



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
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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](mailto:fsb@dhw.idaho.gov)

August 17, 2017

Chuck Lloyd, Administrator  
Bell Mountain Village & Care Center  
620 North Sixth Street  
Bellevue, ID 83313-5174

Provider #: 135069

Dear Mr. Lloyd:

On **July 28, 2017**, a survey was conducted at Bell Mountain Village & 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 actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **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 **August 27, 2017**. Failure to submit an acceptable PoC by **August 27, 2017**, may result in the imposition of civil monetary penalties by **September 19, 2017**.

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

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

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

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

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

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedies:

- A civil money penalty.
- DPNA made on or after October 28, 2017.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 28, 2018**, if substantial compliance is not achieved by that time. **Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.**

Chuck Lloyd, Administrator  
August 17, 2017  
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If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/ta/bid/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 **August 27, 2017**. If your request for informal dispute resolution is received after **August 27, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



David Scott, RN, Supervisor  
Long Term Care

DS/lj

Chuck Lloyd, Administrator  
August 17, 2017  
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Enclosures

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

PRINTED: 11/22/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>BELL MOUNTAIN VILLAGE &amp; CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>620 NORTH SIXTH STREET BELLEVUE, ID 83313</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification and complaint investigation survey conducted July 24, 2017 to July 28, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Linda Kelly, RN Cecilia Stockdill, RN</p> <p><b>ABBREVIATIONS:</b></p> <p>ADL = Activity of Daily Living BP = Blood pressure C2 = second cervical vertebra cc = cubic centimeter CNA = Certified Nursing Assistant cont = continue(d) COO = Chief of Operations CT = computerized axial tomography DNS = Director of Nursing FSS = Food Service Supervisor g-tube = gastrostomy tube (tube for feeding) I&amp;A = Incident and Accident lab = laboratory LPN = Licensed Practical Nurse MDS = Minimum Data Set mmHg = millimeters of Mercury NN = Nurse's Notes NP = Nurse Practitioner NS = Normal saline P&amp;P = Policy &amp; Procedure POA = Power of Attorney rec = received(d) RN = Registered Nurse Rx = Prescription</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

08/29/2017

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

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F 000	Continued From page 1 w/c = wheelchair	F 000			
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14)  (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	F 157		10/20/17	

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F 157	<p>Continued From page 2 resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure physicians and/or resident representatives were notified of accidents resulting in injury, syncope (fainting) and low blood pressure readings. This was true for 2 of 6 (#3 and #4) residents reviewed for physician/interested party notification and had the potential to result in missed opportunities for medical intervention and interested party involvement. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 1/16/17 with diagnoses including cerebral palsy, nausea/vomiting, and presence of a feeding tube.</p> <p>a. An Incident/Accident (I&amp;A) Report documented the resident's g-tube (gastrostomy tube - a feeding tube in the abdomen) was accidentally pulled out on 5/22/17 at approximately 10:00 pm. The report documented a physician and resident representative were notified. However, the space for the names of who was notified was blank and the date and time the physician was notified was</p>	F 157	<p>Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority. Accordingly, the facility has drafted this Plan of Correction in accordance with State Laws which mandate the submission of a Plan of Correction as a condition for participation in the Medicaid program. This Plan of Correction shall constitute this facility's credible allegation compliance with this section.⋮⋮⋮</p> <p>F 157 SS=D ⋮483.10 (g) (14) - Notify of Changes(Injury/decline/room, etc.) The facility does ensure that Physicians, PA's, NP and/or resident representative are notified of incident(s)/accident(s) and</p>		

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F 157	<p>Continued From page 3 also blank</p> <p>A Nurse's Note (NN), dated 5/23/17 at 12:56 am, documented the nurse was notified at 10:00 pm that the g-tube was pulled out, the Director of Nursing Services (DNS) was notified, and the resident was transported to a local hospital for replacement of the g-tube. There was no mention of physician or interested party notification.</p> <p>On 7/27/17 at 6:00 pm, the DNS did not provide information regarding physician and interested party notification regarding the g-tube being pulled out or the need to transport the resident to a hospital for replacement of the g-tube.</p> <p>b. A NN, dated 7/12/17 at 2:35 pm, documented Resident #3's blood pressure as "77/53, 74/52 and 76/5 by aid (sic). Manual done 90/58 [all measurements millimeters mercury - mmHG] ..." The note also documented the resident was weak, and had a headache with nausea and vomiting.</p> <p>On 7/27/17 at 6:00 pm, the DNS stated Resident #3 had a history of low blood pressure and vomiting but the physician should have been notified when the systolic blood pressure was less than 100 mmHg. The DNS did not provide information regarding physician and interested party notification regarding the replacement of the resident's g-tube.</p> <p>2. Resident #4 was admitted to the facility on 2/6/17 with multiple diagnoses, including heart disease, hypertension, and eustachian tube disorder.</p>	F 157	<p>low blood pressure readings.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident #3, regarding Incident/Accident report 05/22/2017 on the g-tube being pulled, and being transported to a local hospital for replacement of the g-tube, Resident #3's representative and physician will be notified by 10/20/2017. Resident #3's, low blood pressure noted in the nurses note (NN) dated 07/12/2017, physician notified, 10/20/17. Resident #4, regarding Incident/Accident report 06/3/2017 on the syncopal episode and loss of consciousness, I&amp;A report completed to include documentation of the Nurse Practitioner name notified and the time of notification, by 10/20/2017. Resident #4, fall incident on 06/4/2017, physician and resident's representative notified, by 10/20/2017.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken: This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.</p> <p>However, all other current residents in the facility may have the potential to be affected by this deficiency, therefore; An Incident/Accident Physician or PA or NP and Resident Representative Notification Checklist Log, will formulated</p>		

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F 157	<p>Continued From page 4</p> <p>a. An I&amp;A Report, dated 6/3/17, documented Resident #4 had a "syncopal episode" and "lost consciousness" at 12:16 pm while standing to be weighed. A Certified Nursing Assistant (CNA) was present and assisted the resident to the floor. The Report documented a Nurse Practitioner (NP) was notified, however the name of the NP and the time notification was provided was not documented in the I&amp;A Report. In addition, the only Nurse's Note for 6/3/17 did not mention the fall or NP notification.</p> <p>b. An I&amp;A Report, dated 6/4/17, documented Resident #4 had an unwitnessed fall at 2:15 am (14 hours after the 6/3/17 fall). The Report documented the resident's blood pressure (BP) while laying down was 95/52 mmHg, pulse was 57 beats per minute (bpm), and the fall resulted in a skin tear injury to the right forearm. The Report did not document that a physician or resident representative was notified.</p> <p>A NN, dated 6/4/17 at 2:15 am, documented the resident fell while walking to the bathroom, did not lose consciousness, the skin tear to the right forearm was cleaned and dressed, and that neuro checks were initiated. The NN also documented that "small abrasions" to the resident's right forehead and right knee were cleaned and left open to air. There was no documentation that a physician or resident representative was notified.</p> <p>On 7/27/17 at 4:50 pm, the DNS said she did not know when the NP was notified of Resident #3's loss of consciousness on 6/3/16, or why the physician and resident representative were not</p>	F 157	<p>by the Director of Nurses for her use to ensure the documentation of the Physician or PA or NP and Resident Representative notification(s), by 10/20/2017.</p> <p>A Blood Pressure Parameter on when to notify Physician or PA or NP (unless otherwise specified by the Resident's Physician or PA or NP), will be developed and in-serviced to nursing staff by the facility Director of Nursing to provide guidance for the License Nurse(s), 10/20/2017</p> <p>Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur: To ensure that the deficiency practice does not recur, 10/20/2017, the Director of Nursing or LN Designee will provide an in-service education to the License Nurses, regarding F-157 with emphasis on the following: The importance of documenting the names, date, and time of the Physician or PA or NP and/or resident representative were notified in the Incident/Accident report. Blood Pressure Parameters will be outlined in the form of a Physician Order for all residents on Blood Pressure medication by the facility Medical Director to provide guidance for the License Nurse(s) on when to notify the Physician</p>		

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F 157	Continued From page 5 notified of the 6/4/17 fall when the resident's BP and pulse were both low.	F 157	<p>or PA or NP (unless otherwise specified by the Resident <input type="checkbox"/>s Physician or PA or NP) by 10/20/2017.</p> <p>Monitoring will be done through: The Medical Record Department or Designee will review all Incident/Accident reports to ensure that the name(s), date, and time of the Physicians or PA or NP and/or resident representative notification is documented in the Incident/Accident report. The Medical Record Department or Designee will audit all Residents Blood Pressures recorded to ensure that the Resident Physician or PA or NP notified in the event of low blood pressure as specified in the Blood Pressure Parameter developed by the facility Medical Director to provide guidance for the License Nurse(s) on when to notify the Physician or PA or NP (unless otherwise specified by the Resident <input type="checkbox"/>s Physician or PA or NP). Monitoring will start on 10/20/2017. This will be done weekly X4, then q 2 weeks X4, then monthly X3. The Medical Record or designee will present to the quarterly QA&amp;A Committee monthly meeting of the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting with the Director of Nursing having overall responsibility.</p>		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		10/20/17	

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

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F 280	<p>Continued From page 6 CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)</p> <p>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:</p> <p>(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.</p> <p>(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.</p> <p>(iv) The right to receive the services and/or items included in the plan of care.</p> <p>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.</p> <p>(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--</p> <p>(i) Facilitate the inclusion of the resident and/or resident representative.</p> <p>(ii) Include an assessment of the resident's strengths and needs.</p> <p>(iii) Incorporate the resident's personal and</p>	F 280			

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

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F 280	<p>Continued From page 8 assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure residents' care plans were reviewed and/or updated to reflect current needs. This was true for 2 of 6 (#2 and #3) residents reviewed for care plan revisions and had the potential for harm if residents did not receive appropriate care and interventions due to inaccurate care plan information. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 1/16/17 with diagnoses that included cerebral palsy, depression, and hydrocephalus.</p> <p>a. The care plan, dated 1/18/17, documented an orthotic brace was to be placed on Resident #3's left leg and worn with shoes during all transfers and while walking.</p> <p>An Interdisciplinary Team (IDT) note, dated 5/19/17, documented Resident #3 refused to wear the left leg brace. A Nurse's Note (NN), dated 6/28/17 at 10:00 am, documented the resident had not been wearing the "splint."</p> <p>On 7/27/17 at 9:15 am, Licensed Practical Nurse (LPN) #1 said the brace for Resident #3's left leg was ordered "to keep it straight," but the resident refused to wear it.</p> <p>On 7/27/17 at 11:10 am, the resident was observed being transferred from a wheelchair to the toilet by Certified Nursing Assistant (CNA) #1 and LPN #1. The brace was not worn during the</p>	F 280	<p>F 280 SS=D ¿483.10 (c)(2)(i-ii,iv,v)(3),483.21(b)(2)-Right to Participate Planning Care-Revise CP</p> <p>This facility does ensure that resident□(s) care plans are reviewed and/or updated to reflect their current needs and status. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident #3, will have a therapy evaluation to determine the need for the left leg brace, by 10/20/2017 Resident #3□s care plan updated to reflect one person for cares and one staff as standby by 10/20/2017. Resident #2□s fall care plan updated to include new interventions to help prevent accidents i.e. resident use of alarms while sitting in a wheelchair or his recliner chair and the use of wheel chair auto-locking brakes, by 10/20/2017. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken: This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, all other current residents in the facility care plans may not be current and reflect the residents current status and may have the potential to be affected by this deficiency, therefore; The Director of Nurses or LN Designee</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>BELL MOUNTAIN VILLAGE &amp; CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>620 NORTH SIXTH STREET BELLEVUE, ID 83313</b>		
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F 280	<p>Continued From page 9</p> <p>observed transfer. CNA #1 stated she was not sure Resident #3 required the left leg brace.</p> <p>A Physician Order Report, effective 7/1/17, did not document that a brace was ordered for Resident #3's left leg.</p> <p>b. A behaviors care plan, dated 3/23/17, documented Resident #3 made "accusatory remarks" and that two staff members were to assist the resident with all cares.</p> <p>On 7/27/17 at 9:05 a.m., CNA #1 was observed providing cares to Resident #3 in the resident's room after the resident returned from bathing. When asked how many staff members were to be present when providing care to Resident #3, CNA #1 said, "She is a one person assist with cares, sometimes 2 [people]." CNA #1 also stated she did not know what level of assistance staff was directed to provide per the resident's care plan.</p> <p>On 7/27/17 at 5:41 pm, the Director of Nursing said the care plan should have been revised as it was no longer necessary for two staff to be present during cares, and the resident had refused to wear the leg orthotic "for months."</p> <p>2. Resident #2 was admitted to the facility on 6/3/16 with multiple diagnoses, including dementia, history of falls, and Parkinson's Disease.</p> <p>The annual MDS (Minimum Data Set) assessment, dated 5/19/17, documented Resident #2 was moderately cognitively</p>	F 280	<p>will review and/or update all current Residents care plans, to reflect current interventions and resident status, by 10/20/2017.</p> <p>Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur: To ensure that the deficient practice does not recur, By 10/20/2017, the Director of Nursing or LN Designee will provide in-service education to the License Nurses, regarding F-280 with emphasis on the importance of reviewing and/or updating when necessary the Resident(s) care plans to reflect current interventions and status of all residents residing in the facility.</p> <p>Monitoring will be done through: The Medical Record or Designee will review all Incident/Accident reports to ensure that the residents fall care plans are reviewed and/or updated when necessary to reflect current interventions and resident status. The Director of Nursing and/or designee will review all resident care plans to ensure they reflect the residents current status. Monitoring will start on 10/20/2017. This will be done weekly X4, then q 2 weeks X4, then monthly X3. The Medical Record or designee will present to the quarterly QA&amp;A Committee quarterly meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the</p>		

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F 280	<p>Continued From page 10</p> <p>impaired, experienced more than two falls with minor injury, and required extensive assistance of 1 staff with transfers.</p> <p>A Falls Care Plan, dated 10/3/16, documented Resident #2 had a history of falls, lacked safety awareness, and experienced dementia, seizures, and shuffled when walking if distracted.</p> <p>Interventions included:</p> <p>* 10/17/16 - "Therapy to review ambulation/gait pattern."</p> <p>*10/17/16 - "[Resident #2] chooses not to use a w/c [wheelchair] at this time as he chooses to direct his own care including his right to maintain his independence with transfers and ambulation. POA [Power of Attorney] and resident are aware of risk of injury with self ambulation/transfers and they choose to maintain Resident #2's quality of life with independence."</p> <p>* 2/16/17 - "[Resident #2] continues to choose not to use assistive devices at times. Does not use call light appropriately."</p> <p>* 2/16/17 - "Increased supervision with neuro's [neurological assessments]."</p> <p>A 1/19/17 Incident and Accident Report (I&amp;A) documented Resident #2 lost his balance, fell backwards while playing catch during a therapy session, struck his left inner arm on a chair, and sat on the floor. Resident #2's care plan was not updated following the 1/19/17 fall.</p> <p>A 5/18/17 I&amp;A documented staff witnessed, but</p>	F 280	<p>QA&amp;A Committee quarterly meeting with the Director of Nursing having overall responsibility</p>		

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

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F 280	Continued From page 11 were unable to prevent, Resident #2 falling despite an alarm that was sounding. Resident #2's care plan was not updated following the 5/18/17 fall.  A 5/30/17 I&A Report documented staff found Resident #2 kneeling by his bedroom sink after attempting to self-transfer to the bathroom. No alarm sounded and Resident #2's care plan was not updated following the 5/30/17 fall.  A 6/2/17 I&A Report documented Resident #2 stood up from an unlocked wheelchair in the dining room. The wheelchair rolled back as he turned around, and Resident #2 fell to his knees. Resident #2's care plan was not updated following the 6/2/17 fall.  Resident #2 was observed from 7/24/17 to 7/28/17 with alarms attached to him while sitting in a wheelchair or in his recliner. The wheelchair was equipped with auto-locking brakes. The Fall Care Plan did not document Resident #2 was equipped with alarms and auto-locking brakes to prevent falls.  On 7/27/17 at 6:20 pm, the DNS said Resident #2's Fall Care Plan should have been updated with new interventions to help prevent accidents after his repeated falls.	F 280			
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i)  (b)(3) Comprehensive Care Plans  The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 281		10/20/17	

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F 281	<p>Continued From page 12 must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of clinical records, Incident/Accident (I&amp;A) reports, and policies and procedures (P&amp;P), it was determined the facility failed to ensure professional standards of quality were maintained for 3 of 11 sample residents (#2, #3 and #4). Specifically, vital signs and/or neurological assessments not performed or were incomplete after Resident #2, #3 and #4 experienced unwitnessed falls; and Resident #3's medications and enteral feeding via gastrostomy tube (g-tube) were administered with force rather than gravity flow. These failures created the potential for harm if a decline in the residents' hemodynamic or neurological status was undetected and untreated and complications arose related to the use of Resident #3's g-tube. Findings included:</p> <p>1. Resident # 3 was admitted on 1/16/17 with diagnoses including cerebral palsy, hydrocephalus, convulsions, and presence of a g-tube (feeding tube inserted into the abdominal wall).</p> <p>a. An Incident/Accident (I &amp; A) Report, dated 4/16/17 at 5:00 pm, documented Resident #3 slid out of her wheelchair. The resident subsequently complained of discomfort to her left shoulder and left side of her face. The vital signs section of the I&amp;A Report was blank.</p> <p>A Nurse's Note (NN), dated 4/16/17 at 5:00 pm,</p>	F 281	<p>F 281 SS=D ¿483.21 (b)(3)(i)- Services Provided Meet Professional Standards This facility does ensure professional standards of quality i.e. vital signs and/or neurological assessment preformed or completed after resident experienced unwitnessed fall(s) and that resident medication(s) and enteral feeding via gastrostomy tube were administered via gravity flow.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #3, the License Nurse(s) who did not document on the unwitnessed fall incident/accident report dated 04/16/17 on vital(s) signs section of the incident/accident report, and neuro check on the neuro flow sheet will be provided with 1:1 in-service education by the Director of Nurses regarding F 281, with emphasis on the importance of performing, completing, and documenting the vital(s) signs in the accident/incident report vital signs section, and neuro check on the neuro flow sheet in the event when there is an unwitnessed fall(s), by 10/20/2017.</p> <p>Resident #3, Registered Nurse (RN) #1</p>		

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F 281	<p>Continued From page 13</p> <p>documented Resident #3 slid out of a wheelchair and onto the floor and directed staff to "see VS [vital signs] and neuro flow sheet." No vital signs were documented on the Vitals/Weight Sheet for 4/16/17 and no Neuro Flow Sheet was provided.</p> <p>b. On 7/25/17 at 10:12 am, Registered Nurse (RN) #1 was observed administering feeding formula and three medications via Resident #3's g-tube. After the administration of the third medication, RN #1 pushed the plunger into the syringe instead of allowing the solution to flow by gravity. RN #1 said the plunger should not be used, but she wanted to ensure all of the feeding formula went through the g-tube.</p> <p>The facility's policy and procedures for administering medication via g-tube documented that the syringe should be attached without the plunger and the administration of medications and enteral feedings was to be by gravity flow.</p> <p>2. Resident #2 was admitted to the facility on 6/3/16 with multiple diagnoses, including dementia, history of falls, and Parkinson's Disease.</p> <p>The annual MDS assessment, dated 5/19/17, documented Resident #2 was moderately cognitively impaired, experienced more than two falls with minor injury, and required extensive assistance of 1 staff with transfers.</p> <p>A Falls Care Plan, dated 10/3/16, documented Resident #2 had a history of falls, lack of safety awareness, dementia, shuffling steps with any distraction, and seizure type events.</p>	F 281	<p>will provided with 1:1 in-service education by the Director of Nurses regarding F281 regarding the importance of making sure that during administering medication(s) via g-tube, that the syringe should be attached without the plunger and the administration of medications and enteral feeding is to be by gravity flow, by 10/20/2017.</p> <p>Resident #2, the Licensed Nurse(s) who did not perform or complete the documentation on the unwitnessed falls incident/accident report dated 02/16/17 and 05/31/17 the neuro check on the neuro flow sheet will be provided with 1:1 in-service education by the Director of Nurses regarding F 281, with emphasis on the importance of performing, completing, and documenting the neuro check on the neuro flow sheet in the event when there is an unwitnessed fall(s), by 10/20/2017.</p> <p>Resident #4 the License Nurse(s) who did not perform or complete the documentation on the unwitnessed fall incident/accident report dated 06/04/17 the neuro check on the neuro flow sheet will be provided with 1:1 in-service education by the Director of Nurses regarding F 281, with emphasis on the importance of performing, completing, the documenting the neuro check on the neuro flow sheet in the event when there is an unwitnessed fall(s), by 10/20/2017.</p> <p>Identification of other residents having the</p>		

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F 281	<p>Continued From page 14</p> <p>Interventions included:</p> <p>* 10/17/16 - Therapists were to "review ambulation/gait pattern."</p> <p>*10/17/16 - "[Resident #2] chooses not to use a w/c at this time as he chooses to direct his own care including his right to maintain his independence with transfers and ambulation. POA [Power of Attorney] and resident are aware of risk of injury with self ambulation/transfers and they choose to maintain Resident #2's quality of life with independence."</p> <p>* 2/16/17 - "[Resident #2] continues to choose not to use assistive devices at times. Does not use call light appropriately."</p> <p>* 2/16/17 - "Increased supervision with neuro's."</p> <p>The facility's Neuro-checks policy and procedure, dated 7/14/16, documented staff were to assess neurological status after a fall in which a resident's head may have been injured every 15-minutes for an hour, every hour for four hours, every four hours for 24 hours, and then every shift for 48 hours.</p> <p>A Fall Scene Investigation Report, dated 2/16/17 at 3:10 pm, documented the following:</p> <p>* Resident #2 was found on the floor in his room. The resident was to have increased supervision and neurological monitoring implemented.</p> <p>A Fall Scene Investigation Report, dated 5/30/17 at 8:20 pm, documented the following:</p>	F 281	<p>same potential to be affected by the same practice and what corrective action(s) taken: This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.</p> <p>All residents who receive enteral feedings/medications by a licensed nurse could be at risk for this citation.</p> <p>All other current residents in the facility that have unwitnessed fall(s) may have the potential to be affected by this deficiency, therefore;</p> <p>An Incident/Accident Vital Signs and Neuro Check(s) Completion and Checklist Log, will be formulated by the Director of Nurses for her use to ensure the performance, completion and documentation of the vital(s) signs in the accident/incident report vital signs section, and neuro check on the neuro flow sheet in the event when there is an unwitnessed fall(s), by 10/20/2017.</p> <p>Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur:</p> <p>To ensure that the deficiency practice does not recur, By 10/20/2017, the Director of Nursing or LN Designee will be provided an in-service education to the License Nurses, regarding F-281 with emphasis on the importance of performing and</p>		

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F 281	<p>Continued From page 15</p> <p>* Resident #2 was in his room, self-transferred to use the bathroom, and the resident was found kneeling by the bedroom sink. A Neurological Evaluation Flow Sheet begun on 5/30/17 at 8:20 pm was blank from 5/31/17 to 6/3/17.</p> <p>The facility failed to follow its neurological assessment policy and procedure; evaluations should have continued from 5/31/17 at 1:05 pm on every shift for 48 hours until 1:05 am on 6/3/17.</p> <p>On 7/27/17 at 6:30 pm, the Director of Nursing Services (DNS) said vital signs and neurological assessments should have been initiated and completed for the 2/16/17 unwitnessed fall. The DNS reviewed the Neurological Evaluation Flow Sheet for the incident on 5/30/17 and confirmed it was initiated, but not completed.</p> <p>3. Resident #4 was admitted to the facility on 2/6/17 with multiple diagnoses, including heart disease, urinary incontinence, and left wrist sprain.</p> <p>A 6/4/17 I&amp;A report documented Resident #4 experienced an unwitnessed fall at 2:15 am and was found awake with his head on the carpet. A Neurological Evaluation Flow Sheet attached to the I&amp;A Report documented the "suggested frequency" of the checks was every 15 minutes for 1 hour, every 30 minutes for 2 hours, every 1 hour for 2 hours and every shift for 72 hours (3 days). The neurological checks started at 2:15 am on 6/4/17 and ended at 7:00 am the same day. The resident's neurological status was not assessed every shift for 3 days after the</p>	F 281	<p>completing the documentation of the vital(s) signs in the accident/incident report vital signs section, and neuro check on the neuro flow sheet in the event when there is an unwitnessed fall(s).</p> <p>All nurses will be in-serviced and demonstrate competence with enteral feedings and that the feeding/medications (not be mixed) are only to be administered by gravity. Monitoring will be done through:</p> <p>The Medical Record or Designee will review all unwitnessed incident/accident report(s) ensure the performance, completion and documentation of the vital(s) signs in the accident/incident report vital signs section, and neuro check on the neuro flow sheet in the event when there is an unwitnessed fall(s), Monitoring will start on 10/20/2017. This will be done weekly X4, then q 2 weeks X4, then monthly X3.</p> <p>The Director of Nursing will review one enteral feeding/medication pass randomly to ensure enteral feedings and medications are completed by gravity, weekly x4, then q2 weeks x4, then monthly starting 10/20/2017.</p> <p>The Medical Records Department or designee will present to the quarterly QA&amp;A Committee quarterly meeting the</p>		

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F 281	Continued From page 16 unwitnessed fall.  Nurses' Notes documented the unwitnessed fall on 6/4/17 at 2:15 am and that at 2:00 pm there were no "gross signs of neuro compromise." There were no other nursing notes on 6/4/17 and the next entry, dated 6/6/17 at 5:00 pm, did not address the resident's neurological status.  On 7/27/17 at 4:50 pm, the Director of Nursing Services reviewed the 6/4/17 Neurological Evaluation Flow Sheet and said it was incomplete.	F 281	findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting with the Director of Nursing having overall responsibility.		
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3)  (d) Accidents. The facility must ensure that -  (1) The resident environment remains as free from accident hazards as is possible; and  (2) Each resident receives adequate supervision and assistance devices to prevent accidents.  (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.  (1) Assess the resident for risk of entrapment from bed rails prior to installation.  (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain	F 323		10/20/17	

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F 323	<p>Continued From page 17 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, record review, Incident &amp; Accident reports, and staff interview, it was determined the facility failed to ensure a seatbelt and wheelchair anchor straps were properly secured for a resident during transport in the facility's van. The facility also failed to ensure adequate interventions and care plan updates were in place to prevent falls and injuries. This was true for 2 of 7 residents (#2 and #10) reviewed for falls. Resident #10 was harmed when he sustained multiple injuries including a scalp laceration, traumatic subarachnoid hemorrhage, and a C2 (second cervical vertebra) fracture related to a fall during transport in the facility's van. Resident #2, who was admitted with a history of falls, experienced minor injuries related to multiple falls without new interventions and care plan updates. Findings include:</p> <p>1. Resident #10 was admitted to the facility on 1/5/15 with multiple diagnoses, including traumatic brain injury and aphasia.</p> <p>A quarterly MDS (Minimum Data Set) assessment, dated 5/23/17, documented Resident #10 was totally dependent on staff for ADLs (Activities of Daily Living) assistance and severely cognitively impaired.</p> <p>A Fall Care plan, dated 5/7/17, documented Resident #10 was totally dependent on staff for all cares and the resident's wheelchair brakes</p>	F 323	<p>F 323 SS=G 483.25 (d)(1)(2)(n)(1)-(3)- Free of Accident Hazards/Supervision/Devices This facility does ensure that seatbelt and wheelchair anchor straps were properly secured for a resident during transport in the facility's van and adequate interventions and care plan updates were in place to prevent falls and injuries. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident #10 is no longer a Resident of the facility. Van Driver #1 is no longer an employee of the facility. As stated in the CMS form 2567, immediately on 07/18/17 incident the van was not used until all drivers passed a competency test. The van involved in the incident was not used until new seatbelts were delivered and installed. Resident #2, fall care plan updated to include new interventions to help prevent accidents i.e. resident the use of wheelchair auto-locking brakes, and other related interventions, by 10/20/2017. Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken: All other current residents in the facility</p>		

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F 323	<p>Continued From page 18</p> <p>were to be locked to prevent falls and provide safety.</p> <p>A Fall Scene Investigation Report, dated 7/18/17 at 5:00 pm, documented the following:</p> <p>* Resident #10 was returning from an appointment in the facility's van. During a turn, Resident #10 fell out of the wheelchair, hitting his head on the van's floor, and sustained a laceration to his head.</p> <p>* Van Driver #1's witness statement documented she was returning Resident #10 from a doctor's appointment in the facility's van when she turned the vehicle and Resident #10 fell out of his wheelchair. She pulled over, called 911, and applied an adult incontinence brief to a laceration on the resident's head, which was bleeding from a laceration when Resident #10's head struck the van floor. Paramedics arrived about five minutes after receiving the 911 call. The statement did not document any information regarding seatbelts.</p> <p>* "Root Cause of This Fall: Assistive/protective device, Medical status/Physical condition/Diagnoses, and Inadequate transport driver training. Resident unable to maintain position in w/c [wheelchair] - was not restrained in chair. Chair was improperly secured in transport van."</p> <p>* "Resident taken to ER [Emergency Room] for evaluation, van drivers to be inserviced on securing w/c in van and securing residents in w/c during transport, and new safety belts have been ordered for vans."</p>	F 323	<p>who are transported via the facility van and are care planned as risk for fall(s) may have the potential to be affected by this deficiency, therefore;</p> <p>The facility Maintenance Supervisor or Designee did a visual re-inspection of all facility van(s) being used for residents transport, to ensure that each facility transport van has seatbelts, by 10/20/2017.</p> <p>The Maintenance Supervisor or Designee did a competency based observation on all facility van transport drivers to ensure that the driver(s) passed a competency test i.e. tightening of the anchor straps, and applying the seatbelt, by 10/20/2017. A facility employee cannot transport a resident until they have passed the competency based observation of how to safely transport a resident.</p> <p>The Director of Nurses or LN Designee will review and/or update all current Residents fall risk care plan, to reflect current interventions, by 10/20/2017.</p> <p>Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur: To ensure that the deficiency practice does not recur, By 10/20/2017, a Facility Transport Van Seat Belt Inspection Checklist Log, will be formulated by the Maintenance Supervisor or Designee, to be used prior to transporting a Resident, by the facility transport van driver, to ensure that the facility van transport seatbelts are</p>		

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F 323	<p>Continued From page 19</p> <p>* "Conclusion: [Resident #10] was injured when he fell from w/c during transport as w/c was improperly secured in w/c van."</p> <p>An ER final report, dated 7/18/17, documented Resident #10 sustained a scalp laceration requiring sutures and staples, an acute traumatic subarachnoid hemorrhage, and an unstable fracture of the second cervical vertebra (C2).</p> <p>On 7/19/17, the Administrator and the Assistant Administrator conducted an interview with Van Driver #1 about the 7/18/17 incident. Van Driver #1, when asked by the Administrator to demonstrate how she secured the wheelchair and resident before transporting him in the van, demonstrated locking the wheelchair brakes, and anchoring the wheelchair to the van's floor metal brackets by attaching the anchor straps to both rear and both front wheel spokes. She then demonstrated the wheelchair was at a 35-degree angle when Resident #10 fell out and struck his head on the van floor. After Van Driver #1 demonstrated how she secured Resident #10 in the van, the Administrator noted the slack and incorrect placement of the wheelchair anchor straps.</p> <p>On 7/25/17 at 12:00 pm, the Administrator said immediately after the 7/18/17 incident the van was not used until all drivers passed a competency test. The van involved in the incident was not used until new seatbelts were delivered and installed. The Administrator said Van Driver #1 locked Resident #10's brakes, used the anchor straps to secure the wheelchair, but did not tighten the anchor straps and did not apply a seatbelt, which led to Resident #10's wheelchair</p>	F 323	<p>installed and are in good working condition.</p> <p>By 10/20/2017, The facility transport van driver(s) will be provided with In-service education by the facility Maintenance Supervisor or Designee regarding F323 on the use of the formulated Facility Transport Van Seat Belt Inspection Checklist Log, to be use by the facility transport van driver(s) prior to transporting a Resident, to ensure that the facility van transport seatbelts are installed and are in good working condition.</p> <p>By 10/20/2017, The Maintenance Supervisor or Designee will do a weekly visual competency observation on the facility van transport driver(s) to ensure that the driver(s) passed a competency test i.e. tightening of the anchor straps and applying the seatbelt, by 10/20/2017. By 10/20/2017, the Director of Nursing or LN Designee will provide an in-service education to the License Nurses, regarding F-323 with emphasis on the importance of reviewing and/or updating when necessary the Resident(s) fall care plan to reflect current interventions.</p> <p>Monitoring will be done through: The Administrator or Designee will do an unannounced visual inspection on all facility van(s) being used for residents <input type="checkbox"/> transport, to ensure that each facility transport van has seatbelts.</p> <p>The Administrator or Designee will do an unannounced visual competency</p>		

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F 323	<p>Continued From page 20</p> <p>tipping over and spilling the resident onto the rubber floor. There was not a seatbelt in the van to secure Resident #10.</p> <p>Resident #10 was harmed when he sustained multiple injuries including a scalp laceration, traumatic subarachnoid hemorrhage, and a C2 fracture during transport in the facility's van. The facility failed to ensure the van was equipped with seatbelts and transport staff knew to apply the seatbelt and how to properly secure the wheelchair anchor straps to prevent the wheelchair from tipping.</p> <p>2. Resident #2 was admitted to the facility on 6/3/16 with multiple diagnoses, including dementia, history of falls, and Parkinson's Disease.</p> <p>The annual MDS assessment, dated 5/19/17, documented Resident #2 was moderately cognitively impaired, experienced more than two falls with minor injury, and required extensive assistance of 1 staff with transfers.</p> <p>A Falls Care Plan, dated 10/3/16, documented Resident #2 had a history of falls and lack of safety awareness, dementia, shuffling steps with any distraction, and seizures.</p> <p>Interventions included:</p> <p>* 10/17/16 - "Therapy to review ambulation/gait pattern."</p> <p>*10/17/16 - "[Resident #2] chooses not to use a w/c at this time as he chooses to direct his own care including his right to maintain his</p>	F 323	<p>observation on the facility van transport driver to ensure that the driver(s) passed a competency test i.e. tightening of the anchor straps, and applying the seatbelt. The Administrator or Designee will present to the quarterly QA&amp;A Committee quarterly meeting the findings and/or corrective actions taken.</p> <p>The Medical Record or Designee will review all Incident/Accident reports to ensure that fall care plan is reviewed and/or updated when necessary to reflect current interventions.</p> <p>The Medical Records Department or designee will present to the quarterly QA&amp;A Committee quarterly meeting the findings and/or corrective actions taken.</p> <p>Monitoring will start on 10/20/2017. This will be done weekly X4, then q 2 weeks X4, then monthly X3.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting with the Administrator and Director of Nursing responsible for compliance.</p>		

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F 323	<p>Continued From page 21 independence with transfers and ambulation. POA [Power of Attorney] and resident are aware of risk of injury with self ambulation/transfers and they choose to maintain Resident #2's quality of life with independence."</p> <p>* 2/16/17 - "[Resident #2] continues to choose not to use assistive devices at times. Does not use call light appropriately."</p> <p>* 2/16/17 - "Increased supervision with neuro's [neurological assessments]."</p> <p>A Fall Scene Investigation Report, dated 1/19/17 at 3:00 pm, documented the following:</p> <p>* Resident #2 fell backwards while playing catch during a therapy session, hit a chair with his left inner arm, and sat on the floor.</p> <p>* The "root cause" of the fall was determined to be "footwear. He had his slip on slippers on, which tend to not be supportive."</p> <p>* Initial interventions to prevent future falls included tennis shoes rather than slippers.</p> <p>* "Conclusion: Resident needs encouraged [sic] to wear tennis shoes rather than slippers when out of room. Staff will assist."</p> <p>A Fall Scene Investigation Report, dated 2/16/17 at 3:10 pm, documented the following:</p> <p>* Root cause of Fall: "Medical status/Physical condition/Diagnoses."</p> <p>* The area to describe initial interventions to</p>	F 323			

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F 323	<p>Continued From page 22 prevent future falls was left blank.</p> <p>* "Conclusion: Longstanding history of balance issues. Has had med[ication] review, therapy-which he refuses to participate in, neurologist review and nephrologist to review. Increased supervision with neuro's implemented."</p> <p>A Fall Scene Investigation Report, dated 5/18/17 at 12:00 pm, documented the following:</p> <p>* Resident #2 experienced a fall that was witnessed by staff who were not able to prevent the fall and an alarm sounded.</p> <p>* The root cause of the fall was determined to be "amount of assistance, medical status, physical condition, diagnoses, and mood or mental status. Resident has diagnosis of dementia resulting in poor safety awareness."</p> <p>* Initial interventions to prevent future falls included directions to staff to keep the resident within view "as much as possible."</p> <p>* The report's conclusion documented staff were to continue with the care plan "as written."</p> <p>On 7/27/17 at 6:40 pm, the DNS said the care plan should have been updated.</p> <p>A Fall Scene Investigation Report, dated 5/30/17 at 8:20 pm, documented the following:</p> <p>* Resident #2 was in his room, self-transferred to use the bathroom, alarm did not sound, and was found kneeling by the bedroom sink.</p>	F 323			

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F 323	<p>Continued From page 23</p> <p>* "Root cause of Fall: Alarm-not on, Medical status/Physical condition/Diagnoses."</p> <p>* "Why did the incident happen: Staff failed."</p> <p>* "Conclusion: Staff did not check pressure alarm in chair - when resident got up, alarm did not sound - Resident very unsteady on his feet and impulsive."</p> <p>A Fall Scene Investigation Report, dated 6/2/17 at 5:35 pm, documented the following:</p> <p>* Resident #2 stood up from a w/c at a dining room table. The w/c, which was not locked, rolled back as he turned around, and the resident fell to his knees.</p> <p>* The root cause of the fall was documented as "assistive/protective device, medical status, physical condition, diagnoses, and mood or mental status. Impulsive ambulation by resident with insufficient stabilization."</p> <p>* Initial interventions to prevent future falls included locking the resident's w/c brakes when the "resident is stationary to prevent w/c from moving when resident spontaneously stands. Increase supervision."</p> <p>On 7/24/17 at 4:45 pm, Resident #2 was observed in w/c at a dining room table reading a book. Alarms were attached to his shirt and automatic locking brakes were observed on the w/c.</p> <p>On 7/25/17 at 9:30 am, Resident #2 was in a</p>	F 323		

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F 323	<p>Continued From page 24</p> <p>recliner in his room reading a book with alarms attached to his shirt.</p> <p>On 7/25/17 at 11:30 am, CNA #3 was observed assisting Resident #2 from a recliner to the bathroom to his w/c. CNA #3 attached the alarm to the resident's shirt.</p> <p>On 7/25/17 at 5:10 pm, Resident #2 was observed eating dinner when his alarm sounded without his moving. CNA #3 said the alarm was very sensitive.</p> <p>On 7/26/17 at 9:00 am, Resident #2 was observed sitting in a w/c at a dining room table reading a book.</p> <p>On 7/26/17 at 10:30 am, Resident #2 was observed sitting in a w/c at a dining room table reading a book.</p> <p>On 7/26/17 at 11:50 am, CNA #3 asked Resident #2 if he needed to use the bathroom prior to lunch and he said, "Yes." CNA #3 then assisted Resident #2 to the bathroom.</p> <p>The facility's fall policy and procedure, dated 7/14/16, documented staff were to determine the root cause of incidents to determine appropriate interventions to prevent repeated falls.</p> <p>On 7/27/17 at 6:20 pm, the DNS said Resident #2 had not fallen since the automatic locking brakes were applied to his w/c following the 6/2/17 incident. The DNS was unable to find documentation in the care plan for the auto-lock brakes or other interventions related to the incidents of 1/19/17, 5/18/17, 5/30/17, and</p>	F 323			

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F 323	Continued From page 25 6/2/17.	F 323			
F 329 SS=D	<p><b>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b> CFR(s): 483.45(d)(e)(1)-(2)</p> <p>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--</p> <p>(1) In excessive dose (including duplicate drug therapy); or</p> <p>(2) For excessive duration; or</p> <p>(3) Without adequate monitoring; or</p> <p>(4) Without adequate indications for its use; or</p> <p>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--</p> <p>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p>	F 329		10/20/17	

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F 329	<p>Continued From page 26</p> <p>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff and physician interview, and record review, it was determined the facility failed to ensure laboratory (lab) monitoring of an antiseizure medication was completed. This was true for 1 of 6 sample residents (#3). The failure created the potential for adverse reactions when blood levels of Lamictal was not monitored as ordered. The findings include</p> <p>1. Resident #3 was admitted to the facility on 1/16/17 with multiple diagnoses, including muscle spasms, convulsions, and congenital malformations of the brain.</p> <p>The resident's Physician Order Report, effective 7/1/17, documented Lamictal was ordered via gastrostomy tube twice a day beginning 1/16/17. The resident's July 2017 Medication Administration record documented the medication was administered as ordered.</p> <p>Resident #3's clinical record documented a lab test for Lamictal level was drawn on 4/25/17 at 2:42 p.m. The previous quarterly lab report documented the Lamotrigine level was high 3, there was no lab result for the sample drawn on 4/25/17.</p> <p>A 4/26/17 telephone order documented a Lamotrigine level was to be drawn in seven days. The lab should have been completed by 5/3/17.</p>	F 329	<p>F 329 SS=D</p> <p>¿483.45 (d)(e)(1)-(2)- Drug Regimen is Free From Unnecessary Drugs</p> <p>This facility does ensure completion of laboratory monitoring for of an anti-seizure medication.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #3, a repeat order obtained from the physician for Lamotrigine level, by 10/20/2017.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.</p> <p>However, all other current resident(s) on anti- seizure medication(s) may have the potential to be affected by this deficiency, therefore;</p> <p>The Director of Nurses or LN Designee will review all current resident(s) on anti-seizure medication(s) to ensure that any seizure related lab is completed as ordered by the physician.</p> <p>Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur:</p> <p>To ensure that the deficiency practice</p>		

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F 329	Continued From page 27  On 7/27/17 at 5:40 pm, the DNS stated the lab sample was drawn in May, but the sample was "not good" and the lab did not notify the facility there was a problem. She said the facility should have followed up with the laboratory but did not.	F 329	does not recur, By 10/20/2017, the Director of Nursing or LN Designee will provide an in-service education to the License Nurses, regarding F-329 with emphasis on the importance of following up with the laboratory to ensure completion of anti-seizure lab level when ordered by the physician. Monitoring will be done through: The Director of Nurses or LN Designee will review all Resident(s) on anti-seizure medication(s) to ensure completion of anti-seizure lab level when ordered by the physician. Monitoring will start on 10/20/2017. This will be done weekly X4, then q 2 weeks X4, then monthly X3. The Director of Nurses or LN Designee will present to the quarterly QA&A Committee quarterly meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting, with the Director of Nursing being responsible for overall compliance.		
F 332 SS=D	FREE OF MEDICATION ERROR RATES OF 5% OR MORE CFR(s): 483.45(f)(1)  (f) Medication Errors. The facility must ensure that its-  (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 332		10/20/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>BELL MOUNTAIN VILLAGE &amp; CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>620 NORTH SIXTH STREET BELLEVUE, ID 83313</b>		
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F 332	<p>Continued From page 28</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure less than 5-percent of medications provided to residents were not done so in error. This was true for 6 of 25 medications (24%) affecting 3 of 6 residents (#3, #7, and #12) observed during medication passes and placed residents at risk for harm from the administration of medications not consistent with physician orders, professional standards of practice, and facility policies and procedures. Findings include:</p> <p>1. Resident #3's Physician Order Report, effective 7/1/17, documented the following:          * Jevity 1.5 bolus 1 can 4 times a day via g-tube (gastrostomy feeding tube in the stomach);          * Lamictal 200 mg 1 tab twice a day via g-tube          * Nexium 40 mg packet 1 every morning via g-tube;          * Depakote 500 mg twice a day via g-tube.</p> <p>The facility's policy for administering medications through an g-tube documented medications were not to be mixed and administered together nor added directly to enteral feeding formula.</p> <p>On 7/25/17 at 9:40 am, Registered Nurse (RN) #1 was observed mixing Laictal, Nexium, and Depakote together for administration via Resident #3's g-tube and obtaining Jevity 1.5 enteral feeding formula for administration via Resident #3's g-tube. As RN #1 left the nurses' station with the cup of mixed medications and the bottle of Jevity in hand, she said she was about to administer the medications and feeding formula to the resident. At that point, RN #1 was informed facility policy directed that enteral medications should be administered separately</p>	F 332	<p>F 332 SS=D          483.45 (f)(1)- Free of Medication Error Rates of 5% or More          This facility does ensure less than 5 percent medication error rate.          Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:          Resident #3, the Registered Nurse (RN #1), identified during the survey process will be given a 1:1 in-service education by the Pharmacist Consultant or Pharmacist Designee, by 10/20/2017;          Regarding F332 with emphasis on the importance of enteral medication(s) are not to be mixed and administered together nor added directly to enteral feeding (should be administered separately unless the physician ordered them to be administered concurrently).          Regarding F332 with emphasis on the importance of reading the medication pharmacy label i.e. administering Nexium 1 hour before the tube feeding to ensure effectiveness of the medication.          Resident #3, the License Practical Nurse (LPN#1), identified during the survey process will be given a 1:1 in-service education by the Pharmacist Consultant or Pharmacist Designee, by 10/20/2017;          Regarding F332 with emphasis on the importance of enteral medication(s) are not to be mixed and administered together nor added directly to enteral feeding (should be administered separately unless the physician ordered them to be administered concurrently).          Regarding F332 with emphasis on the</p>		

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F 332	<p>Continued From page 29</p> <p>unless the physician ordered them to be administered concurrently. RN #1 said she was not aware of the requirement, returned to the medication cart where she separated the 3 medications, and then went to Resident #3's room with the medications and feeding formula.</p> <p>On 7/25/17 at 9:45 am, RN #1 was observed connecting extension tubing to Resident #3's g-tube, attaching an enteral syringe to the end of the extension tubing, pouring Jevity into the syringe, and opening the extension tubing stopcock to allow the Jevity to flow by gravity into the g-tube. With Jevity still in the syringe, RN #1 then poured Nexium into the syringe.</p> <p>The Nursing 2017 Drug Handbook administration instructions for Nexium documented, "To give oral suspension via NG [nasogastric] tube ... add 15 mL [milliliters] of water to a syringe, then add contents of ... 40 mg packet. Shake syringe and leave for 2 to 3 minutes to thicken. Shake syringe again and inject through NG or gastric tube within 30 minutes. Flush remaining contents into the stomach with additional water." Patient Teaching included administration of the drug at least 1 hour before a meal.</p> <p>The pharmacy label on the Nexium, dated 7/3/17, documented the medication was to be administered every morning before breakfast.</p> <p>On 7/27/17 at 9:45 am, Licensed Practical Nurse (LPN) #1 was observed administering Nexium to Resident #3 via g-tube with the DNS present. Prior to administering Nexium, LPN #1 administered Jevity feeding solution through the g-tube and more Jevity after the Nexium was</p>	F 332	<p>importance of reading the medication pharmacy label i.e. administering Nexium 1 hour before the tube feeding to ensure effectiveness of the medication.</p> <p>Resident #7, the Registered Nurse (RN #1), identified during the survey process will be given a 1:1 in-service education by the Pharmacist Consultant or Pharmacist Designee, regarding F332 i.e. with emphasis on the importance following physician's order on administering eye drops, by 10/20/2017.</p> <p>Resident #12, the DNS will be given a 1:1 in-service education by the Pharmacist Consultant or Pharmacist Designee regarding F332 with emphasis on the importance following the medication pharmacy label i.e. administration of IV medication(s) and flushing after IV medication(s) is administered, by 10/20/2017.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.</p> <p>However, all other current residents who are on enteral feeding(s), eye drop(s), and IV medication(s) may have the potential to be affected by this deficiency, therefore,</p> <p>By 10/20/2017, the Pharmacist Consultant or Designee will review random Licensed Nurses medication pass through visual observation with regards to F332 with emphasis on making</p>		

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F 332	<p>Continued From page 30</p> <p>administered. When asked about administering Nexium with a tube feeding, the DNS said she instructed LPN #1 to interrupt the feeding in order to observe her administer the medication. The Nexium was not administered 1 hour before the tube feeding to ensure the effectiveness of the medication.</p> <p>2. On 7/26/17 at 9:25 am, Registered Nurse (RN) #1 was observed administering one Systane eye drop to each of Resident #7's eyes.</p> <p>Resident #7's 7/18/17 physician's order documented staff was to administer two eyedrops of Systane in both eyes every 4 hours.</p> <p>When asked how many Systane eye drops were ordered for Resident #7, RN #1 reviewed the order and said she should have given 2 drops to each eye.</p> <p>3. Resident #12's Physician Order Report, effective 7/1/17, documented staff was to administer Venofer (iron supplement) 100 mg via the intravenous (IV) route every 14 days.</p> <p>On 7/27/17 at 2:05 pm, while gathering supplies to start an IV for Resident #12, the DNS said the Venofer infusion would take 10 minutes to administer. The pharmacy label on the Venofer documented to "infuse 100 mg over 30 minutes." At 2:10 pm, the DNS started the IV Venofer infusion, which was halfway infused within 5 minutes. When asked to reread the pharmacy label on the Venofer, the DNS slowed the rate of the Venofer infusion.</p> <p>On 7/28/17 at 3:00 pm, the DNS disconnected</p>	F 332	<p>sure that;</p> <p>Enteral medication(s) are be mixed and administered together nor (should added directly to enteral feeding be administered separately unless the physician ordered them to be administered concurrently). License Nurse(s) reading the medication pharmacy label i.e. administering Nexium 1 hour before the tube feeding to ensure effectiveness of the medication. License Nurse(s) following physician's order on administering eye drops. License Nurse(s) following the medication pharmacy label i.e. administration of IV medication(s) and flushing after IV medication(s) is administered.</p> <p>Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur: To ensure that the deficiency practice does not recur, By 10/20/2017, the Pharmacist Consultant or Designee will provide an in-service education to the License Nurses regarding F332 with emphasis on the following; The importance of enteral medication(s) are not to be mixed and administered together nor (should added directly to enteral feeding be administered separately unless the physician ordered them to be administered concurrently). The importance of reading the medication pharmacy label i.e. administering Nexium 1 hour before the tube feeding to ensure effectiveness of the medication. The importance following physician's</p>		

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F 332	<p>Continued From page 31</p> <p>the IV line with Venofer medication still in the tubing and then flushed the IV catheter with Normal Saline (NS) from a 10 mL syringe. The 10 mL NS syringe used to flush the IV catheter had 8.5 mL remaining in the syringe, indicating 1.5 mL of NS was used to flush the IV. The DNS said she used a small amount of flush because the resident was "fragile."</p> <p>On 7/27/17 at 4:05 pm, Pharmacist #1 stated 2 to 3 syringes (20 to 30 mL) of NS flush should be used to flush an IV after administration of Venofer.</p>	F 332	<p>order on administering eye drops. The importance following the medication pharmacy label i.e. administration of IV medication(s) and flushing after IV medication(s) is administered.</p> <p>Monitoring will be done through: The Director of Nurses or LN Designee will do a random unannounced medication pass visual observation to ensure that; Enteral medication(s) are not mixed and administered together nor added directly to enteral feeding but are to be administered separately unless the physician ordered them to be administered concurrently. Licensed Nurse(s) reading the medication pharmacy label ( i.e. administering Nexium 1 hour before the tube feeding) to ensure effectiveness of the medication. Licensed Nurse(s) following physician's order on administering eye drops. License Nurse(s) following the medication pharmacy label( i.e. administration of IV medication(s) and flushing after IV medication(s) is administered).</p> <p>Monitoring will start on 10/20/2017. This will be done weekly X4, then q 2 weeks X4, then monthly X3. The Director of Nurses or LN Designee will present to the quarterly QA&amp;A Committee quarterly meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the</p>		

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F 332	Continued From page 32	F 332			
F 333 SS=D	<p>RESIDENTS FREE OF SIGNIFICANT MED ERRORS CFR(s): 483.45(f)(2)</p> <p>483.45(f) Medication Errors.</p> <p>The facility must ensure that its-</p> <p>(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff, pharmacist and physician interview, and record and policy review, it was determined the facility failed to ensure residents were free of significant medication errors. This was true for 1 of 6 residents (#12) during medication pass observations and created the potential for adverse reactions when the medication was infused to rapidly and when the amount of IV flush was insufficient. Findings include:</p> <p>Resident #12's Physician Order Report, effective 7/1/17, included a 6/1/17 order for Venofer (iron supplement) 100 mg/5 miliLiters (mL), inject into the vein every 14 days.</p> <p>On 7/27/17 at 2:10 pm, the DNS started a peripheral IV in Resident #12's right arm and immediately started the Venofer infusion, which was completed by 2:35 pm, except for a small amount of the medication still in the IV line connected to the resident's peripheral IV.</p>	F 333	<p>QA&amp;A Committee quarterly meeting with the Director of Nursing being responsible for compliance.</p> <p>F 333 SS=D  <input checked="" type="checkbox"/> 483.45 (f)(2) <input type="checkbox"/> Residents Free of Significant Med Errors                      This facility does ensure that residents were free of significant medication errors. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:                      Resident #12, the DNS will be given a 1:1 in-service education by the Pharmacist Consultant or Pharmacist Designee regarding F332 with emphasis on the importance following the medication pharmacy label i.e. administration of IV medication(s) and flushing after IV medication(s) is administered.                      Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken:                      This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.</p>	10/20/17	

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F 333	<p>Continued From page 33</p> <p>On 7/27/17 at 3:00 pm, the DNS disconnected the IV line with Venofer from Resident #12's peripheral IV then flushed the IV catheter with a small amount of normal saline (NS). The DNS and 2 surveyors checked the 10 mL NS flush syringe used and observed 8.5 mL remained in the syringe, indicating only 1.5 mL of NS was used to flush the IV catheter. The DNS said she used a small amount of NS flush because the resident was "fragile."</p> <p>On 7/27/17 at 4:05 pm, the DNS called the facility's contract pharmacy and spoke to Pharmacist #1. The pharmacist said 2 to 3 syringes (20 to 30 mL) of NS flush were needed to flush the IV after administration of Venofer.</p>	F 333	<p>However, all other current residents who are on IV medication(s) may have the potential to be affected by this deficiency, therefore, by 10/20/2017; The Pharmacist Consultant or Designee will do random weekly medication pass visual observation with regards to F332 with emphasis on making sure that License Nurse(s) following the medication pharmacy label i.e. administration of IV medication(s) and flushing after IV medication(s) is administered.</p> <p>Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur: To ensure that the deficiency practice does not recur, By 10/20/2017, the Pharmacist Consultant or Pharmacist Designee will provide an in-service education to the License Nurses regarding F332 with emphasis on the importance following the medication pharmacy label i.e. administration of IV medication(s) and flushing after IV medication(s) is administered.</p> <p>Monitoring will be done through: The Director of Nurses or LN Designee will do a random unannounced medication pass visual observation to ensure that; Licensed Nurse(s) following the medication pharmacy label ( i.e. administration of IV medication(s) and flushing after IV medication(s) is administered).</p>		

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F 333	Continued From page 34	F 333	Monitoring will start on 10/20/2017. This will be done weekly X4, then q 2 weeks X4, then monthly X3. The Director of Nurses or LN Designee will present to the quarterly QA&A Committee quarterly meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		
F 354 SS=F	<p>WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON CFR(s): 483.35(b)(1)-(3)</p> <p>(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p> <p>(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</p> <p>(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of nursing schedules and records of actual hours worked, it was determined the facility failed to ensure a registered nurse (RN) was on duty at least 8 consecutive hours a day, 7 days a week. The failure created the potential for insufficient staff to meet residents' direct care needs, assessments, planning, evaluation and supervision with the</p>	F 354	<p>F 354 SS=F ¿483.35 (b)(1)-(3) □ Waiver-RN 8 Hrs 7 Days/WK, Full-Time DON This facility does ensure to use the services of a Registered Nurse for at least 8 consecutive hours a day, 7 days a week. Corrective action(s) accomplished for</p>	10/20/17	

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F 354	<p>Continued From page 35</p> <p>potential to affect all residents living in the facility, including 9 of 9 sample residents (#s 1 - 9). Findings include:</p> <p>A 7/2/17 to 7/22/17 Three-Week Nursing Schedule, completed by the facility on 7/25/17, contained documentation that no RNs worked on Thursday, 7/20/17.</p> <p>The facility's July 2017 nursing schedule documented two licensed practical nurses (LPNs) worked the day shift and one LPN worked the night shift on 7/20/17 and that no RNs were scheduled to work that day.</p> <p>Employee Time Card Report records documented one RN worked 0.95 hours (less than one hour) on 7/20/17.</p> <p>On 7/27/17 at 4:45 pm, the Director of Nursing Services (DNS) said no RNs, including herself, were on duty Thursday, 7/20/17.</p>	F 354	<p>those residents found to have been affected by the deficient practice: Facility will schedule adequate services of a Registered Nurse for at least 8 consecutive hours a day, 7 days a week, by 10/20/2017.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken: All residents may have the potential to be affected by this deficiency, hence; Facility will schedule adequate services of a Registered Nurse for at least 8 consecutive hours a day, 7 days a week, by 10/20/2017. By 10/20/2017, the facility Administrator or Designee and/or the DNS or Designee will review the current facility for RN (Registered Nurse) coverage to ensure adequate services of a Registered Nurse for at least 8 consecutive hours a day, 7 days a week. Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur: To ensure that the deficiency practice does not recur, By 10/20/2017, the facility Director of Nurses or Designee will be reviewing the weekly License Nurses schedule for RN (Registered Nurse) coverage to ensure adequate services of a Registered Nurse for at least 8 consecutive hours a day, 7 days a week Monitoring will be done through: The facility Administrator or Designee will</p>		

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F 354	Continued From page 36	F 354	review the current License Nurses schedule for RN (Registered Nurse) coverage to ensure adequate services of a Registered Nurse for at least 8 consecutive hours a day, 7 days a week on a weekly basis. Monitoring will start on the week of 10/20/2017. This will be done weekly X4, then q 2 weeks X4, then monthly X3. The Administrator or Designee will present to the quarterly QA&A Committee quarterly meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting with the Administrator and Director of Nursing responsible for compliance.		
F 360 SS=D	PROVIDED DIET MEETS NEEDS OF EACH RESIDENT CFR(s): 483.60  The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure residents received meals to meet their special dietary needs and food preferences. This was true for 2 of 9 sample residents (#3 & #6) and 1 random resident (#15) observed during meal services. The failure created the potential for residents to experience weight loss and choking when portion size, choice of food and	F 360	F 360 SS=D ¿483.60-Provided Diet Meets Needs of Each Resident This facility does ensure that Residents received meals to meet their special dietary needs and food preferences. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:	10/20/17	

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F 360	<p>Continued From page 37</p> <p>texture of food was incorrect. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 1/16/17 with diagnoses including cerebral palsy, nausea/vomiting, GERD (gastroesophageal reflux disease), protein calorie malnutrition, and presence of a feeding tube.</p> <p>The Nutrition Care Plan, dated 1/18/17, documented Resident #3 was to receive an enhanced soft regular diet, small portions at lunch and dinner, and thin liquids.</p> <p>A Physician Order Report and medication administration records, both effective 7/1/17, documented Resident #3 was to receive an enhanced soft regular diet, small portions at lunch and dinner, and thin liquids.</p> <p>The medication administration records documented a meal was offered to Resident #3 on 11 of 54 opportunities from 5/1/17 through 6/30/17. In addition, there was no documentation that staff offered lunch or dinner to the resident on 7/5/17 or from 7/8/17 through 7/25/17.</p> <p>On 7/26/17 at 1:00 pm, Resident #3 said staff had not offered her lunch that day and that she could not remember when staff last offered her lunch to eat.</p> <p>On 7/27/17 at 9:17 am, Licensed Practical Nurse #1 stated she "tries to encourage" Resident #3 to eat and that "sometimes" the resident would come out of her room for dinner.</p> <p>On 7/27/17 at 5:35 pm, the Director of Nursing stated Resident #3 "quit eating" because she</p>	F 360	<p>Resident #3 will be interviewed by the Food Services Supervisor with regards to food preference, in an effort to accommodate the Resident's food preference, unless otherwise specified by the physician, by 10/20/2017.</p> <p>Resident #15, the Cook identified during the survey process (Cook #1), provided with 1:1 in-service education by Registered Dietician or Administrator or Designee regarding F360, with emphasis on the importance of following the Resident(s) meal card, by 10/20/2017.</p> <p>Resident #6, the Food Services Supervisor, provided with 1:1 in-service education by Registered Dietician or Administrator or Designee regarding F360, with emphasis on the importance of following the Resident(s) meal card, by 10/20/2017.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.</p> <p>However, all other current residents may have the potential to be affected by this deficiency, hence;</p> <p>The facility Food Services Supervisor or Designee will audit all of the current Resident(s) food preference documentation, by 10/20/2017.</p> <p>The facility Food Services Supervisor or Designee and Director of Nurses or Designee will audit all of the current Resident(s) diet order(s) and change as</p>		

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F 360	<p>Continued From page 38</p> <p>was angry with a relative, but the resident would eat an entire meal when family provided a hamburger, fries and drink from a fast food restaurant. The nursing director did not provide documented evidence that the facility tried to accommodate the resident's food preferences.</p> <p>2. During the lunch meal service on 7/26/17 at 12:45 pm, Cook #1 plated meals for residents in Building 3, the Food Service Supervisor (FSS) was present, and the following was observed:</p> <p>* Resident #15's meal card documented regular mechanical soft texture food. Cook #1 placed a whole slice of roast turkey on the plate and a regular portion of mixed vegetables and mashed potatoes and gravy for Resident #15 and handed it to CNA #4. The CNA was immediately stopped and the Cook was asked to review the meal card, which she did. The Cook said, "When did that change" as she took the plate from CNA #4. The Cook set the plate of food to the side, cut up a slice of roast turkey, added mixed vegetables and mashed potatoes and gave that to CNA #4 for Resident #15.</p> <p>* Resident #6's meal card documented regular texture, small portions for lunch and dinner. The FSS gave the plate with the whole slice of roast turkey and regular portion sizes of mixed vegetables and mashed potatoes with gravy that had been set to the side moments earlier to CNA #4 for Resident #6. CNA #4 was immediately stopped and the FSS was asked to read the meal card. The plate of food was again moved to the side. The Cook then plated small portions of the food items and gave it to CNA #4 for Resident #6.</p>	F 360	<p>necessary, by 10/20/2017.</p> <p>Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur: To ensure that the deficiency practice does not recur, By 10/20/2017, the Registered Dietician or Administrator or Designee will in-service the Food Service Supervisor, with emphasis on the importance of interviewing and documenting Resident(s) food preference. By 10/20/2017, the Registered Dietician or Administrator or Designee will in-service the Food Service Supervisor and Dietary Cooks regarding F360, with emphasis on the importance of following the Resident(s) meal card.</p> <p>Monitoring will be done through: The facility Director of Nurses or Designee will review all Residents, ensuring that Residents were interviewed and document Resident(s) food preference. The facility Director of Nurses or Designee will conduct random unannounced visual observations during meal preparation to ensure all current Residents' food served matches the meal card. Monitoring will start on the week by 10/20/2017. This will be done weekly X4, then q 2 weeks X4, then monthly X3. The Director of Nurses or Designee will present to the quarterly QA&amp;A Committee quarterly meeting the findings and/or</p>		

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F 360	Continued From page 39	F 360	corrective actions taken.		
F 371 SS=E	<p>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3)</p> <p>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was</p>	F 371	<p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting, The Administrator and Assistant Administrator are responsible for compliance.</p>	10/20/17	
			F 371 SS=E		

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F 371	<p>Continued From page 40</p> <p>determined the facility failed to ensure food was covered, expired dairy products were discarded, and measures were in place to prevent possible cross-contamination of dirty to clean areas in the kitchen. This had the potential to affect 8 of 9 sample residents (#1 - #7 and #9) observed during survey and all other residents consuming food prepared and/or served from the facility's two kitchens. The failure created the potential for harm if residents contracted foodborne illnesses or contagious diseases. Findings include:</p> <p>1. On 7/24/17 at 1:33 pm, the Director of Nursing Services (DNS) accompanied the surveyor to the kitchen in Building 1. A small bowl of canned pear chunks was on the kitchen counter near 1 of 2 large window-sized openings to the dining room. The bowl of pears was uncovered and within reach if a resident came to the opening. Three residents were in the dining room at the time of the observation. The DNS said that pears had been served at lunch and threw the fruit away.</p> <p>2. On 7/24/17 at 1:45 pm, Cook #1 accompanied the surveyor to the kitchen in Building 3 where the following was observed in the refrigerator:</p> <ul style="list-style-type: none"> <li>* Two partial containers of cottage cheese with open dates of 5/7/17 and 7/9/17; and</li> <li>* Two partial containers of sour cream with open dates of 6/3/17 and 6/18/17.</li> </ul> <p>The cook said sour cream "lasts longer" but cottage cheese was good "only 4, 5 days" after it had been opened. She discarded both cottage cheese containers and returned the sour cream containers to the refrigerator.</p>	F 371	<p>¿483.60(i)(1)-(3)- Food Procure, Store/Prepare/Serve-Sanitary This facility does ensure that food procure, store/prepare/serve sanitary. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Upon identification during the survey process, the uncovered canned pears were disposed immediately. Upon identification during the survey process, the two partial containers of cottage cheese and sour cream with open dates were disposed immediately. Cook #2 provided with 1:1 in-service education regarding F-371, with emphasis on the importance of removing dirty apron or washing hands before reaching the clean area or before removing the rack of clean dishes from the dishwasher, by 10/20/2017.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken:</p> <p>All other current residents may have the potential to be affected by this deficiency, hence; The facility Food Services Supervisor or Designee will do visual observation to ensure that open canned food(s) covered, expired dairy product(s) are discarded, and measures were in place to prevent cross contamination i.e. Cook(s) removing dirty apron or washing hands before reaching the clean area or before</p>		

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F 371	Continued From page 41  On 7/26/17 at 11:45 am, the Food Service Supervisor (FSS) said that once opened sour cream and cottage cheese last 10 days in their container in the refrigerator.  3. On 7/27/17 at 2:15 pm, Cook #1 and Cook #2 were observed in the kitchen in Building 1. Cook #1 was in the area by the stove and Cook #2 was in the dirty area at the 3 compartment sink. Cook #2 placed a rack of dirty dishes on a rolling cart then moved the rolling cart next to the dishwasher in the clean area of the kitchen. Enroute to the dishwasher, Cook #2 passed the handwashing sink. Cook #2 opened the dishwasher and removed a rack of clean dishes then put the rack of dirty dishes into the dishwasher and turned it on. Cook #2 did not remove her dirty apron or wash her hands before she reached the clean area or before she removed the rack of clean dishes from the dishwasher. Cook #2 was asked about the dirty apron and lack of hand washing. Cook #2 looked at her apron and said "dirty."	F 371	removing the rack of clean dishes from the dishwasher. Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur: To ensure that the deficiency practice does not recur, The Registered Dietician will provide an in-service education to the Food Service Supervisor and Cooks, regarding F371, with emphasis on the importance of ensuring that open canned food(s) covered, expired dairy product(s) are discarded, and measures were in place to prevent cross contamination i.e. Cook(s) removing dirty apron or washing hands before reaching the clean area or before removing the rack of clean dishes from the dishwasher, by 10/20/2017. Monitoring will be done through: The facility Food Services Supervisor or Designee will conduct a visual observation to ensure that open canned food(s) covered, expired dairy product(s) are discarded, and measures were in place to prevent cross contamination i.e. Cook(s) removing dirty apron or washing hands before reaching the clean area or before removing the rack of clean dishes from the dishwasher. Monitoring will start on 10/20/2017. This will be done weekly X4, then q 2 weeks X4, then monthly X3. The Food Services Supervisor or Designee will present to the quarterly QA&A Committee quarterly meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation		

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

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F 371	Continued From page 42	F 371			
F 431 SS=E	<p>DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h)</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</p>	F 431	<p>of monitoring will be discussed during the QA&amp;A Committee quarterly meeting with the Administrator and the Assistant Administrator being responsible for compliance.</p>	10/20/17	

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F 431	<p>Continued From page 43</p> <p>professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>(h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure expired medications were not available for administration to residents, prescription medications were labeled, and controlled medications were consistently disposed of by two nurses. This was true for 2 of 11 sample residents (#4 and #8), 2 random residents (#13 and #14), and any resident for whom EpiPen or Pneumovax may be needed/ordered. The failure created the potential for harm when Resident #4's Novolog insulin was unlabeled and in use for more than 28 days after it was opened; Resident #13 and Resident #14's topical steroidal medications were expired; diversion of narcotic</p>	F 431	<p>F 431 SS=E 483.45(b)(2)(3)(g)(h)-Drug Records, Label/Store Drugs &amp; Biologicals This facility does ensure that expired medication(s) are not available for administration to residents, prescription medications are labeled, and controlled medication(s) are consistently disposed of by two nurses. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Building C medication cart: Novolog insulin for Resident #4 disposed by RN#1, pharmacy called and new</p>		

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F 431	<p>Continued From page 44</p> <p>medications when Resident #9's pain medication and antianxiety medications were not disposed of by two nurses; and the inability to respond to emergent situations requiring epinephrine when all available EpiPens were expired. Findings include:</p> <p>1. On 7/25/17 at 9:25 am, the Building C medication cart was inspected with Registered Nurse (RN) #1 in attendance and the following was observed:</p> <p>a. An unlabeled opened bottle of Novolog insulin. RN #1 said the Novolog insulin was for Resident #4 as he was the only resident in the building with orders for Novolog. The insulin bottle was marked with a faded open date of 6/1/17. The RN said the insulin was out of date and that she would procure a new bottle with a label on it.</p> <p>b. EpiPen (2 pak) - Expired May 2017. RN #1 said these were the only EpiPens in the building. She said more EpiPens were ordered 7/6/17 but had not yet arrived and that RN #2 called the pharmacy about the EpiPens on 7/16/17.</p> <p>2. On 7/26/17 at 10:15 am, the Building A medication cart was inspected with the Director of Nursing Services (DNS) in attendance and the following was observed:</p> <p>a. A tube of Hydrocortisone 1% for Resident #13, expired May 2017.</p> <p>b. A tube of Proctozone HC 2.5% for Resident #14, expired March 2017.</p> <p>The DNS said she would dispose of the expired</p>	F 431	<p>supply was provided by pharmacy, by 9/1/2017.</p> <p>(2 pak) RN#1 called the pharmacy on 07/16/17, disposed and new supply provided by the pharmacy.</p> <p>Building A medication cart: Hydrocortisone 1% for Resident #13 disposed by the DNS, pharmacy called and new supply was provided by pharmacy, by 9/1/2017. Proctozone HC 2.5% for Resident #14 disposed by the DNS, pharmacy called and new supply was provided by pharmacy, by 9/1/2017.</p> <p>Building A, regarding records of Disposition of remaining doses, of controlled medications for Resident #9, by 10/20/2017, the Director of Nurses or LN Designee will provide an in-service education to the License Nurses regarding F431, with emphasis on the importance of having 2 nurses to witness disposal of controlled medications. The two syringes of Pneumovax vaccination in the nurses' office refrigerator, disposed by the DNS, pharmacy called and new supply was provided by pharmacy, by 9/1/2017.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken: All other current residents may have the potential to be affected by this deficiency, hence; The Director of Nurses or LN Designee will conduct an inspection of Medications</p>		

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F 431	<p>Continued From page 45 medications.</p> <p>3. On 7/25/17 at 10:50 am, Building A's records of "Disposition of Remaining Doses" of controlled medications for Resident #9's Hydrocodone (analgesic) and Alprazolam (antianxiety) documented that 2 nurses did not consistently witness the disposal of medications as follows:</p> <p>Hydrocodone 5/325 tablets: * On 7/8/17 at 6:00 am, 1 tablet was administered and 50 doses were left in stock. On 7/8/17 at 11:30 pm, 1 tablet was administered but 49.5 doses were left in stock. On 7/9/17 at 7:20 am, 1 tablet was administered and 48.5 doses remained. A second nurse did not witness when the 1/2 tablet was disposed of on 7/8/17.</p> <p>* On 7/14/17 at 5:25 pm, 1/2 tablet was administered and 1/2 tablet was disposed of. Only 1 nurse signed as having disposed of the 1/2 tablet.</p> <p>* On 7/16/17 at 7:30 am, 1/2 tablet was administered and 1/2 tablet was disposed of. Only 1 nurse signed as having disposed of the 1/2 tablet.</p> <p>Alprazolam 0.5 milligram (mg) tablets: * On 7/20/17 at 12:10 am, a 1/2 tablet was disposed of. Only 1 nurse signed as disposing of the 1/2 tablet. * On 7/20/17 at 12:00 pm, a 1/2 tablet was disposed of. Only 1 nurse signed as disposing of the 1/2 tablet.</p> <p>On 7/28/17 at 10:15 am, the DNS said that 2 nurses did not consistently witness the disposal</p>	F 431	<p>carts to ensure that expired medication(s) are not available for administration to residents, prescription medications are labeled, by 10/20/2017. The Director of Nurses will review the records of Disposition of remaining doses, of controlled medications to ensure that 2 nurses are to witness disposal of controlled medications, by 10/20/2017. The Director of Nurses or LN Designee will conduct an inspection of the nurses <input type="checkbox"/> office refrigerator to ensure that expired medication(s) are not available for administration to residents, by 10/20/2017.</p> <p>Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur: To ensure that the deficiency practice does not recur, By 10/20/2017, the Director of Nurses or LN Designee will provide in-service education to the facility License Nurses regarding F431, with emphasis on making sure that that expired medication(s) are not available for administration to residents, prescription medications are labeled, and controlled medication(s) are consistently disposed of by two nurses.</p> <p>Monitoring will be done through: The Director of Nurse or LN Designee will check all resident medication to ensure that their medications in the medication carts and medications in the nurses <input type="checkbox"/> office refrigerator are unexpired.</p>		

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F 431	Continued From page 46 of Resident #12's Hydrocodone pain medication and Alprazolam antianxiety medications. 4. On 7/28/17 at 8:54 am, two syringes of Pneumovax (pneumonia vaccine) were observed with the expiration date of 5/28/17. The expired vaccines were located in the nurses' office refrigerator. When asked about the expired vaccines, RN #3 said they should not be used and the facility would order more. She did not know the last time the vaccine was administered.	F 431	The Director of Nurses will audit the records of Disposition of remaining doses, of controlled medications to ensure that 2 nurses are witnessing disposal of controlled medications Monitoring will start on 10/20/2017. This will be done weekly X4, then q 2 weeks X4, then monthly X3. The Director of Nurses or LN Designee will present to the quarterly QA&A Committee quarterly meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting with the Director of Nursing having overall responsibility for compliance.		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f)  (a) Infection prevention and control program.  The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);  (2) Written standards, policies, and procedures	F 441		10/20/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>BELL MOUNTAIN VILLAGE &amp; CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>620 NORTH SIXTH STREET BELLEVUE, ID 83313</b>		
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F 441	<p>Continued From page 47 for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p>	F 441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2017</b>
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F 441	<p>Continued From page 48</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined the facility failed to ensure staff demonstrated proper hand hygiene and resident care in a manner consistent with prevention of infection and cross-contamination. This was true for 2 of 9 sample residents (#3 and #12) observed during survey and created the potential for harm if residents were exposed to organisms from caregivers' hands and equipment not adequately cleansed. Findings include:</p> <p>1. Resident #3 was admitted on 1/16/17 with multiple diagnoses, including cerebral palsy, convulsions, and presence of a feeding tube.</p> <p>On 7/25/17 at 9:45 am, Registered Nurse (RN) #1 was observed in Resident #3's room preparing to administer medications and an enteral feeding via the resident's g-tube (gastrostomy tube - tube inserted into the abdomen). RN #1 rinsed her hands at the sink in the room, used her bare hands to turn off the faucet, dried her hands with paper towels, then donned gloves. The RN rinsed her hands at the sink in the room and turned off the faucet with her bare hands 2 more times during the medication and enteral feeding administration. When asked about the hand hygiene technique, RN #1 said</p>	F 441	<p>F 441 SS=E ¿483.80(a)(1)(2)(4)(e)(f)-Infection Control, Prevent Spread, Linens This facility does ensure that staff demonstrated proper hand hygiene and resident care in a manner consistent with prevention of infection and cross contamination. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident #3, the Registered Nurse (RN#1) provided with 1:1 in-service education by the Director of Nurses or LN Designee regarding F441, with emphasis on the importance of hand hygiene and that enteral feeding (i.e. gastrostomy tube feeding supplies) are adequately cleansed, by 10/20/2017. License Practical Nurse (LPN #2), provided with 1:1 in-service education by the Director of Nurses or LN Designee regarding F441, with emphasis on the importance of hand hygiene, by 10/20/2017.</p> <p>Identification of other residents having the same potential to be affected by the same</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2017</b>
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F 441	<p>Continued From page 49</p> <p>there was no soap at the sink in the room but there was soap at the sink in the bathroom.</p> <p>Upon completion of the medication and enteral feeding administration, RN #1 placed the supplies (enteral syringe, triangle measuring canister and feeding tube extension) directly into the sink in the room. RN #1 then went into the attached bathroom where she applied soap to her hands, returned to the sink in the room and washed her hands over the supplies in the sink. The RN rinsed off the supplies and placed them on a paper towel next to the sink.</p> <p>On 7/28/17 9:30 am, the Director of Nursing Services was informed of the issues regarding hand hygiene and cleaning of enteral feeding supplies.</p> <p>2. On 7/27/17 at 2:05 pm, Licensed Practical Nurse (LPN) #2 was observed donning examining gloves, performing a finger stick on Resident #12's left index finger, obtaining a blood sample, and assessing the resident's blood glucose (BG) level. Upon completion of the BG check, the LPN doffed the gloves then left the resident's room without performing any type of hand hygiene.</p> <p>Immediately afterward, LPN #2 returned to the nurses' station and made a phone call.</p> <p>On 7/27/17 at 2:15 pm, LPN said he did not perform hand hygiene because he was "in a hurry."</p>	F 441	<p>practice and what corrective action(s) taken:</p> <p>All other current residents may have the potential to be affected by this deficiency, hence;</p> <p>By 10/20/2017, the Director of Nursing or designee will conduct observations to ensure that Nurses demonstrated proper hand hygiene and that enteral feeding (i.e. gastrostomy tube feeding supplies) are adequately cleansed.</p> <p>Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur:</p> <p>To ensure that the deficiency practice does not recur,</p> <p>By 10/20/2017, the Director of Nurses or LN Designee will provide in-service education to the License Nurses regarding F441, with emphasis on the importance of proper hand hygiene and that enteral feeding i.e. gastrostomy tube feeding supplies are adequately cleansed.</p> <p>Monitoring will be done through:</p> <p>The Director of Nurse or LN Designee will do visual observations 3 times a week to ensure that all License Nurse(s) are practicing proper hand hygiene and that enteral feeding (i.e. gastrostomy tube feeding supplies) are adequately cleansed.</p> <p>Monitoring will start on 10/20/2017. This will be done weekly X4, then q 2 weeks X4, then monthly X3.</p> <p>The Director of Nurses or LN Designee will present to the quarterly QA&amp;A Committee quarterly meeting the findings</p>		

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

PRINTED: 11/22/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2017</b>
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F 441	Continued From page 50	F 441	and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting with the Director of Nursing having overall responsibility for compliance.		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001050</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BELL MOUNTAIN VILLAGE &amp; CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>620 NORTH SIXTH STREET BELLEVUE, ID 83313</b>
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C 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the state licensing, and complaint investigation survey conducted July 24, 2017 to July 28, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Linda Kelly, RN Cecilia Stockdill, RN</p> <p>Abbreviations:</p> <p>COO = Chief of Operations LPN = Licensed Practical Nurse mg = milligram(s) tab = tablet</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on review of Quality Assurance Performance Improvement meeting minutes and staff interview, it was determined the facility failed to ensure the Dietary, Maintenance, and Housekeeping managers participated in the facility's Infection Control Meetings at least quarterly. This failure created the potential for negative outcomes for residents, visitors, and staff in the facility related to the prevention of infections and disease. Findings included:</p> <p>On 7/28/17 at 10:00 am, the Infection Control</p>	C 664	<p>C 664-02.150,02, a Required Members of Committee This facility does ensure that Dietary Manager or Designee, Maintenance/Housekeeping Manager or Designee participate in the facility Infection Control Meetings at least quarterly. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: By 9/15/2017, the Director of Nurses or</p>	9/18/17

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
Electronically Signed

TITLE

(X6) DATE  
08/29/17

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001050</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2017</b>
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C 664	<p>Continued From page 1</p> <p>Meeting Attendance Sheet was reviewed with the COO (Chief of Operations). The COO said the facility held its Quality Assurance Performance Improvement meetings monthly and infection control was a component of those meetings.</p> <p>The COO provided attendance records, dated 1/25/17, February 2017, 5/31/17, and June 2017, that documented the Dietary Manager failed to attend any of those Infection Control Meetings, and the Maintenance and Housekeeping managers failed to attend the Infection Control Meetings on 5/31/17 and June 2017. The COO said the Housekeeping Manager was represented by the Maintenance Manager. The COO was unable to locate attendance records for the March 2017 and April 2017 meetings.</p>	C 664	<p>Designee will provide a 1:1 in-services education to the Dietary Manager, Maintenance/Housekeeping Manager regarding C664, with emphasis on the importance of participating in the facility Infection Control meetings at least quarterly and signing in in the quarterly Infection Control attendance sign-in sheet.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken: There were no residents affected by this deficiency, as the deficiency only pertains to the missed signing of the Dietary Manager and Maintenance/Housekeeping Manager on the Quarterly Infection Control Committee meetings attendance sign-in sheet.</p> <p>Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur: To ensure that the deficiency practice does not recur, By 9/15/2017, the Director of Nurses or Designee will provide an in-service education to the Infection Control Committee regarding C664, with emphasis on the importance of participating in the facility Infection Control meetings at least quarterly and signing in in the quarterly Infection Control attendance sign-in sheet.</p> <p>Monitoring will be done through: The Director of Nurse or Designee will review the quarterly Infection Control</p>	

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C 664	Continued From page 2	C 664	<p>Committee meeting attendance sheet to ensure that Infection Control Committee members participate in the facility Infection Control meetings at least quarterly and sign in, in the quarterly Infection Control attendance sign-in sheet.</p> <p>Monitoring will start on 9/15/2017. This will be done weekly X4, then q 2 weeks X4, then monthly X3.</p> <p>The Director of Nurses or Designee will present to the quarterly QA&amp;A Committee quarterly meeting the findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting with the Administrator and Director of Nursing are responsible for overall responsibility.</p>	
C 833	<p>02.201,02,g No Alteration of Original Legend</p> <p>g. No alteration or replacement of original prescription legend shall be allowed.</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined that original prescription legends were altered on medication packages for 1 of 6 residents (# 9) when the medication cart in Building 1 was inspected. The failure created the potential for harm to to residents through possible medication errors. Findings included:</p> <p>On 7/25/17 at 10:50 am, the medication cart in Building 1 was inspected with Licensed Practical Nurse (LPN) #2 present and the pharmacy label on 3 packages of Resident #9's Alprazolam 0.5</p>	C 833	<p>C 833-02.201,02,g No Alteration of Original Legend</p> <p>This facility does ensure no alteration of the original prescription legend.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: By 9/15/2017, the Director of Nurses on 07/19/17, had called the pharmacy for new labels for Resident #9 Alprazolam.</p> <p>Identification of other residents having the</p>	9/18/17

Bureau of Facility Standards

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C 833	Continued From page 3  milligrams (mg) were found to be altered. The original instructions for 1 tablet by mouth 5 times a day had a single line through it on all 3 packages. In handwriting on one package label was written, "1/2 tab [tablet] = 0.25 mg" and "dose 0.25 mg." This package was dispensed on 6/12/17. In handwriting on the other two package labels was written, "1/2 tab = 0.25 mg." Both of these packages were dispensed 7/19/17. LPN #2 said Resident #9's dose of Alprazolam was changed to a 1/2 tab "about 2 weeks ago." Later that day, the Director of Nursing Services said she had already called the pharmacy for new labels for Resident #9's Alprazolam.	C 833	<p>same potential to be affected by the same practice and what corrective action(s) taken: Other Residents in the facility may have the potential to be affected by this deficiency, hence the Director of Nurses will do a random visual check on the facility medication carts to ensure that medication(s) label (s) have no alteration of the original prescription legend, by 9/15/2017.</p> <p>Measures that will be put into place or systemic changes to ensure that the deficient practice does not recur: To ensure that the deficiency practice does not recur, By 9/15/2017, the Director of Nurses or Designee will provide an in-service education to the Licensed Nurses regarding C833, with emphasis on making sure that when there is a change in the medication instruction or dosage or frequency of administration, that pharmacy should be notified to ensure medication with appropriate label as ordered by the physician to make sure that medication(s) label (s) have no alteration of the original prescription legend</p> <p>Monitoring will be done through: The Director of Nurse or Designee will review all Residents to ensure that their medication(s) label have no alteration of the original prescription legend.</p> <p>Monitoring will start on 9/15/2017. This will be done weekly X4, then q 2 weeks</p>	

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C 833	Continued From page 4	C 833	<p>X4, then monthly X3. The Director of Nurses or Designee will present to the quarterly QA&amp;A Committee quarterly meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting with the Director of Nursing being responsible for overall compliance.</p>	



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
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September 22, 2017

Chuck Lloyd, Administrator  
Bell Mountain Village & Care Center  
620 North Sixth Street,  
Bellevue, ID 83313-5174

Provider #: 135069

Dear Mr. Lloyd:

On **July 28, 2017**, an unannounced on-site complaint survey was conducted at Bell Mountain Village & Care Center. The complaint was investigated in conjunction with the facility's on-site recertification survey conducted from July 24, 2017 to July 28, 2017.

Immediately after entering the facility on the first day of the survey, the survey team conducted a general tour of residents' rooms, bathrooms, and common areas. Throughout the survey, nine individual residents and all residents in general were observed for quality of care and quality of life concerns. In addition, facility staff were observed providing care, interacting with residents and responding to resident needs and requests.

The clinical record of the identified resident and nine other residents were reviewed for quality of care and quality of life concerns. The facility's Grievance file from July 2016 to July 2017 was reviewed. Resident Council minutes from January to July 2016 were reviewed. The facility's Maintenance logs from July 2016 to July 2017 were reviewed.

Several residents were interviewed regarding quality of care and quality of life concerns and quality of life concerns. Several nurses, Certified Nursing Assistants (CNA), and management staff were interviewed regarding quality of care and quality of life concerns. The Maintenance Supervisor, Director of Nursing, Administrator, and Chief of Operations were interviewed.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007326**

**ALLEGATION #1:**

The Reporting Party said there was an inadequate number of staff to meet residents needs.

**FINDINGS #1:**

The identified resident no longer resided in the facility at the time the complaint was investigated.

Facility staff were observed answering call lights and assisting residents in a timely manner with no concerns identified.

Nine individual residents and several residents in the Group meeting were interviewed and no concerns were identified regarding insufficient staffing. Several nurses and CNAs said they ensured residents were assisted in a timely manner to meet their needs.

Based on observation, record review, and resident and staff interview, it was determined the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.  
Allegation #2:

The reporting party was concerned the shower bench for the identified resident and all other residents were broken.

**FINDINGS:**

Several intact shower benches were observed throughout survey. Several residents interviewed did not voice any concerns regarding shower benches. Maintenance logs did not include documented concerns regarding broken shower benches.

The Administrator and Chief of Operations said there were some shower benches not properly anchored in the wall last year, but that those had been repaired. They said the facility had not encountered any problems with the shower benches for the past year.

Chuck Lloyd, Administrator  
September 22, 2017  
Page 3 of 3

Based on observation, record review, and resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The reporting party said the resident's bathroom had no heater.

FINDINGS:

Several bathrooms were observed with controls for adjusting the heat.

Several residents interviewed did not voice any concerns related to heat in their bathrooms.

The Administrator said all the bathrooms have heat in the floors.

Based on observation, record review, and resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

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

DS/lj