directed staff to cleanse the wound and cover it with a foam dressing every 3 days.</p> <p>Resident #20's June 2017 treatment record did not include treatment orders or document wound care was performed. The July 2017 treatment record included the physician's wound care orders, but did not document wound care was provided on 7/3/17 as scheduled.</p> <p>A Weekly Skin Integrity Data Collection tool, dated 6/8/17, documented the following:</p> <ul style="list-style-type: none"> * 1 of 3 assessments was unsigned and undated. Edema was noted to both of Resident #20's lower extremities. * 6/15/17 - Skin intact. * 6/29/17 - Skin dry and intact. No documentation of a sacral wound, for which the physician wrote care orders on 6/27/17. <p>Resident #20's clinical record did not include a weekly skin assessment due the week of 6/18/17 to 6/24/17.</p> <p>Resident #20's clinical record did not include a pressure ulcer assessment, progress notes, or other skin assessments describing the sacral wound.</p>	{F 314}		

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{F 314}	Continued From page 27 On 7/6/17 at 4:20 pm, the RCM stated Resident #20's sacral wound healed and the orders for wound care should have been discontinued. She was unable to find documentation in Resident #20's record that wound care was provided as ordered on 6/27/17, 6/30/17 or 7/3/17, or when the wound was determined to be resolved. The RCM stated the weekly skin assessment did not document care had been provided from 6/18/17 to 6/24/17.	{F 314}			
{F 329} SS=D	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 (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--	{F 329}		7/26/17	

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{F 329}	Continued From page 28 (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 record review, policy review, and resident and staff interview, it was determined the facility failed to ensure: * Residents' behaviors were identified prior to the administration of psychotropic medications * Physicians' medication orders included specific indications for use * Medications were monitored for effectiveness * Gradual Dose Reductions (GDR) were attempted for psychotropic medications This was true for 3 of 9 residents (#7, #19 and #23) reviewed for psychoactive medication use and had the potential for harm if residents received inappropriate, ineffective, or excessive dosages of psychotropic medications. Findings include: 1. Resident #19 was admitted to the facility on 6/14/17 with diagnoses that included respiratory failure, Type II diabetes mellitus, and Stage V Chronic Kidney Disease. Resident #19's diagnoses did not include insomnia.	{F 329}	Resident #7: Medication regimen reviewed by MD and IDT. Trazadone was discontinued. Will continue dose reduction of Remeron over next 30 days. Remeron care plan was reviewed and updated. Resident #19: No longer resides in facility. Resident #23: Ativan orders reviewed for appropriate use and monitoring. Orders and care plan were updated as needed. All other residents utilizing psychoactive medications were audited to ensure adequate indications for use, specific targeted behaviors identified, and behavior monitoring in place. Licensed Nurses and Social Services staff have been trained in identification of targeted behaviors and behavior monitoring for psychoactive medications		

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{F 329}	Continued From page 29 The admission Minimum Data Set (MDS) assessment, dated 6/21/17, documented Resident #19 was cognitively intact and had minimal signs of depression. A Behavior Management Care Plan, dated 6/21/17, documented Resident #19 had mood alterations related to insomnia. Resident #19's July 2017 Physician's Orders, dated 6/14/17, documented staff was to administer 1 milligram (mg) Clonazepam at bedtime as needed (PRN) for insomnia, and 50 mg Trazodone at bedtime PRN for insomnia. The Medication Administration Record (MAR) for 6/14/17 through 6/30/17 documented Resident #19 received 14 doses of PRN Clonazepam and 14 doses of PRN Trazodone. The MAR documented the medication's efficacy was not monitored for 9 of those 28 administrations. The MAR for 7/1/17 through 7/5/17 documented Resident #19 received 4 doses of PRN Clonazepam and 4 doses of PRN Trazodone. The MAR did not document the reason (signs/symptoms) the medications were used and the medications' efficacy was not monitored for 7 of those 8 administrations. According to the Nursing 2017 Drug Handbook, Clonazepam was indicated for seizures, bipolar disorder, and panic disorder, and Trazodone was indicated for use with depression and insomnia. On 7/6/17 at 11:34 am, the Resident Care Manager (RCM) stated Resident #19 received	{F 329}	with focus on assuring adequate monitoring to prevent the use of un-necessary medications. DNS or designee will conduct an audit of all new psychoactive medications to assure adequate indications for use, behaviors identified, and behavior monitoring is in place on a weekly basis for 4 weeks then monthly for 3 months. Regional Nurse will review monthly for 4 months to assure ongoing compliance. Findings will be reviewed by the Director of Nursing and forwarded to the Quality Assurance/Performance Committee for ongoing review and recommendations.		

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

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{F 329}	<p>Continued From page 30</p> <p>Clonazepam for anxiety related to shortness of breath and Trazodone for insomnia. She stated the resident was diagnosed with insomnia during a recent hospitalization and that she did not know why Resident #19's list of diagnoses at the facility did not include insomnia. The RCM noted she could not find evidence of consistent monitoring of the medications' efficacy or documentation that would explain why the Clonazepam and Trazodone were administered.</p> <p>On 7/6/17 at 2:45 pm, Resident #19 stated he did not have insomnia, but rather he was claustrophobic and wearing a CPAP (Continuous Positive Air Pressure) mask at night made him "anxious and stressed out." He stated he wanted a medication to help alleviate the stress from the mask.</p> <p>On 7/6/17 at 3:40 pm, the Medical Director stated Resident #19's Trazodone was for depression and the Clonazepam was for anxiety related to wearing a mask at night.</p> <p>2. Resident #7 was readmitted to the facility on 2/22/17 with diagnoses that included depression and respiratory failure. Resident #7's diagnoses did not include insomnia.</p> <p>Resident #7 quarterly MDS assessment, dated 6/1/17, documented no cognitive impairment and mild signs of depression.</p> <p>A Behavior Management Care Plan, dated 2/27/17, documented Resident #7 experienced depression and received medication to stimulate appetite. The care plan did not document Resident #7 experienced insomnia.</p>	{F 329}			

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

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FORM APPROVED
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{F 329}	Continued From page 31 Resident #7's June 2017 Physician's Orders documented staff was to provide 150 mg Bupropion twice a day for depression, ordered 2/22/17; 15 mg Remeron at bedtime as an appetite stimulant, ordered 2/22/17; and 50 mg Trazodone at bedtime, ordered 5/18/17. The Trazodone order did not contain an indication for use. According to the Nursing 2017 Drug Handbook, Bupropion was indicated for use with depression and to "promote weight loss." The handbook documented side effects of the medication included anorexia, weight loss, and insomnia. The Handbook documented Remeron was indicated for depression and potential side effects included increased appetite and weight gain. The Handbook documented Trazodone was indicated for depression and insomnia. The Behavior Monitor for 6/1/17 through 7/6/17 documented staff monitored Resident #7's meal consumption, hours of sleep per shift, grief related to poor health, and episodes of tearfulness. An undated GDR (Gradual Dose Reduction) Consideration form notified Resident #7's physician that Resident #7 currently received three different antidepressants, which posed an increased risk of potential side effects. The GDR did not include recommendations. On 6/7/17, the physician responded, "I do not recommend changes at this time due to the following reason: Stable on current Rx [prescription]." On 7/5/17 at 4:45 pm, the Social Services	{F 329}			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 329}	<p>Continued From page 32</p> <p>Assistant stated she did not know why Resident #7 received Trazodone as the order did not include a diagnosis, Remeron was ordered as an appetite stimulant, and the physician denied the last request for a GDR without providing a clinical rationale.</p> <p>On 7/6/17 at 11:34 am, the RCM stated Resident #7 received Remeron as an appetite stimulant; she was aware the effective dose of Remeron as an appetite stimulant was 7.5 mg, which was half the ordered dosage; Trazodone was for insomnia, and the original order should have included a diagnosis/indication for use; and that the Trazodone and Remeron orders should have been clarified before administration.</p> <p>On 7/6/17 at 3:40 pm, the Medical Director stated Resident #7's depression was being treated with Remeron and Bupropion, and the Trazodone was for insomnia, which should have been specified on the order. The physician did not provide a clinical rationale for the use of two medications to treat Resident #7's depression.</p> <p>3. Resident #23 was admitted to the facility on 6/12/17 with diagnoses that included depression, anxiety, and dementia.</p> <p>The admission MDS assessment, dated 6/19/17, documented Resident #23 was cognitively intact and had minimal signs of depression.</p> <p>The Behavior Management Care Plan, dated 6/14/17, documented Resident #23 had alterations in mood and behavior related to depression. The care plan was updated 6/21/17 to include a diagnosis of anxiety.</p>	{F 329}			

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

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{F 329}	Continued From page 33 A 6/16/17 Physician's Order documented Ativan 0.25 mg every 6 hours PRN was initiated for anxiety. A 6/19/17 Physician's Order documented Resident #23 was to receive Ativan 0.25 to 0.5 mg every 6 hours PRN for anxiety. The 6/16/17 through 6/30/17 MAR documented Resident #23 received PRN Ativan on 6/17/17, twice on 6/19/17, and again on 6/20/17. Dosages were not documented for 6/17/17 and 6/19/17. There was no documentation of behaviors prompting administration of the Ativan, whether nonpharmacological interventions were attempted prior to administration of the medication, and there was no staff monitoring for effectiveness associated with these administrations. The MAR documented Ativan was administered twice on 6/18/17, and administered on 6/22/17, 6/23/17, 6/25/17, 6/27/17, and 6/30/17. The clinical record did not include staff monitoring of effectiveness associated with these administrations. Resident #19 received the PRN Ativan dosages at various times throughout the day from 10:00 am to 11:30 pm. A 6/21/17 Physician's Order changed Resident #23's Ativan to 0.5 mg daily at bedtime for anxiety. On 7/6/17 at 6:27 pm, the RCM stated the PRN Ativan was changed to scheduled administrations because Resident #23 received it at night. After reviewing administration times on the MAR, the RCM stated it was unclear why the Ativan was	{F 329}			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/06/2017
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COEUR D'ALENE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST AQUA AVENUE COEUR D ALENE, ID 83815		
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{F 329}	<p>Continued From page 34 changed from PRN to scheduled.</p> <p>The 6/21/17 through 6/30/17 MAR documented Resident #23 received 9 doses of scheduled 0.5 mg of Ativan at night, but did not document staff monitored its effectiveness.</p> <p>Resident #23's behavior monitoring for Ativan was initiated on 7/6/17, 20 days after the medication was initiated. There was no other documentation in the resident's clinical record related to behavior monitoring for the 20 days prior to the initiation of the behavior monitor.</p> <p>On 7/6/17 at 4:54 pm, the RCM stated Resident #23's record did not include documentation of consistent monitoring for the effectiveness of the Ativan.</p>	{F 329}		